

THE IMPACT OF RELIGIOUS TRAUMA ON THE LGBTQ+ COMMUNITY: A
SYSTEMATIC REVIEW

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Abstract

Religious and spiritual practices have shown to be an integral part of developing positive health and mental health outcomes for many individuals; however, evidence shows that this is not the case for most LGBTQ+ individuals. Adverse religious experiences can lead to religious trauma which has significant and profound impacts on spiritual and sexual identity development, mental health outcomes, and social and family support. Trauma-informed clinical interventions have shown significant reduction of poor mental health outcomes; however, the efficacy of these interventions are undetermined in response to religious trauma. The current study involved a systematic review to determine the impact of adverse religious experiences on mental health outcomes within the LGBTQ+ community and to examine the clinical outcomes and treatment of trauma related to negative religious experiences. Of 383 articles identified and screened, 17 articles met eligibility guidelines. The current review found that the majority of LGBTQ+ individuals faced adverse religious experiences manifested by microaggressions and abuse within a religious setting, rejection based on sexual identity, conflict between religious identity and sexual identity, and extent of rejection of religious practice throughout the lifespan. The impact on mental health included increased rates of depression, anxiety, internalized sexual stigma, suicidality, substance abuse, and high-risk sexual activity. The study also determined a significant lack of research conducted to determine the outcomes of clinical treatment of religious trauma within the LGBTQ+ community.

Keywords: LGBTQ+, Religious Trauma, Mental Health

This report is a preprint of an article that has been submitted to a journal for publication. Below is a list of co-authors, in order of their contribution to the final manuscript.

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To my children, I hope you always value education, hard work, and passion the things that excite you. Stand up for what you believe in, even if you are standing alone.

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The future belongs to those who believe in the beauty of their dreams.

-Eleanor Roosevelt

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Introduction

Background

Individuals identifying as members of the LGBTQIA+ community are subject to higher rates of discrimination and oppression than cisgender individuals (Higbee M., Wright E., & Roemerma, 2020). According to the National Center for Child Traumatic Stress common forms of trauma among LGBTQIA+ individuals include parental rejection, bullying, physical and sexual harassment and hate crimes (Barba et al., n.d.). This in turn leads to higher rates of mental illness due to increased exposure to trauma and adverse experiences (Levenson, Craig, & Austin, 2021). This is partly due to societal stigma and prejudice (Winell, 2008), which can include religious practices and cultures. Although there is a lack of literature studying the impact of religious culture on trauma in the LGBTQIA+ community, there are multiple studies that examine the relationship among sexual identity and orientation and trauma experiences (Parra & Hastings, 2018, Travers et al., 2020, The National Council, 2021, Roberts et al., 2012, Dentato, 2018). There has also been literature published related to harmful clinical practices, such as conversion therapies and sexual orientation change efforts, which have been and continue to be supported by certain religious communities and are related to clinical treatment and sexual orientation and identity (Dessel et al., 2017).

Problem Statement

Given the intersectionality of sexual minority identity and the impact that negative religious experiences within this community has on mental health outcomes, there is a growing need to further explore the assessment, prevalence, and treatment of this phenomenon.

Therefore, attention to this issue needs to be woven within advocacy efforts within the social

work community, throughout all levels of practice. As clinical social workers, we have an ethical and clinical obligation to provide safe and affirming treatment for LGBTQIA+ individuals (NASW, 2012). This includes creating an environment throughout all levels of social work practice that is free of judgement, ridicule, and discrimination. As practitioners, we must be able to critically assess and identify factors that contribute to traumatic experiences by utilizing evidence-based practices. Without asking these questions, it is impossible for clinicians to validate, understand, and affirm the persons who endure these traumatic experiences. This directly impacts treatment outcomes and development of further evidence-based practices. Stone (2013) indicates that there is little information on spirituality's impact on mental health when it is used to bypass problems, feelings, and needs. Academic pursuit is incumbent on clear and concise descriptions and rigorous testing, which can be difficult given the lack of definition in the terms religiosity and spirituality as it contributes to negative experiences in the LGBTQIA+ population.

Another indication for further awareness includes the intersection of cultural competency and clinical implications of trauma. For example, practitioners may not be aware of the unique challenges faced by LGBTQ individuals and how this impacts their coping mechanisms and mental health outcomes. Another important aspect of educational need as related to cultural competence is that while some religious organizations have shifted their view of sexual identity as accepting and affirming, others continue to view homosexuality and non-cisgender relationships as immoral and sinful (APA, 2009). Practitioners should be aware that while the professional psychological community considers same-sex attractions and behaviors to be a positive variant of sexuality, some traditional faiths continue to consider it a disorder that needs to be changed (APA, 2009). While some religious perspectives and values can give way to the

development of personal identity and awareness, others are more rigid cause individuals to experience internal and external conflict between their ideal self and their sexual needs and desires (Lefevor et al., 2020). In 2008, the APA recognized two types of prejudice related to religion: one derived from religious beliefs and another directed at religions and their adherents, today they condemn both (APA, 2009). Religious trauma is more prevalent than research suggests and despite the historical and sociopolitical impact it has on LGBTQ+ individuals, it remains to be further defined and studied in the population.

Historically, researchers have studied ways in which religious identity and practices can be used to respond to and treat adverse experiences and trauma (Knapp, 2021). However, there continues to be a dearth of information that examines the relationship between religious trauma and mental health outcomes as a result of adverse spiritual experiences, especially within the LGBTQ+ community. There is also little known about the clinical assessment, diagnosis, and treatment of religious trauma.

Literature Review

Religiosity Among LGBTQ+ Individuals

The U.S. Census Bureau found that approximately 8% of adults ages 18-25 openly identify as lesbian, gay, or bisexual (LGB) and further estimated that another 2% identify as a sexual orientation other than LGB or heterosexual (2021). As a demographic, 48% of lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults reported being religiously unaffiliated. However, 51% of LGBTQ individuals did report a religious affiliation with 42% of these individuals identifying as Christian, 27% Protestant, 14% Catholic, and 1% as some other Christian faith. LGBT youths are less likely than LGBT adults to ascribe to a religious

affiliation, and LGBT adults in the south (57%) are more likely than LGBT adults in the northeast (41%) to identify as religious. Lesbian individuals were most likely to ascribe importance to faith (56%), followed by bisexual persons (40% overall, 42% bisexual women), and lastly gay men (39%) (Pew Research Center, 2021).

The LGBTQ+ community has long represented a source of conflict to some within the Christian community who, in many doctrines view same-sex sexual behavior and cross-gender identification as expressions of immorality and a departure from biblical and Christian values (Wood & Conley, 2013). Research also indicates that 33% of religious LGBT adults experience conflict between their beliefs and sexual orientation (Pew Research Center, 2021). While mainstream LGBTQ+ culture may not always be a safe place for queer people of faith, conservative branches of the church have been experienced as places that may contribute to distress, so much so that jettisoning one's faith may be viewed as an adaptive choice when faced with the tension and minority stress found in balancing faith and sexual minority identities (Rostosky & Riggle, 2017). However, many sexual minorities choose to retain their faith identities, affiliations, and practices even in these more conventionally religious spaces (Super & Jacobson, 2011). Despite a growing literature on the experiences of sexual minority Christians, limited research appears to focus on the damage inflicted in religious settings on the emotional, physical, and spiritual well-being of these individuals, and the hardiness of this demographic to stay committed to their faith despite the struggle they may internally feel (Mosher et al., 2019).

Perceptions of LGBTQ+ Within Religious Communities

According to a Pew Research Center survey conducted in September 2020, a sampling of 34 different countries yielded that religiously unaffiliated people are more accepting of homosexuality and sexual minorities. Another study completed by the Pew Research Center

(June 2020), indicated that globally, there has been a rise in overall acceptance of homosexuality in the past two decades; however, there is still an overall divide amongst many countries.

Various factors contribute to this divide including the economic development, religious, and political views of the country overall. In the United States, social acceptance of homosexuality grew from 49% in 2007 to 72% in 2020 (Pew Research Center, June 2020).

A pivotal issue among religious practices and discrimination within the lesbian, gay and bisexual community has been the decision to approve same-sex marriage. In the landmark case of *Obergefell v. Hodges* (2015), the U.S. Supreme Court legalized same-sex marriage. This decision created significant and groundbreaking success within social justice and advocacy movements for members of the LGB community; however, it also caused further dissent within many religious communities. In addition, the Public Religious Research Institute found that Americans who stated that their sexual identity was very important only 37% agreed that religious diversity is also important within the U.S. (PRRI, 2021).

In 2015, NASW released a national position statement in response to sexual orientation change efforts (SOCE) and conversion therapy in the LGBT community. These approaches include any practice seeking to change a person's sexual orientation, including, but not limited to, efforts to change behaviors, gender identity, or gender expressions, or to reduce or eliminate sexual or romantic attractions or feelings toward a person of the same gender (Ashley, 2020). Within the NASW position statement, SOCE includes any form of reparative therapy, conversion therapy, and/or transformational ministries that use interventions claiming to "repair" or "convert" a person to reduce or eliminate a person's sexual desire for a member of his or her own gender. The use of SOCE can include use of psychotherapy, medical approaches, aversion therapy, religious and spiritual approaches (Kinitz et al., 2021). There are no studies of adequate

scientific rigor to conclude whether SOCE or conversion therapy can modify or change sexual orientation or gender identity or expression (APA, 2009).

Since 2015, several studies have been conducted denouncing the use of sexual orientation change efforts within the medical and psychological community (Kinitz et al., 2021, Ashely, 2020, Higbee, Wright, & Roemeran, 2020); however, few continue to exist in response to the transformational ministries and religious or spiritual approaches. In 2020, the Human Rights Committee (HRC) deemed those practices of “conversion therapy” provoke profound psychological and physical damage in lesbian, gay, bisexual, trans or gender-diverse persons of all ages, in all regions of the world (HRC, 2020). Following this global call to action, the responsibility fell to individual states to enforce a ban on all types of conversion therapy including religious and spiritual practices. To date, many states in the U.S. have adopted legislation and policies to protect the rights of LGBTQ+ individuals; however, Alabama continues to fail to have any policies in place admonishing the practices of conversion therapy (Movement Advancement Project, 2021). The World Professional Association for Transgender Health (WPATH) developed a standard of care to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, to maximize their overall health, psychological well-being, and self-fulfillment (WPATH, 2012). WPATH recognized the importance in assessment, cultural considerations, and equity in further developing affirming interventions and sociopolitical changes to improve the overall health of transgender individuals.

According to the APA (2009), religious trauma leads to harmful outcomes and a dichotomous identity that may increase mental illness. Griffith (2010) posits that religious belief

systems are powerful social systems that tend to categorize human nature into good and bad sectors which promote the development of a rigid false self. These rigid belief systems, especially in relation to the self can lead to various symptoms of mental illness including anxiety, depression, and development of personality disorders (Stone, 2013). Many dogmatic religious practices teach individuals to filter their emotions and thoughts through a lens in which negative emotions are unacceptable or immature, focusing only on maintaining positive thoughts and feelings (Winell, 2008). This in turn creates an incapability to express or cope with negative emotions, resulting in an increase in negative emotions such as fear, shame, and self-loathing (Travers et al., 2020). In the LGBTQ+ community, this is exacerbated by the rejection of their identity. This can lead to even more significant mental health symptoms including suicidal thoughts and rejection of self (NAMI, 2021).

According to the National Alliance of Mental Illness or NAMI (2021), lesbian, gay, and bisexual individuals are twice as likely to experience mental health conditions than cisgender individuals. Transgender individuals are 43% more likely to attempt suicide in their lifetime according to NAMI (2021). The number of Americans who identify as LGBTQ has grown from 3.5% to 4.5% from 2012-2019 (LGBT Demographic Data Interactive, 2019). Therefore, social workers and other healthcare professionals may be treating more LGBTQIA+ individuals in their practice settings than in previous years. Another risk factor for increased mental health concerns is that members of the LGBTQIA+ community face many forms of discrimination including labeling, stereotyping, denial of opportunities or access to care as well as verbal, mental and physical abuse (NAMI, 2021). The process of revealing one's sexual identity to others or "coming out" can be particularly traumatic and result in rejection from their family, friends, and faith community (Hallman, Yarhouse, and Suarez, 2018).

The National Center for Education Statistics or NCES (2022) report that in 2019, approximately 50 million students were enrolled in public schools in the U.S. and 5 million students attended private schools. Of these private schools, 59% identified as having a religiously affiliated curriculum. In addition, the U.S. Department of Education states, there are over 7,000 colleges and universities that report a religious affiliation (NCES, 2022). According to a 2019 national school climate survey (Kosciw, Clark, Truong, & Zongrone, 2020), 86% of LGBTQ+ youth reported being harassed or assaulted at school. This report also concluded that LGBTQ public school students were most likely to hear homophobic remarks at school and experienced the greatest levels of gender-based victimization, whereas those in religious schools were most likely to hear negative remarks about gender expression. Inclusive and supportive climates can serve as a protective factor in mental health outcomes (Levenson, Craig, & Austin, 2021); however, individuals also often meet other challenges outside of these supportive realms (The National Council, 2021). In a 2015 U.S. transgender survey completed by the National Center for Transgender Equality, 1 in 5 individuals reported being rejected from a faith community, and 40% report leaving their faith community for fear of rejection based on their sexual identity (James et al., 2016). Further, the Trump administration has worked to expand religious exemptions from federal civil rights laws, which negates the protections offered through Title IX policy for all students including those who identify as LGBTQ+ (U.S. Department of Education, 2021). Such exemptions allow private religious schools to discriminate against students and teachers based on their sexual orientation or gender identity without any legal consequences. Although the Trump Administration has attempted to block civil rights from the LGBTQ community, in February 2021 The Equality Act (H.R.5 - 117th Congress 2021-2022), was passed by the U.S. Senate. This bill prohibits discrimination based on

sex, sexual orientation, and gender identity in areas including public accommodations and facilities, education, federal funding, employment, housing, credit, and the jury system. Specifically, the bill defines and includes sex, sexual orientation, and gender identity among the prohibited categories of discrimination or segregation.

One impact of family and community rejection is the increased number of LGBTQ+ individuals, including youth who experience homelessness (The Trevor Project, 2021). Often community faith-based organizations serve to aid individuals needing charitable and other services. However, if these organizations reject or deem an individual's identity as "sinful or amoral" they may refuse to provide aid for these individuals, or the individuals may not feel that they can receive such services based off this knowledge. Individuals who have survived religious trauma may also be less likely to accept aid from faith-based organizations because of their traumatic experiences associated with a faith-based organization (Stone, 2013). Religious trauma shares many symptoms with posttraumatic stress disorder including avoiding any stimuli that are reminiscent of the trauma which often translates to avoiding any religious environments (Stone, 2013). In addition, Mosher et al., (2019) found that cultural arrogance in religious communities could lead to increased minority stress and pose a threat to the well-being of sexual minorities.

Documented cases of rejection from services such as housing, counseling, adoption, childcare services, religious/spiritual traditions such as marriage, etc. have served as a historical basis for policy changes and advocacy for decades. According to a 2019 report from the Center for Law and Social Policy (CLASP), the number of faith-based daycares in Alabama is three times the national average. According to CLASP in 1983, the Alabama approved an exemption for faith-based childcare programs from childcare licensing requirements. Notably, some

childcare programs operated by religious institutions are licensed and regulated, and there are other, non-faith-based license-exempt childcare providers in the state, but faith-based programs are the lion's share of Alabama's license-exempt childcare providers. The availability of non-faith based childcare options can decrease exponentially given the geographical location within the state and are usually non-existent in more rural areas (Alabama Department of Human Resources, 2021).

Although there are many services offered to respond to the needs of individuals who require housing assistance, mental health, and substance abuse treatment; many of these may also be rooted in faith-based practices. Serving clients with diverse religious and spiritual belief systems may prove to be difficult in geographic areas in which certain doctrines are most widespread. For example, in the southern United States, the most prominent religious group is Southern Baptist, with over 3,300 churches dominating 65 of the 67 counties in Alabama alone (Association of Statisticians of American Religious Bodies, 2010). This has undeniable impact on public and private services in this geographic region, especially given that the southern Baptist faith and message publicly continues to encourage members of the faith to denounce any form of homosexuality (Southern Baptist Church, 2021). Therefore, services that are provided in association with specific doctrines who discriminate against the LGBTQ community are less likely to be utilized by this population (Dessel et al., 2017). In the past year, nearly half of LGBTQ youth have wanted counseling from a mental health professional, but did not receive it (The Trevor Project, 2021).

Social workers shall be change agents who demonstrate the leadership skills to work effectively with multicultural groups in agencies, organizational settings, and communities (NASW, 2015). Social workers should also demonstrate responsibility for advancing cultural

competence within and beyond their organizations, helping to challenge structural and institutional oppression and build and sustain diverse and inclusive institutions and communities (NASW Cultural Standards, 2015).

Religious Trauma

There has been an increasing interest in the impact of spirituality and religion in social work practices, including how religious and spiritual mechanisms can improve the quality of life for individuals who have experienced trauma (Kerry, 2009). For many people, spirituality and religious practices can have positive outcomes and aid in overcoming trauma experiences (Ginicola, Filmore, and Stokes, 2017). However, some individuals experience trauma within their sphere of religious practice and theological beliefs, perspectives, and teachings. While there have been extensive studies completed on how to utilize positive religious and spiritual practices in the treatment of mental health, few have analyzed how adverse religious experiences can be a root cause for trauma and intensify mental health problems (Stone, 2013, Darmansjah, Kalra, & Ventriglio, 2019, Krause, Pargament, & Ironson, 2017). This can be especially true for minority sexual groups who are often, by the nature of the theological teachings, shunned from or discriminated against in many religious communities (Darmansjah, Kalra, and Ventriglio, 2019).

Spirituality has been described as acceptance and “loving kindness” (McCann, Donohue, & Timmins, 2020). In fact, this is a skill taught as part of dialectical behavioral therapy to increase interpersonal effectiveness and emotional regulation (Linehan, 2015). Spirituality also includes the connection found between the universe, environment, or even a divine being (Groen, Coholic, & Graham, 2012). It is important to distinguish between religiosity and spirituality when examining constructs as they are often interchanged in terminology. Religiosity refers to

structured practice of a specific doctrine or set of beliefs related to an individual's religious affiliation and devoutness (Kucharska, 2018).

Religious communities have often served as a place of refuge for marginalized groups, which has played an important role in promoting positive health despite discrimination (Walker & Longmire-Avital, 2013). In the context of racial discrimination, the identities of race/ethnicity and religious/spirituality overlap or tend to be congruent (Mosher, 2019). For sexual minorities living within religious communities with a conservative sexual ethic, one's sexual attraction and desires conflict directly with the religious teachings of appropriate sexual expression which can lead to problems with mental health (Barnes & Meyer, 2012; Page et al., 2013). In addition to the stress of discrimination, LGB members within a non-affirming community may also have difficulty or lose access to positive coping resources that once served as a source of resilience (Koenig, 2012).

Furthermore, spiritual struggles have been linked with existential distress, negative health outcomes, and risk of disruptive changes in religiosity which may lead to negative coping and unresolved trauma (Mosher, 2019). In a 2013 Pew Research Center survey of 1,197 individuals who identified as LGBT+, individuals ranked the following religious groups as unfriendly toward LGBT+ individuals: Muslim religion (84%), Mormon church (83%), Catholic church (79%), Evangelical Christian (73%), Jewish (47%), and non-evangelical Christians (44%) respectively. This also corresponds to the institutions beliefs and theologies that the respective groups hold in response to same-sex marriage policies.

Religious institutions and practices can also include fundamentalist, patriarchal, legalistic, and abusive systems (Nason-Clark, 2000). This includes tribalistic and isolating points of view that often include an imbalance of power and control within the system (Bohall,

Bautista, Musson, 2016). Categories of religious power and control include loss of autonomy, isolation, minimizing, denying, blaming, emotional abuse, spiritual abuse, sexuality and gender defining, economic control and threats, accusations, and intimidation (Anderson, 2019).

There is a cycle of abuse that occurs within religious settings that includes adverse events which leads to trauma experiences. This is similar to the cycle of abuse within a domestic violence relationship. The cycle of abuse includes the tension building phase, explosion phase and then the honeymoon and recommitment phase (Bohall, Bautista, & Musson, 2016).

Anderson (2019) explains that within religious abuse cycles the tension building phase includes a decreased tolerance for not learning or applying religious teachings, increased rule following that is expected, decreased explanations for why things are done (referring to a higher power, scripture, or religious leader), focus on decreased reasoning and logic, decreased sense of self and villainizing critical thinking skills – what to think vs. how to think. The tension building phase also includes increase submission to authority and increase to shame and self-blame when religious protocols are not followed. Increased requirements of compliance with the group and an increased dependence on external authorities which can lead to a decreased sense of self and increased self-doubt.

Anderson (2019) also states that as these tensions build, an individual will inevitably experience an explosion. This is a period in which the stressors overflow. Some examples may include punishment for sins or behavior, threats of excommunication, removal from the religious group or system, or public humiliation. Forcing individuals to take responsibility for abuse inflicted upon them. This can also include physical and/or sexual violence.

Following the explosion phase, the reconciliation phase includes a period of the person of authority repenting for the acts that were taken against the individual. There may be repentance

on both parts and apologies for abusive behavior. There can also be placating statements and promises of restoration of relationships as well as a focus on the positive aspect of the relationship. There is also a strong focus on recommitment to the belief that the religious establishment knows what is best. This can loop the individual back into the cycle. This honeymoon phase can make it difficult for the individual to leave the relationship and dynamic of abuse. There are seven main reasons that individuals stay in the cycle of abuse. This is not primarily resulting in choice, but the dynamic of power and control over the individual. Getting out of the cycle of abuse is more accurately defined as what is the frequency and severity of control in the following areas of the relationship (RTI, 2022): a) brainwashing and indoctrination b) hopes, dreams, and possibilities c) denial d) fear and terror e) family, friends, and relationships, f) love and g) cultural views of religion. This is synchronous with the results found in the literature review.

Experiencing adverse religious events is not an automatic designation for religious trauma. Trauma is subjective, perceptive, subconscious, and embodied (Van der Kolk, 2014). Individuals can exist in the same environment and have vastly different experiences and reactions to the environment. This is how adverse religious experiences can translate into trauma. For an individual to feel safe and secure in their environment they need to have a strong sense of autonomy (Trentini et al., 2015). The inability to establish and maintain safe and healthy boundaries, a strong sense of autonomy, and a strong sense of self can then inform trauma experiences.

Religious trauma is defined as the physical, emotional, or psychological response to religious beliefs, practices, or structures that overwhelm an individual's ability to cope and return to a sense of safety (The Religious Trauma Institute, 2022). Adverse religious experiences are

any experiences of a religious belief, practice, or structure that undermines an individual's sense of safety or autonomy and/or negatively impacts their physical, social, emotional, relational, or psychological well-being (Stone, 2013).

Stone (2013) also suggests that religious trauma is often a contributing factor to many of the problems that bring individuals to therapy including depression, anxiety, and poor interpersonal relationships. A unique component of religious trauma includes the pervasive exposure to traumatic events and distressing messages that undermine positive mental health. Many individuals may be born into belief systems within their families and religious communities that are inundated with homonegative messages that impact healthy identity development (Winell, 2008).

Children who are exposed to multiple adverse experiences in life exhibit neurological, cognitive, emotional, and physical deficits in development (McCullough and Mathura, 2019). Brain development begins before birth and continues to evolve throughout life with a bottom-up approach (Van der Kolk, 2014). This vertical organization begins with the brainstem then moves to the midbrain, limbic, and finally cortical areas (Carter et al., 2019). The brain's systems also go through critical periods of development in which massive amounts of growth occur (Doidge, 2007) which is important to understand when considering effective evidence-based interventions.

In order to better formulate interventions for all areas of practice (macro, mezzo, and micro) social workers must understand the impact trauma has the brain and during which developmental periods the trauma occurs. Several studies have indicated the negative impact that trauma has on the brain (Delima and Vimpani, 2011; Perry, 2009; Long et al., 2020; Jenness et al, 2020). If trauma goes untreated, further damages in brain function occurs which impacts

various aspects of life including healthy attachment and positive peer relationships, learning disabilities, physical health, and emotional regulation (Delima and Vimpani, 2011). The brain and body hold the scars of trauma in forms of deactivation of neuronal connections (Van der Kolk, 2014) which continues to impact individuals later in life and may lead to intergenerational contributions to maltreatment and psychopathology. The literature depicts the importance of early detection and intervention in prognosis and recovery from trauma (Nelson and Gabard-Durnam, 2020).

Clinical social workers should recognize that identifying religious trauma is not about discussing doctrines or the abusive behavior; instead focusing on acknowledging the individual's responses to the experience and processing through these trauma responses. The physiological response to the event and experience is the focus. This physiological response continues to live within the body (Van der Kolk, 2014).

Trauma lives within the nervous system. An individual cannot simply think their way out of trauma because trauma exists within the nervous system. Survivors of trauma and abuse often feel stuck cognitively and experience intrusive thoughts, memories of the event, and persistent negative emotions. Polyvagal theory and evolutionary development – sense of safety, and security, no threats, calmness. Humans evolved to feel safe in social situations. Most individuals feel safe and secure in social settings and situations and most people respond to religious settings in the positive way. However, survivors of religious trauma have negative responses within the social realm of religious environments. They experience a “fight or flight” response, in which scanning the environment for threats is necessary. Once the threat is effectively neutralized, a sense of safety is resumed. However, if the system or circumstances are too big and powerful and it is unsafe to fight or run, the neurological response is different. The physiological response

is a freeze or collapse response. The brain releases cortisol and shuts down higher level functions (Carter et al., 2019). This leads to a persistent feeling of helplessness and powerlessness because the individual was not able to respond to protect themselves (Delima & Vimpani, 2011).

Mirror neurons located in the premotor cortex, Broca's area, and parietal lobe are integral for early emotional, motor, and language development (Carter et al., 2019). Trauma occurring during the development of early mirror neurons can stunt this development (Doidge, 2015). Teaching positive parenting interactions creates a feeling of safety and attachment and stimulates healthy development including the release of oxytocin and dopamine in the brain, reinforcing the experience and creating a "wanting" effect (Long et al., 2020). This can also be seen in evidence of extreme neglect in which children are shunned or isolated from developing appropriate attachments. Often LGBT+ youth experience this type of neglect within family systems, organized activities such as schools, and religious institutions (Gibbs & Goldbach, 2015). This may be a neurological basis for the increased rates of depression, anxiety, and increased risk of suicidal ideation among LGBT+ youth.

Theoretical Framework for Understanding Religious Trauma

The premise of minority stress theory states that those with a stigmatized social identity may experience stressors relative to that identity, above and beyond the general stressors experienced by all individuals and that being exposed to these stressors over time results in a lifetime of harassment, maltreatment, discrimination, and victimization (Meyer, 2003). Minority stress theory also proposes that health disparities are the product of distal and proximal stressors experienced disproportionately by minority groups (Lefevor, Boyd-Rogers, Sprague, & Janis, 2019). Distal stressors include prejudicious events such as discrimination and violence based on

minority status while proximal stressors include expectations of rejection, concealment of sexual identity, and internalized homophobia (Meyer, 2015).

This may perpetuate fear and an increase in concealment of sexual identity among some members of the LGBTQ community. Furthermore, prior research suggests that concealment of sexual identity may lead to poor mental health outcomes including but not limited to depression, anxiety, and PTSD (Riggle, Rostosky, Black, & Rosenkrantz, 2017). Holding two or more stigmatized identities (Latina, lesbian, female) places an individual at increased risk for prejudice and discrimination in both a majority and minority role, therefore exacerbating the amount of stress incurred (Dentato, 2018).

Meyer (2003, 2015) also proposes that there is an intersectionality to minority stress. This includes how stress processes attenuate coping processes and negatively impact mental health outcomes. Research has shown that positive structural interventions can improve coping processes, which have a positive impact on mental health outcomes (Woodford et al, 2018). There is support by social service and healthcare providers for further study of discrimination faced by LGBTQ individuals and how to reduce health disparities (Logie & Lys, 2015). Support from religious organizations may be helpful in challenging proximal and distal stressors. However, non-affirming societal beliefs around same-sex intimacy or gender identity can exacerbate minority stress and internalized homophobia (Meyer, 2003; Rostosky and Riggle, 2017).

The term intersectionality was first coined by activist Kimberle Crenshaw in a Harvard Law Review article exposing disparities based on race and gender pertaining to sociopolitical and legal oppression (Crenshaw, 1988). Intersectionality theory is reinforced by critical race

theory and social systems theory, emphasizing human behavior in the social environments (Carbado, Crenshaw, Mays, & Tomlinson, 2013). Thus, intersectionality perspective provides a comprehensive approach with a commitment to social justice and captures transactions in the person in environment configuration that form the common base for social work knowledge and practice (NASW, 2015). Intersectionality is an analytic framework that addresses how interlocking systems of power impact those who are most marginalized in society and addresses issues of discrimination ranging from gender, race, religion, gender identity, sexual orientation, and other identities (Reynolds, 2010). Since inception, intersectionality theory has also come to encompass other marginalized groups such as LGBTQIA+ individuals (Parra & Hastings, 2018).

Intersectionality theory (grounded in a feminist perspective) examines forms of oppression, discrimination, and domination as they manifest themselves through diversity components (Crenshaw, 1988). These diversity components include such multiple identities as race and ethnicity, immigration, refugee and tribal status, religion and spirituality, sexual orientation, gender identity and expression, social class, and mental or physical disabilities. An intersectionality approach to social work practice at the micro, mezzo, and macro levels includes integrating the various diversity components and identities and approaching practice from a holistic point of view.

Coupling this intersectional approach with transformational learning theory can help further develop a multifaceted and multicultural approach to learning how to apply social work knowledge to practice settings. Exposure to topics of diversity, equity, and inclusion (DEI) is a key component in social work education (Philip & Reisch, 2015). Perez, Robbins, Harris, & Montgomery (2020) found that many fields of graduate study do not offer courses in DEI topics

or address diversity, equity, and inclusion in their curriculum. Therefore, leaving social workers underprepared.

Mezirow introduced the concept of Transformative Learning Theory (TLT) in 1978, a teaching approach based on promoting change and challenging learners to “critically question and assess the integrity of their deeply held assumptions about how they relate to the world around them” (Balestrery, 2016). Mezirow sums up his understanding of transformative learning as “the process by which we transform problematic frames of reference (mind-sets, habits of mind, meaning perspectives) - sets of assumptions and expectations - to make them more inclusive, discriminating, open, reflective, and emotionally able to change” (Mezirow, 2009, p.92). Viewing the impact of religion and spirituality on the lives of LGBTQ+ individuals through a transformative lens may help social workers improve micro, mezzo, and macro practice and better respond to the needs of the LGBTQ community.

Transformative learning incorporates three core elements: the role of critical reflection, the role of dialogue, and the role of individual experience (Mezirow & Taylor, 2011). Schnepfleitner and Ferreira (2021) also propose a fourth element to consider in transformative learning: the role of context. According to Western Governors University (2021), transformative learning includes applying critical thinking skills with the ability to recognize, examine, and assess assumptions and beliefs about a dilemma and then develop knowledge to plan an alternative course of action to the dilemma.

Pittman and Gioia (2020) found that transformative learning experiences can help develop skills in all nine of the competencies outlined by the CSWE and can be particularly impactful in demonstrating professional identity and behavior, increasing awareness and

appreciation of difference, and understanding the global interconnections of oppression and human rights violations. Applying this lens through social work education and training in religious trauma for the LGBTQIA+ population can narrow the disparities among awareness, education gaps, and practice implications.

Educational interventions should be applied to all levels of practice through critical thinking (Bransford, 2011). At an organizational level, policy advocacy is needed to identify states that have no policies or protections in place and change discriminatory policies impacting the LGBTQIA+ community. Social workers can work with affirming religious organizations, advocating for social reform, assessing for religious trauma, and developing interventions to help develop healthy spaces to heal through transformative learning. Most of the LGBTQ youth polled in 2015 did not identify as religious (James et al., 2016) In fact, in over 16,600 respondents, 67% had no religious affiliation, identified as atheist or agnostic while only 12% identified as Christian. Clinicians who are aware of these intersections can then provide education at all levels of practice.

Project Rationale and Aim

Social work practice is built atop a foundation of professional values including ethical principles and standards that uphold the core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW Code of Ethics, 2022). According to the professional code of ethics, a social worker's primary goal is to help people in need and address social problems. Oppressive treatment of sexual minorities has been well documented throughout the past few decades (Sadika et al., 2020, Garcia-Perez, 2020, Saraff et al., 2022); however, recent political and social tensions have brought these issues to the

forefront of social justice movements. Ethically, social workers are to pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people (NASW Code of Ethics, 2022). Understanding the mechanisms of injustice toward a particular vulnerable population such as individuals who identify as lesbian (L), gay (G), bisexual (B) or transgender (T) is important to develop evidence-based practices and ethical standards of care. Other sexual identifiers will be cited within the literature and can include queer/questioning (Q), intersex (I), asexual (A), and other non-specified identities (+). Therein lies a responsibility to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity.

There is a litany of research that outlines a scoping health crisis among individuals who identify as lesbian, gay, bisexual, and transgender (LGBT). According to the Centers for Disease Control and Prevention (CDC) LGBT+ youth are twice as likely as peers to use illegal drugs, 47% have seriously contemplated suicide, and 16% have experienced sexual dating violence (CDC, 2022). The potential dissonance between sexual identity and behavior and the social rejection sexual minority youths often experience can contribute to increased suicidal ideation and behaviors along with an increased risk for suicide (Ivey-Stephenson et al., 2020). This study also concluded that prevalence estimates of suicidal ideation, suicide plans, attempts, and attempts requiring medical treatment were highest among sexual minority youths and youths who reported having had sexual contact with the same or with both sexes. The CDC also acknowledges that data has not been specified for transgender, queer/questioning, and other sexual minority identities. LGBT+ youth are also at an increased risk for homelessness (NAMI, 2021).

It is also important to note increased stressors to the LGBTQ+ community during the global pandemic caused by COVID-19. In March 2020 the United Nations issued a statement

concluding that COVID-19 has a disproportionate impact on LGBTQ+ persons; that, with few exceptions, the response to the pandemic reproduces and exacerbates the patterns of social exclusion and violence already identified resulting in an urgent call for policies to be put into place to prevent further discrimination against LGBTQ+ individuals during the pandemic. In June 2020, the UN released ASPIRE guidelines to increase response and recovery for LGBTQ+ individuals. The United States Census Bureau launched the Household Pulse Survey (HPS) in response to the challenges presented during COVID-19 with accurate data collection. In July 2021, The USCB began collecting data related to sexual orientation and gender identity from respondents and found that individuals who identified as LGBTQ+ experienced nearly doubled the rates of food insecurity, loss of income or employment, depression, and anxiety than non-LGBTQ+ respondents during the COVID-19 pandemic.

Methodology

The purpose of this review is to synthesize current evidence regarding the experiences of LGBTQ+ individuals regarding adverse religious/spiritual experiences and/or religious trauma and how these experiences impact social work practice. The research questions presented for this review are:

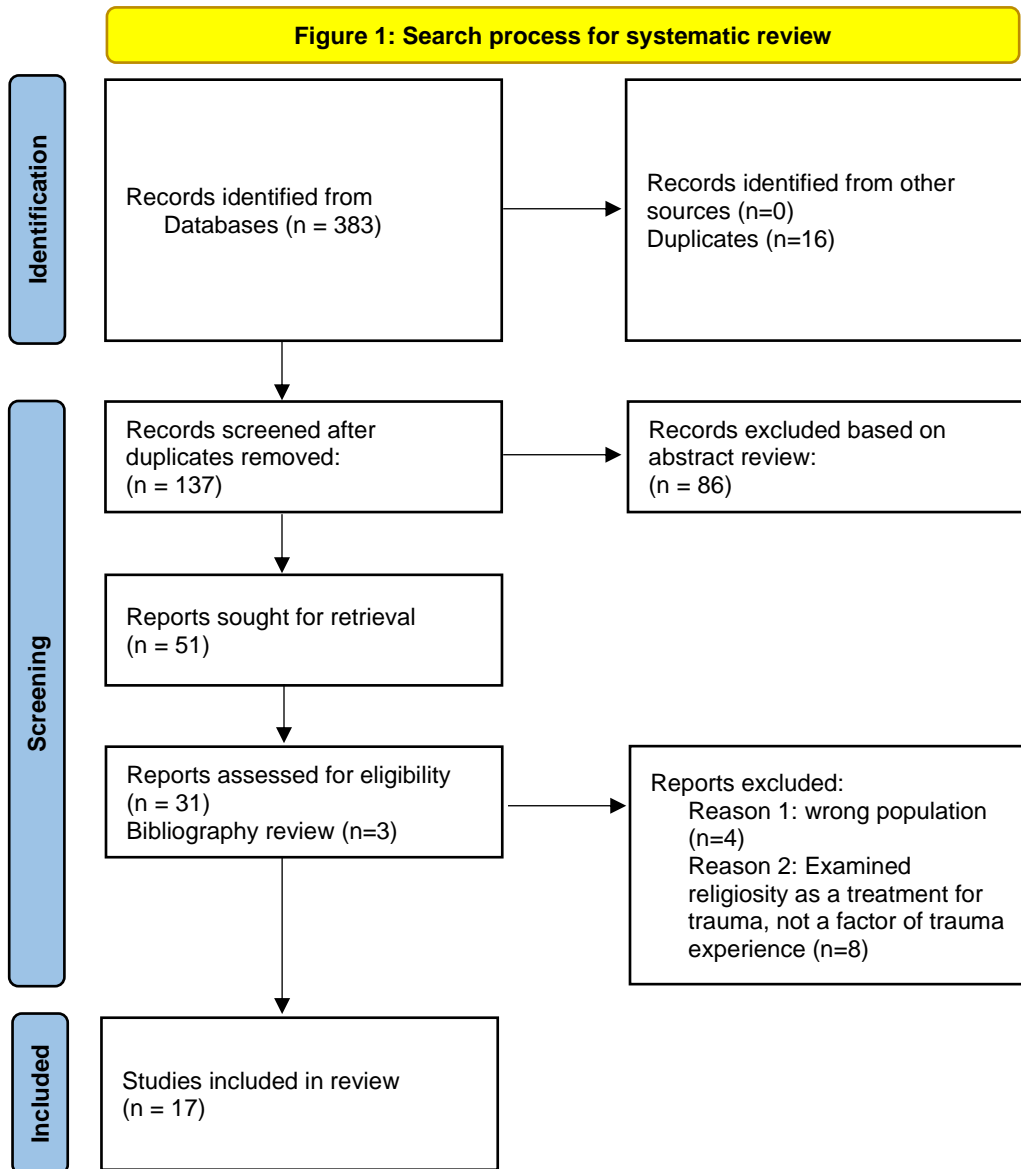
1. What is the reported relationship between adverse religious/spiritual experiences and mental health outcomes in the LGBTQ+ community?
2. What are the implications for clinical assessment, diagnosis, and treatment of religious trauma based on the mental health needs and experiences of LGBTQ+ individuals?

Data Analysis

Data analysis utilized a PICO (Population, Intervention, Comparison, and Outcomes) framework to develop and outline the research questions for data collection and review. PICO framework includes population, intervention, comparator, and outcome criteria. Inclusion and exclusion criteria were then defined according to the research questions. Studies were then selected that met inclusion criteria as outlined. The articles were then critically analyzed to assess for bias.

Search and Selection Process

Databases were chosen based on subject material related to LGBTQ+ issues, medical information, psychiatric and mental health specialty, social sciences, and religion/spiritual practices. Specific databases used for the search included Academic Search Premier, APA PsychINFO, Encyclopedia of Social Work, JSTOR, GenderWatch, LGBT Life, SocINDEX, Project MUSE, Social Services Abstracts, and Sociological Abstracts. The search terms and keywords used to identify religious and spiritual domains were religious trauma OR spiritual abuse OR adverse spiritual experiences OR adverse religious experiences OR spirit* abuse OR spiritual trauma. Those domains were coupled using AND with sexual minority OR gay OR lesbian OR bisexual OR LGBT OR LGBTQ OR LGBTQIA+, OR Trans* OR Transgender. The domain for mental health included searching AND mental health OR psychological OR mental health outcomes. Inclusivity date timelines included peer reviewed articles from 2012-2022 in English language. An electronic database was maintained using Zotero software. A flowchart was created (Figure 1) utilizing the PRISMA guidelines for conducting systematic reviews adapted from Page et al (2020).



Eligibility Criteria

Articles were examined for eligibility within marked parameters of a) population, any inclusion of LGBTQIA+ b) adverse religious experiences, and c) mental health outcomes based on specified religious experiences d) peer-reviewed research articles written in English between 2012-2022. The reviewer did not restrict research based on geographical location. Age was not

included in exclusion criteria of subjects, as individuals can have religious and spiritual experiences throughout the life span. Studies not meeting the criteria were excluded. Reasons for exclusion included a) unspecified or incorrect population, b) unrelated subject (trauma disassociated with religious experiences), c) studies examining religion as a treatment modality for generalized trauma as opposed to a factor implicating trauma experiences, d) outside timeline parameters, or e) studies that failed to address the research questions. After generating an initial search, Zotero was used to remove duplicates from the list.

Results

The initial search yielded 383 results in total following the removal of duplicates and examining articles for relevance. After initial screening 137 articles remained. A second screening of abstracts left 51 full text articles to be fully reviewed. The studies ranged in date from 2012-2022. The bibliographies of identified articles were also reviewed for inclusion, which resulted in five additional articles being identified. A total of seventeen studies were retained for analysis.

Study Design

The seventeen studies that addressed the stated research questions are outlined and detailed in Table 1 (Appendix A). The sample sizes of sexual minority population within the studies ranged from 18 to 1,518. Of the studies, eight (47.1%) utilized quantitative methods, six (35.3%) used qualitative analysis, and three (17.6%) included mixed method analysis,

Of the six qualitative studies, all utilized phenomenological research designs to capture lived experiences of participants. All studies involved interviews with participants, five studies identified that interviews lasted between one to three hours. Interviews took place in-person and

via online modalities such as video calls. Interview questions focused on gathering information on life history, religious experience/identity, sexual identity, and the lifelong impact among these constructs.

Of the quantitative studies four (50%) included descriptive study designs and four studies (50%) were correlational study designs. All the descriptive studies included populations of young adults under the age of 30. Sexual identities varied among the studies, including lesbian, gay, bisexual (75%) and transexual, self-identifying, and queer (25%). Three of the studies examined phenomenon of stress related factors within religious experiences for sexual minority youths (75%), while one study investigated stressors on mental health within sexual minority youth. The correlational studies examined the relationships between sexual orientation change efforts (SOCE) and suicide morbidity (25%), sexual stigma and mental health (50%), and family and social supports on negative health outcomes (25%). The correlational studies included a variety of participant age ranges: two studies examined ages 18-25 (50%), two studies included a larger population range from 18-59 (50%), one study divided participants into three generational age categories.

Three study designs included mixed method modality designs. All three (100%) included descriptive quantitative data designs along with qualitative interviews of participants. Two studies explored religious experiences among sexual minorities (66.6%), while one study examined perceived levels of family acceptance or rejection of sexual orientation and gender identity during teen years (33.3%). All study participants were under the age of 35. Of the three studies, population for sexual identity included LGB+, gay and bisexual men, and bisexual and transgender individuals.

Applied Theoretical Frameworks

Most studies (n=9, 52.9%) included a theoretical framework incorporated within their study design. Several studies did not identify a specific framework or theoretical construct (n=8, 47.1%). Four studies (44.4%) identified multiple constructs of theory as a basis for the study design. Five articles (55.6%) focused on a single theoretical framework. Of the studies with theoretical frameworks, three (33.3%) identified minority stress theory as a basis for their study design. Two studies (22.2%) identified critical theory and two other studies (22.2%) identified cognitive dissonance as the frameworks for study development. Other theoretical considerations included: generativity, microaggression, transactional, coping, stigma, intersectionality, sexual identity, identity conflict, and identity integration.

Population

The purpose of the current review was to examine data based on both sexual and religious identities. As mentioned previously, gender and sexuality constructs have been of particular interest due to the various ways individuals self-identify. Many of the studies included LGBT+ population parameters (n=8, 47.1%). Four studies (23.5%) examined lesbian, gay and bisexual identities. Three studies (17.6%) targeted gay populations, which included gay males (n=2, 11.8%) and gay/lesbian individuals (n=1, 5.9%). One study (5.9%) examined gay and bisexual individuals. One study (5.9%) focused exclusively on individuals who identified as male-to-female transgender. Three studies (17.6%) compared sexual minority groups to heterosexual or cisgender groups for data analysis.

Most of the studies (n=7, 41.2%) focused on Christian affiliated religious identities. Two of these studies (11.8%) compared Christian and non-religious (atheist/other) identities. Five

studies (29.4%) did not specify the religious affiliation or identity of participants; however, they utilized the construct of religious experiences. Four studies (23.5%) employed multiple religious backgrounds including Christian, Jewish, Muslim, Buddhist, Pagan, Hinduism. One study (5.9%) focused specifically on the Orthodox Jewish community.

Geographical significance

More than half of the studies (n=10, 58.8%) were conducted in the United States. One study was a collaboration between the U.S. and Canada (n=1, 5.9%). Studies were conducted internationally in Australia (n=3, 17.65%), Italy (n=1, 5.9%), Thailand (n=1, 5.9%), and Canada (n=1, 5.9%). Of the six international studies, one (16.7%) identified a specific city location (Bangkok, Thailand) for sampling. The other five studies (83.3%) were non-specific in region or territory when obtaining participant sampling.

Of the studies conducted in the U.S., 40% (n=4) included recruiting samples on a national scale. The collaborative study between the U.S. and Canada utilized a national U.S. sample. Three study samples (30%) were identified as regional to “southeast, northeast, and Midwest”. Two studies (20%) included statewide sampling in Wisconsin and Oregon. Two samples (20%) were non-specific to geographic locations. It is of note that non-specific geographic locations were utilized in several studies to provide increased anonymity for participants.

Study Findings

Overall, 17 studies examined the religious experiences in a variety of ways including rejection of the individual based on sexual identity, experiencing trauma within the religious setting, conflict between religious beliefs/identity and sexual identity, and individual abandonment of religious beliefs. Eight studies reported outcomes related to rejection of the

individual because of their sexual identity. Studies by Beagan & Hattie (2015), Jones, Power, & Jones (2022), Yadegarfar, Meinhold-Bergmann, & Ho (2014) and Hollier, Clifton, & Smith-Merry (2022), identified loss of community, family, and friends. Vanderwaal, Sedlacek, & Lane (2017) noted parental rejection based on sexual identity also led to homelessness. Gattis et al. (2014) discussed lifestyle choices including disapproval of same-sex marriage and Sumerau, Mathers, & Lampe (2018) identified damnation of sexual identity for bi+ and trans individuals as reason for rejection. Another form of rejection included excommunication (Itzhaky and Kissil, 2015) and being excluded following coming out (Jones, Power, & Jones, 2022).

Seven studies identified trauma experiences within the religious construct. Trauma experiences that were identified included sexual orientation change efforts (SOCE) (Blosnich et al., 2020, Vanderwaal, Sedlacek, & Lane, 2017) and exorcism of sexual identity (Jones, Power, & Jones, 2022). Hollier, Clifton, & Smith-Merry (2022) discussed constructs of microaggressions such as mischaracterization, being viewed as a threat, experiencing erasure, and experiencing relational distancing as well as overt abuse which was less frequent than microaggressions. Three studies referred to non-specific negative church experiences which had profound and long-lasting effects on psychological and spiritual health (Hollier, Clifton, & Smith-Merry, 2022, Jones, Power, & Jones, 2022, and Jefferies et al., 2014). Lauricella et al. (2017) reported that 99% of people with same-sex attraction experienced religious heterosexism. Bi+ and trans individuals almost entirely experience religion as a source of damnation and trauma (Sumerau, Mathers & Lampe, 2018).

Thirteen studies reported outcomes that resulted from conflict between religious beliefs/identity and sexual identity. Page et al. (2013), Beagan & Hattie (2015), and Jones, Power, & Jones (2022) identified outcomes of integration of sexual identity into religious self,

denial of self, and delayed sexual activity. Experiencing interpersonal discrimination within the religious community due to sexual identity (Gattis et al., 2014) and religious climates that are less supportive (Hatzenbuehler et al., 2012) increased negative coping among sexual minorities. Jeffries et al. (2014) identified a small percentage of participants disclosed sexual identity to religious community. Lauricella et al. (2017), Page et al. (2013), and Nardelli et al. (2020) reported outcomes based on sexual stigma experienced by sexual minority participants. Subhi & Geelan (2012) found that 80% of participants experienced interpersonal and intrapersonal conflict between Christianity and homosexuality.

Eight studies also revealed outcomes related to sexual minorities abandoning or questioning their religious beliefs. Beagan & Hattie discussed outcomes related to adopting new paths and traditions, including creating a path to spirituality rather than through specific religious doctrines. Other studies considered outcomes such as LGBT+ individuals identifying as more secular (Gattis et al., 2014), not attending religious services (Jeffries et al., 2014) or doubting religious convictions (Bower et al., 2021) but not abandoning faith altogether. Subhi & Geelan (2012) stated that a small percentage (20%) abandoned their faith or continued to identify as Christian but did not actively practice the faith. Finally, Vanderwaal, Sedlacek, & Lane (2017) and Itzhaky & Kissil (2015) discuss the difficulty participants had in abandoning faith despite the conflict between religious and spiritual identity and significant negative experiences within the church.

Various mental health outcomes were discussed throughout the research. Studies by Gattis et al. (2014), Subhi & Geelan (2012), and Yadegarfar, Meinhold-Bergmann, & Ho (2014) all reported greater levels of depression among sexual minority individuals. Specifically, 68.7% of sexual minority individuals who experience conflict between religious identity and

sexual identity reported significant levels of depression (Subhi & Geelan, 2012). Yadegarfar, Meinhold-Bergmann, & Ho (2014) described loneliness as the most common predictor of depression in both transgender and cisgender populations. Interestingly, this study also found that family rejection was a significant predictor of depression among transgender individuals.

Four studies reported measures related to suicidality and suicidal behavior among LGBTQ+ individuals. Blosnich et al. (2020), reported outcomes stating that 75% of sexual minorities who experienced SOCE had increased odds of planning to attempt suicide and 88% increased odds of a suicide attempt resulting in injury. This study also reports that LGBTQ+ individuals are 50% more likely than non-LGBTQ+ populations to experience suicidal ideation. According to Subhi & Geelan (2012), 25% of homosexuals who experience conflict between religious identity and sexual identity reported suicidal ideations. Vanderwaal, Sedlacek, & Lane (2017) reported that 31.7% LGBTQ+ teens experience suicidal ideations, while 29% have attempted suicide. Risk factors for suicidal ideations among transgender adolescents included family rejection, loneliness, and lower social support (Yadegarfar, Meinhold-Bergmann, & Ho, 2014).

Four studies reported outcomes related to how LGBT+ individuals utilize coping mechanisms in response to negative religious experiences. Itzhaky & Kissil (2015) learned that most Orthodox Jewish gay men had difficulty accepting their sexual identity and utilized coping mechanisms of getting married to hide sexual identity, nondisclosure of identity to family, friends, or community, engaging in religious rituals to “scrub the sin of being gay”, and seeking out other sexual orientation change efforts. Page et al. (2013) reported that LGB youth who are involved with religious systems who cast negative or rejecting messages about sexual minorities

is associated with more internalized negative self-messages as well as greater challenges in developing and accepting one's sexual identity.

In contrast, Jeffries et al. (2014) reported positive religious coping outcomes and found that 35.7% of participants utilized faith to cope with negative life experiences including anti-gay treatment, abuse, and HIV infection. A smaller subsection utilized prayer as a coping mechanism. In addition, Lauricella et al. (2017) provided outcomes that people with same-sex attraction (PSSA) utilized both positive and negative religious coping mechanisms. Of the 260 participants, 20% reported utilizing positive religious coping such as connecting with God and 14.6% reported utilizing negative religious coping such as feelings and thoughts of punishment by God and religious community. Negative religious coping was tied to more mental health problems, less spiritual growth, and less existential well-being.

Three studies reported high risk behavioral outcomes in sexual minority populations. Hatzenbuehler et al. (2012) discussed that the effect of religious climate on health behaviors was stronger among LGB than heterosexual youth. In climates with lower religious support of sexual identity, there were significantly higher rates of alcohol abuse, tobacco use, and more sexual partners for LGB individuals than heterosexual youth. Vanderwaal, Sedlacek, & Lane (2017) shared outcomes that a sample of LGBT+ youth from strong traditional abstinence-based doctrines had higher rates of weekly alcohol (22.3%), tobacco (10%), and marijuana use (10%). This sample also reported significant high risk sexual behaviors including unprotected sex (22%) with casual partners or non-monogamous relationships as well as engaged in intercourse with someone who had HIV (4%). Furthermore, Yadedgarfard, Meinhol-Gergemann, & Ho (2014) discovered that family rejection, loneliness, and social isolation were not significant when predicting high risk sexual behaviors of transgendered youth.

Five studies reported outcomes related to religious trauma and emotional distress and dysregulation. Hollier, Clifton, & Smith-Merry (2022) reported that microaggressions within the religious community were categorized into four components: mischaracterization of identity, being viewed as a threat within the religious community, experiencing erasure from the religious community and relational distancing. Participants discussed both unconscious and direct microaggressions, including lack of understanding by church leaders. These negative experiences within the church had profound and long-lasting impacts on psychological and spiritual well-being. Jones, Powers, & Jones (2022) reported that individuals who experienced conversion practices reported shame, guilt, and outrage. These participants also reported damage to spiritual self-concept and experiences. Grief was also a common theme due to impairment of relationships and isolation from the religious community. Lefevor, Smack, & Giwa (2020) reported that family, social and religious support were negatively related to distal stressors such as sexual assault, trauma, and harassment. Distal stressors were universally related to psychological distress. This study also discussed that black sexual minorities experience distal stressors at a high rate (1/3 experienced sexual assault, 1/6 reported multiple sexual assaults, 1/2 experienced harassment, and 1/2 reported a trauma history). Nardelli, Baiocco, Tanzilli, & Lingardi (2020) found that dissociation was positively associated with all dimensions of internalized sexual stigma (ISS) which includes identity, social, discomfort and sexuality in Caucasian gay males. Sexuality had a stronger correlation with disacitive symptoms than any other dimension. This study also found that the effect of ISS on dissociation was amplified in Catholic participants, which suggests that religiosity could be a moderating factor.

Discussion

The aim of the current systematic review was to examine and synthesize current evidence regarding the experiences of LGBTQ+ individuals involving adverse religious/spiritual experiences including religious trauma and how these experiences impact their mental health. Furthermore, it was of particular interest to determine clinical social work practices that could be applied with attention to evidence-based practices and trauma-informed care specific to the LGBTQ+ population. Currently, most studies report the relationship between religious and spiritual identity and sexual identity, the conflict between the two and how this impacts mental health outcomes and identity development. It is also significant that very few studies have discussed adverse religious experiences in the context of trauma among LGBTQ+ individuals. It is also pertinent to identify that there have been no studies to date that have conducted clinical trials or intervention testing to determine efficacy of treatment in response to religious trauma among LGBTQ+ individuals given the copious research that shows the psychosocial impact it has on this population including increased risk for depression, anxiety, suicidal ideation, substance use, and high-risk sexual behavior. This adds to the challenges in diagnostic procedures and clinical treatment. It may also fuel the stigma felt by the LGBTQ+ community in seeking mental health treatment to improve coping mechanisms in response to adverse religious experiences and religious trauma. This lack of research impacts social work practice at all levels and highlights a critical need for further training and competence in understanding key components that impact the LGBTQ+ community. Furthermore, this study reviewed research published in English and sample sizes that mainly identify as Christian based pedagogy. Given this, there could be other research that identifies religious pedagogies which have shifted to more

affirming practices that have not yet been published as global trends show a shift in sociopolitical acceptance overall of diverse sexual identities.

Social workers cannot make religiously affiliated organizations safe for people; however, we can help people learn to protect themselves from abuse and adverse experiences through education and understanding. Social workers can also address and expose the behaviors of non-affirming organizations to bring an awareness for the need to be healthier and supportive systems, shifting the power and authority dynamic, which is critical when discussing trauma and abuse. Spiritual self-care is an important part of an individual's holistic healthcare need as well as a fundamental component that extends into social and systemic practices (Phoenix, 2020). In clinical social work practice, spirituality accounts for a foundational structure of self-care and a platform to build coping mechanisms (Groen, Coholic, and Graham, 2012).

It is particularly interesting that given the clinical knowledge social workers possess on trauma-informed interventions, there have been no clinical interventions tested for efficacy in treatment of religious trauma. A plethora of research has been conducted on interventions including cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), and eye movement desensitization and reprocessing (EMDR), providing evidence-based and efficacious clinical treatment of trauma experiences. Eye contact and social touch can increase neuroplasticity in the motor cortex and kickstart new learning and brain development as well as improve attachment (Levy, 2011). Eye movement desensitization and reprocessing therapy (EMDR) has shown to improve higher level brain functioning in children with maltreatment histories (Trentini et al., 2015). EMDR targets deactivated cognitions through rapid eye movements and bilateral stimulation of the brain to evoke processing of repressed or deleted memories suffered from trauma. Slow rocking, swinging, or calming repetitive movements

(tapping) can also help regulate overactivation of lower brain functions and involuntary fear responses, which leads to improved higher executive brain function (Van der Kolk, 2014). Given the high percentage of sexual minorities who report emotional dysregulation, trauma, and negative mental health outcomes, there is a critical need to explore clinical research to respond to the needs of the LGBTQ+ community and their religious experiences.

Social workers can be on the forefront in prevention strategies by advocating to screen for adverse childhood experiences in relation to religious practice and to identify parental trauma and target specific parental education opportunities from early childhood. This may be particularly beneficial for parents with their own history of religious trauma experiences to help reduce maladaptive responses to sexual minority identities and provide greater support through the coming out process.

Hatchard et al., (2017) concluded that mindfulness-based stress reduction techniques improve emotional regulation by reducing activation in the amygdala. Exposure to threatening environments early in childhood leads to biological changes in the amygdala and heightened emotional responses to both positive and negative experiences, increasing production of cortisol and slowed activity in the brain (McLaughlin, et al., 2015).

The neuroscience literature has proven that trauma and maltreatment impacts brain development (Jenness et al., 2020). As social workers, deepening our understanding of where and when these events occur in the brain can better shape clinical judgement and treatment. Social workers need to be advocates for physical and developmental screenings for children through schools, pediatricians, and childcare programs, especially when many public programs are based in religious teachings beginning in early developmental years. It is also important to

note that many of these settings can be religiously affiliated and may be contributing to adverse experiences for LGBTQ+ youth.

Social workers must improve competencies in all aspects of biopsychosocial development to be able to ethically serve youth and their families. This includes advocating for reform of anti-LGBTQ+ policies within religious based institutions such as schools and medical facilities. Finally, as social workers sharing our knowledge of trauma-informed interventions coupled with data on how treatment of religious trauma impacts the mental health outcomes of LGBTQ+ individuals will form a more holistic treatment modality. This will also help create a stronger relationship among service providers, spiritual and religious leaders/organizations and the community leading to improved services for LGBTQ+ individuals and other vulnerable populations who have experienced religious trauma.

As stated above, there is a shift in the global acceptance of homosexuality and sexual minority practices of LGBTQ+ individuals by religious communities; however, this depends on the doctrine of practice, geographical location, and political climate. Studies have demonstrated that LGB youth living in countries with more supportive religious climates showed fewer health risk behaviors (McCann et al., 2020; Vanderwaal et al., 2017) meaning that religion can be a protective factor for LGB youth. However, other studies have examined how rejection of sexual identities impact rejection by families, religious communities, and social support systems (Wood and Conley, 2014). Stronger senses of spirituality have been reported in sexual minority individuals when they in turn choose to refrain from or reject the negative aspects of the religious teachings based on sexual identity (Higa et al., 2014). Clinicians can assist in processing negative experiences with religion and assist in progression of sexual identity development. Also, understanding that some populations are more resistant to seeking identity acceptance and

developing modalities to improve overall clinical functioning and reduction of mental stressors and maladaptive coping mechanisms.

Family support

Particularly in Black sexual minority groups, individuals respond to intersectional forms of discrimination by creating support structures comprised of individuals sharing similar marginalized identities (religious, sexual, racial) to foster resilience (Lefevor et al., 2020). Lefevor (2020) also concluded that Black sexual minorities are more likely to find support within their family than other sexual minorities of color. Several factors can contribute to lack of familial support or family rejection including disrespect of family culture and heritage, unwillingness to fulfill familial responsibilities (related to typical gender roles within the family of origin's belief system), rejection by the family's religious institution or faith teachings, inability to accept sexual identity (Vanderwaal et al., 2017, Yadegarfard et al., 2014). This can lead to individuals feeling forced to remain "closeted", prolonged decisions to engage in the coming out process to others especially family members, and internalized sexual stigma.

In a study of 310 sexual minorities raised in the Seventh Day Adventist Church, 82% reported that their parents struggled to accept their sexual identity (Vanderwaal et al., 2017). Expressions of rejection included public humiliation, ridicule of physical appearance, demeaning language about their sexual orientation and/or identity including using homophobic slurs. The financial dependence on family is another mitigating factor in a shift of balance and power within the relationship; therefore, individuals felt compelled to comply with parental preference of sexual identity to maintain this support. In a sample of Thai transgender adolescents experienced more exclusion from family activities, physical punishment, financial deprivation, ejection from the house and social deprivation (Yadegarfard et al., 2014). This study also

revealed utilizing physical punishment to force their children to change sexual and gender identities rather than accepting their identities. Family rejection is also a significant predictor of rates of depression, running away from home, social isolation, and poor school performance.

Social support

When families are non-supportive of sexual orientation, social supports are often sought out to build resilience and offset general stressors, microaggression, and discrimination (Lefevor et al., 2020). However, due to increased minority stress and intersectionality of multiple minority identifies (sexual orientation, gender, race, etc.) can lead to more fragmented social support systems and increased isolation and poor mental health outcomes. In many sexual minority communities, family rejection leads to finding a “chosen family” that is not the family of origin, but rather a supportive community of individuals who accept and affirm their sexual identity. Friends were found to be a strong social support despite LGBT+ individuals feeling a lack of support in both familial and religious domains (Vanderwaal, 2017). Older adults reflect on their experiences through the HIV/AIDS epidemic and the social impacts of stigma associated with sexual orientation and identity. These experiences included discussing transferring knowledge related to medical treatment and services and survival through these past traumatic experiences to cultivate hope for the future through social activism (Bower et al., 20021). This has created a new facet of social support among older adults and LGBTQ+ youth.

Religious support

Several sexual minorities continue to report a religious affiliation despite repetitive evidence that they encounter adverse religious experiences (Super and Jacobson, 2011). As noted repeatedly, religious support can serve as a form of resilience and coping against

discrimination, racism, and rejection for intersections of identity (LeFevor, 2021). It is also common for many sexual minorities of color to conceal their identities within their religious communities due to homonegative messaging and trauma within their religious doctrines (LeFevor, 2020). This makes seeking support more difficult. It is also important to note that individuals may experience abuse and trauma directly from a spiritual leader (Blosnich et al., 2020), fostering a mistrust for individuals in positions of authority including clinicians, educators, and other service providers. Finally, despite all the evidence and testimony given about experiencing religious trauma, microaggressions and discrimination within religious settings, LGBTQ+ individuals continue to struggle with reconciling conflict between spiritual and sexual identities. These individuals often seek out sexual orientation change efforts and remain secretive, or “closeted” among their religious communities for fear of erasure, damnation, and isolation (Blosnich et al., 2020; Itzhaky & Kissil, 2015; Jeffries et al., 2014; Jones, Power, & Jones, 2022; Subhi & Geelan, 2012; Vanderwaal Sedlacek, & Lane, 2017).

Beliefs, attitudes, and experiences among LGBTQ+ Individuals

Several studies examined LGBTQ+ individuals negative religious experiences related to their sexual identity, including experiencing damnation in religions because of their sexual identity as well as inconsistency in acceptance (Sumerau et al., 2018). Sumerau et al. (2018) also concluded that although some religious institutions have become more affirming and accepting, even tolerant of sexual minority identities, damnation targeted at bi+ and trans individuals has intensified. Another common theme includes inconsistent teachings, especially among more conservative Christian religions, that often target specific groups for discrimination and damnation (women, sexual minorities, other non-affiliated religious groups). Additionally, many respondents report religious institutions utilizing specific scriptures and doctrines to condemn

sexual orientation and behaviors although sexual identity is not explicitly stated within religious texts (Sumerau et al., 2018). These inconsistencies and abuse of power and authority leads to sexual minorities choosing to leave the religious institutions and faith altogether. Bi+ and trans people almost entirely experience religion as a source of damnation and trauma (Sumerau et al., 2018).

It is important to note that many LGBT+ youth have reported negative religious experiences including biphobia, homophobia, and transphobia (McCann et al., 2020). Trauma during this time can impact development physically, emotionally, and spiritually (Reinert et al., 2016). This can also cause wariness of religious institutions which may include schools, churches, and providers of social supports such as mental health services, shelters, and food services. Consequently, as youth navigate the life cycle and spans of development, they may be less likely to engage in seeking help from religious providers. Black LGBT+ youth often remain active in the church despite a push for heteronormativity (McCann et al., 2020, LeFevor et al., 2020).

Mental health outcomes

LGBTQ+ individuals have reported positive aspects from psychotherapy when they can openly discuss their sexual identity, have an established positive and affirming relationship with the therapist, and the therapist has knowledge about issues related to effective practice related to LGBT+ issues (Heiden-rootes et al., 2020).

Negative experiences in therapy often include affirming practitioners who misattribute mental health issues to being out as an LGBT+, therapists may not consider the serious negative

consequences to family or community, and therapists who hold conservative and/or religious values which can lead to overt rejection of the individual (Heiden-rootes et al., 2020).

Efforts to change sexual orientation have serious negative effects on LGB+ people and have been ethically and professionally refuted by several professional governing organizations (NASW, APA, WPATH, etc.). LGBT+ individuals have reported higher rates of suicidal ideation, depression, and anxiety (LeFevor et al., 2020; Hollier et al., 2022; Vanderwaal et al., 2017). Research shows that conversion practices have shown to be harmful with increased experiences of abuse, mental health problems and suicidality (Jones, Powers, & Jones, 2022). Blosnich et al. (2020) conducted a wide scale study of over 1500 sexual minority adults and found that these individuals were at a greater risk of sexual orientation change efforts when they lived with parents who had depression, suicidal ideations, inter-partner violence, or reported emotional, physical or sexual abuse. For each adverse childhood experience (ACE) reported, the odds of sexual orientation change experience (SOCE) increased by 25% (Blosnich et al., 2020), on average participants reported three ACEs. These results also noted a positive correlation between SOCE and suicidality.

Lefevor et al. (2021) concluded that religiousness and spirituality can have a positive impact on health outcomes; however, the strength of this relationship depends on the degree of sexual identity integration, individual's specific belief and practices, and the amount of support within the environment. Positive experiences may include practitioners assisting in validating negative experiences within religious practices and how to reconcile the spectrum of acceptance and rejection of spiritual and sexual identities. Some lesbian and gay individuals of faith report no conflict between sexual identity and faith because they either abandoned their faith prior to coming out or continued identifying as a Christian but did not practice or attend church

(Wilkinson & Johnson, 2020). Resolution for some included alternative exploration of spirituality separately from religious practices, compartmentalization or finding a new path or space to practice the positive aspects of their spiritual identity. Better mental wellness correlated to individual focus on their interpretation of the Bible, spiritual beliefs, and ignore social implications of religious teachings (Wilkinson & Johnson, 2020).

Belongingness is another protective factor related to mental well-being. This is a continuance of how many of the studies reviewed correlate rejection with trauma experiences and higher accounts of negative mental health outcomes. Hollier (2022) found that LGBTIA+ individuals were subject to mischaracterization, viewed as a threat and consequently experienced erasure, social distancing, and experienced psychological trauma within the Evangelical church. Religiosity can have positive impacts on mental health and serve as a protective factor for some LGBT+ individuals (Hatzenbuehler et al., 2012; Jeffries et al., 2014; Lauricella et al., 2017); however, these also note that this is dependent on affirming practices and development of religious identity. This is also related to the strength of religious, social, and family support provided within the religious community, when this is absent the relationship between mental health and religiosity is not a protective factor but inversely has shown a detrimental impact on functioning. This effect has been documented within clinical analysis across various mental health services including substance abuse programs, group therapy, and suicide prevention efforts. Kucharska (2019) found that religious appraisal seemed to be a significant predictor of the outcome of trauma (the notion of being punished by God). However, negative religious coping has been most often studied within military trauma and sexual assault trauma, little to no evidence exists related to adverse religious experiences within LGBTQ+ individuals. This has

also made it difficult to explore the assessment, diagnosis, and treatment of religious trauma within the LGBTQ+ community.

Limitations

The current systematic review has limitations that should be identified. The search criteria placed limitations on the studies identified. As addressed, categorizing sexual identity provides inconsistencies within the literature. Defining sexual identity, orientation, and gender identity varies among geographical, cultural, and sociological platforms, and this terminology is consistently changing and adapting to expand with diversity, equity and inclusion of all sexual minority individuals. Terminology through the studies included was reviewed as identified within the respective study including using identifies such as “other” or “+” as part of the construct. This may also in turn exclude other sexual minority populations as they intersected with other demographic characteristics such as race, ethnicity, and/or age. For example, no studies focused solely on lesbian populations and data from samples of specific racial and ethnic groups were not identified (ex. Asian, Pacific-Islander, Native American) or even excluded due to size of the sample. Another limitation regarding population is the average age of study participants. Most of the sample sizes examined youth or younger adults under the age of thirty. This leaves a gap in knowledge about adults and older adults who identify as LGBTQ and their experiences with religious trauma and mental health outcomes throughout the lifespan.

This study provided methodological limitations. This review focused on religious experiences and mental health outcomes. Other themes of the included studies such as researcher bias, recruitment strategies, and quality of outcomes were not examined. However, methodology of the studies was examined. To ensure the quality of the review a second review

participated in the exclusion and appraisal stages of the review to help organize the review process. The use of systematic review software was also utilized.

Conclusion

LGBTQ+ individuals report negative religious experiences at a significantly higher rate. These experiences can lead to religious trauma and higher risk for negative mental health outcomes over time. Religion and spirituality are an integral foundation for most psychosocial developmental theories and social work practices, and when experienced in a negative way can lead to fractured identity development and conflict that is often irreconcilable among the LGBTQ+ community. Affirming religious practices, leaders, and communities can serve as a protective factor in reducing negative religious coping and overall improved mental health outcomes for LGBTQ+ individuals. More research is needed to determine the clinical efficacy of evidence-based trauma-informed interventions in the treatment of religious trauma. Special consideration should be given in the ethical social work practices outlined by NASW, CSWE, and other governing organizations developing training and education in specialized areas of practice with considerations given to religious experiences, trauma, and mental health outcomes in the LGBTQ+ community. Finally, further research is needed to create advocacy for service brokerage within social work and other healthcare settings, which may be dominated by religiously affiliated practices. This can help improve service seeking, treatment, and quality of life for LGBTQ+ individuals by reducing stigma, discriminatory practices, and increasing affirming and ethical social work practice.

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Appendix A

Table 1: Assessment of Current Studies

Author (Year)	Location	Purpose	Sample	Methods	Key Findings
Beagan & Hattie (2015)	Canada (regional)	To explore how LGBTQ individuals experience and perceive religion and spirituality, as well as identity conflicts Theoretical Framework (TF): Critical Theory	LGBTQ+ adults ages 20-68 Men = 11 Women = 19 (n = 35) Religious identity noted: multiple	Qualitative – semi-structured interviews recruited via LGBTQ websites and LGBTQ community locations. Interviews lasted 1-3 hours Measures: sexual identity, disclosure, R/S identity in youth, change in identity and R/S beliefs and practices, integration of LGBTQ self and religious self (personal and community) Data analysis: ATLAS.ti	Conflict between LGBTQ identity, religion, and spirituality a) Delayed sexual activity b) Denial of self c) Loss of community, friends, and family d) Negative effects on emotional wellbeing Resolving conflict between LGBTQ identity, religion, and spirituality a) Separating religion, church, and spirituality b) Remaining with the faith tradition of upbringing c) Adopting a new path or tradition d) Creating an individual relationship to spirituality
Blosnich et al. (2020)	USA (National – census data)	Examine how sexual orientation change efforts (SOCE) are associated with suicide morbidity after controlling for ACEs TF: minority stress theory	Cisgender or gender nonbinary sexual minority adults (LGBT+) 3 age groupings a) 18-25 b) 34-41 c) 52-59 (n=1518) - (Excluded Asian, Alaskan native and American Indian) Religious identity noted: none	Quantitative – Correlative, cross-sectional, multiple regression analysis - Data from 3 generations, 2 phase sampling (2016-2018) - Phase I – random sampling - Phase II – purposive sampling using web-based and paper questionnaires Measures: sexual identity, race/ethnicity, education, ACE score, experiences of sexual orientation change efforts (SOCE), suicidality (Columbian suicide severity rating scale – C-SSRS)	a) 7% of participants experienced SOCE, of them 80.8% reported SOCE from a religious leader b) Sexual minorities exposed to SOCE were nearly twice as likely to experience suicidal ideation c) Of sexual minority youth who experienced SOCE, 75% increased odds of planning to attempt suicide, and 88% increased odds of suicide attempt with injury
Bower, Lewis, Bermudez, and Singh (2021)	USA - southeast	Examining the ways LGBT+ midlife and older adults find meaning in response to lifelong adversity and stigma TF – Generativity (Rubinstein, 2015), Critical Theory	LGBT+ males and females ages 45-76 (n=18) Lesbian (n=4) Cisgender gay (n=12) Transgender (n=2) Religious identity noted: none	Qualitative Face-to-face semi-structured interviews lasting approx. 2 hours, completed July-Oct. 2016 - Open-ended questions from the life history approach Data Analysis: ATLAS.ti and CAQDAS coding	Narrative themes included: a) Experiencing the AIDS/HIV pandemic b) Negotiating the absence of positive role models Questioning religious convictions Internalized stigma
Gattis et al. (2014)	USA - Midwest	Investigate gay affirming	Sexual minority (LGB) youth (n=393)	Quantitative	a) religions not supporting same sex

		religious affiliation as protective factor among sexual minority youth TF – Minority Stress Theory	& heterosexual youth (n=1727) Ages 18-29 Religious identity noted: none	Descriptive Research Design (measures): 1. Kinsey homosexual-heterosexual rating scale 2. depression subscale from Brief Symptom Inventory 3. Religious affiliation 4. Perceived interpersonal discrimination Anonymous online survey sent to full/part time students - Census of sophomore and junior undergraduates, random sample of graduate students, convenience sampling of LGBT campus group leaders and organizations Data analysis: - T-test - Chi Square	marriage had harmful discrimination effects on minority youths b) depression was greater among sexual minority youth c) Increased interpersonal discrimination was reported among sexual minority youth d) Sexual minority youth identified as more secular than heterosexual participants
Hatzenbuehler et al. (2012)	USA (Oregon – statewide)	Examine health risk behaviors and religious climate in sexual minority youth TF - None	LGB students (n=1413) (gay/lesbian n=301, bisexual n=1112, and unsure = 653) Non-LGB students (n=31,852) Religious identity noted: Christian	Quantitative: 3 phases 1. Descriptive 2. Correlational 3. GEE (correlational) - Survey from the Oregon Healthy Teens Study data set collected from 8 th and 11 th graders in 2006-2008) measures of gender, race/ethnicity, sexual orientation - Glenmary Research Center – religious climate variable (degree of support for homosexuality via support of same sex marriage) Outcome variables: alcohol use sxs in last 12 months, cigarette use in last 30 days, number of lifetime sexual partners	a) LGB youths living in climates supportive of their sexuality had fewer alcohol related issues and fewer sexual partners. b) No significant effect of religious climate on tobacco use.
Hollier, Clifton, and Smith-Merry (2022)	Australia (non-specific)	Explore the dynamics of and mechanisms of spiritual abuse on LGBTQIA+ individuals TF- Minority stress and microaggression theory	LGBTQIA+ adults who spent 2+ years in Australian Evangelical churches (n=24) Religious identity noted: Christian	Qualitative: Semi-structured interviews - Convenience sampling via social media - Purposive sampling (diverse sample) - 1.5-hour interview a) Reviewed individual accounts of trauma - NVIVO software	a) Microaggressions identified included: 1. Mischaracterization 2. Being viewed as a threat 3. Experiencing erasure 4. Relational distancing b) Negative experiences of the Church had profound and long-lasting impact on psychological and spiritual health. c) Microaggressions are reaffirmed through church

					<p>leaders and unequal distribution of power</p> <p>d) Overt abuse was less frequent than microaggressions</p> <p>e) Clinical implications: validation of identity and trauma experiences</p>
Itzhaky & Kissil (2015)	USA - northeast	Examines the intersection of sexual orientation and religion in the Orthodox Jewish community TF – none identified	Gay males (did not disclose sexual identity) (n=22) Ages 18-46 Religious identity noted: Orthodox Jewish	Qualitative content analysis of individual in-depth semi-structured interview <ul style="list-style-type: none"> - Snowball sampling - 1.5-3-hour interviews - Life history approach (open-ended) - All interviews conducted by same person 	<p>a) emotional turmoil</p> <p>b) negative coping including difficulty accepting sexual identity, SOCE, hiding identity through marriage, rituals and nondisclosure</p> <p>c) impact on family relationships</p> <p>d) important context of religious community including strict rules, sexual identity, and excommunication</p> <p>e) clinical implications: not looking for acceptance via the Jewish community, majority wanted to change sexual identity, sought out conversion therapy through marriage, prayer</p>
Jeffries et al. (2014)	Milwaukee , WI, USA (State and national sample)	Explore religion and spirituality among HIV infected gay and bisexual men TF – None identified	Men who had sex with men (MSM), HIV+, ages 13-29 (n=44) Religious identity noted: Christian	Mixed methods: <ol style="list-style-type: none"> 1. Descriptive Study 2. Quantitative Surveys included: Wisconsin Dept of Health, Milwaukee Health Dept. and CDC data on HIV diagnoses in response to public health crisis (2000-2008) (n=44) <ol style="list-style-type: none"> A) 25-minute self-interview on computer B) Measure outcomes included: frequency of religious attendance, type of service attended, perception of religious community, knowledge of participant's sexuality, ability to be "out" at church, sex being a "sin" C) Chi square analysis of ethnicity 	<p>a) 66% attended church</p> <p>b) 16% could disclose sexuality</p> <p>c) 37% thought homosexuality as sinful</p> <p>d) 64.3% reported negative experiences in religious settings</p> <p>e) 76% of black religious community did not know participant's sexual activity (MSM)</p> <p>f) Prayer as a coping strategy</p> <p>g) 60% reported a disconnection with or abandonment of religious participation</p>

				3. Qualitative Interviews – semi-structured (n=28) Used NVIVO	
Jones, Power, and Jones (2022)	Australia (non-specific)	Examining religious trauma and moral injury from LGBTQ+ conversion practices TF – none identified	Survivors of change and suppression (conversion) practices (n=42) Age 20-59 Religious identity noted: multiple	Qualitative: 1:1 interview (n=29) Group interviews (n=15) Semi-structured Occurred between 2016-2021 Measures included: Past and current religious experiences, exposure to conversion practices, and impact of conversion practices on mental health - Inductive thematic analysis (no software) - Life history approach	a) Negative experiences of spiritual practices b) Grief at impairment of relationship with religious community c) Damage to spiritual self-concept, meaning and experience d) Shame and outrage as emotional responses e) Exorcism for sexual identity due to “purity culture” f) Excluded when coming out, did not come out or leave religious community before coming out occurs g) Prayer/fasting/seeking conversion efforts online
Lauricella et al. (2017)	USA – national sample	Assess sexual stigma and religious coping in youth with same sex attraction TF – transactional theory of coping, stigma management, cognitive dissonance theory	People with same sex attraction (PSSA) (n=260) Average age 20.68 years SD = 2.07 Recruited from social and digital media targeting PSSA Religious identity noted: Christian and non-religious (atheist)	Quantitative (Correlational): a. Background measure Sexual orientation victimization measure D’Augelli et al., 2002) 1. Religious coping (Brief R-COPE measure) -MANOVA of 4 religious variables (religiosity, spirituality, prayer, church attendance) 2. Psychological adjustment a. religious outcome scale Pargament et al., 1998) b. Stress related growth scale short form Park, 2005) c. Existential well-being scale (Paloutzian & Ellison, 1982) d. Brief Symptom Inventory	a) Most PSSA individuals rarely used religious coping to deal with sexual stigma b) 20% of PSSA used positive religious coping (PRC), 14.6% used negative religious coping (NRC) c) PRC was associated with better adjustment in PSSA d) NRC was tied to more mental health problems, less spiritual growth, and existential well-being in PSSA e) 99% of PSSA experienced religious heterosexism f) Religious PSSA with less advanced sexual identity development were marginally more likely to use PRC than religious PSSA with advanced sexual identity development g) All PSSA reported low levels of NRC

				(Zabora et al., 2001) 3. Sexual identity development a. 9 item Outness Inventory (Mohr & Fassinger, 2000) b. Multigroup ethnic identity measure (Mohr & Fassinger, 2000) c. Personal homonegativity scale (Mayfield, 2001) to assess internalized sexual stigma (ISS)	
Lefevor, Smack, and Giwa (2020)	USA/Canada U.S. national sample	Prevalence of stressors and support on mental health of black sexual minorities, role of families TF – intersectionality and minority stress	Black sexual minority college students Gay (16.1%) Lesbian (18.6%) Bisexual (28.1%) Queer/Questioning (18.1%) Self-Identifying (14.7%) (n=1123) Ages 18-26 Religious identity noted: multiple	Quantitative (Descriptive) Bivariate correlation and regression analysis through SPSS 24 Convenience sampling questionnaires through CCMH at intake: Standardized Data Set (SDS) and Counseling Center Assessment of Psychological Symptoms (CCAPS-34) Data set (2013-2014)	a) Family and partner support are negatively related to distal stressors b) Social and religious support are not related to distal stressors c) Family, social, and religious support are negatively related to psychological distress, partner support was not d) Distal stressors (sexual assault, trauma, harassment) are positively related to psychological distress e) 33.4% reported being sexually assaulted, 43.7% reported sexual harassment, 47.8% have experienced trauma within their lifetime
Nardelli, Baiocco, Tanzilli, and Lingardi (2020)	Italy (non-specific)	Examine the relationship between internalized sexual stigma (ISS) and dissociation TF – none identified	Caucasian gay males 80.8% Catholic 19.2% Atheist/agnostic (n= 120) Age 18-53 Religious identity noted: Catholic/atheist/agnostic	Quantitative (Correlational)– multivariate analysis using SPSS 22 Snowball sampling The Measure of Internalized Sexual Stigma for Lesbians and Gay Men (MISS-LG) and the Dissociation Scale (DIS) of the Trauma Symptom Inventory (TSI)	a) Dissociation was positively associated with all dimensions of ISS (identity, social discomfort, and sexuality). Sexuality had a stronger correlation with dissociative symptoms than any other dimension. b) The effect of ISS on DIS was amplified in Catholic participants.

					suggesting a moderating role of religiosity in this population.
Page et al. (2013)	USA 81% - southeast U.S. Various states (NY, MD, VA, GA, WA)	Investigate religious stress, sexual identity, and mental health in LGB youth TF – sexual identity theory	LGB youth (n=170) 33% Lesbian 47% gay male 14% bisexual female 8% bisexual male Age 14-24 Religious identity noted: multiple	Quantitative (Descriptive) multivariate analysis, (MANOVA, ANOVA, confirmatory factor analysis) longitudinal data Measures: 1) Religious, Spiritual and Sexual Identities Questionnaire (RSSIQ) 2) Measure of gay related stress (MOGS, Lewis et al., 2001) 3) Lesbian, Gay, and Bisexual identity scale (LGBIS), (Mohr & Fassinger, 2000) 4) Behavior Assessment System for Children, 2 nd Edition. Self-report-adolescent version (BASC-II, SRP-A; Reynolds & Kamphaus, 2004).	a) Being involved with religious systems that cast negative or disapproving messages about sexual minorities is associated with increased internalized self-messages and greater challenges in developing and accepting individual sexual identity b) Social identity development – a risk of maladjustment increases for LGB youth when conflict makes it difficult to accept their sexual identity c) Religious stress and gay -related stress were stronger related to negative LGB identity and mental health.
Subhi & Geelan (2012)	Australia Non-specific	Explore the conflict between Christianity and homosexuality faced by the respondents TF – cognitive dissonance, identity conflict/identity integration	Homosexual/Christian identity age 20-51 10 males 10 females (n=20) Religious identity noted: Christian	Qualitative – multiple in-depth interviews - Snowball sampling - Two 1-hour interviews, 1 week interval in between - First interview: background and sexual identity - Second interview: religious/spiritual development and conflict between religiosity/spirituality and orientation - Thematic analysis (Braun & Clarke, 2006, Boyatzis 1998).	a) 80% faced conflict between Christianity and homosexuality (interpersonal and intrapersonal conflict) b) 20% had no conflict between Christianity and homosexuality (abandoning faith before coming out process or continued identifying as Christian but did not practice) c) 80% of respondents wanted to maintain Christianity and homosexuality d) Of the participants who experienced conflict between religious identity and sexual identity, the following mental health outcomes were reported: depression (68.8%), self-blame/guilt (37.5%), anxiety (31.3%), alienation (25%), suicidal ideation (25%)
Sumerau, Mathers, and Lampe (2018)	USA Non-specific	Explore the ways bi+ and trans individuals experience religion	Bisexual and Transexual (n=249) Ages – 18+, (mean 30.8)	Mixed methods, inductive analysis - Survey of three values including a) gender and (non)religion b)	a) Bi+ and trans people almost entirely experience religion as a source of

		TF – none identified	<p>Bisexual (16.5%) Pansexual (28.1%) Queer (50.6%) Fluid (4.8%)</p> <p>*All identities were self-identified rather than preassigned categories</p> <p>Religious identity noted: “religious vs. non-religious”</p>	<p>sexualities and (non)religion c) (non)religious experiences of bi+ and trans individuals</p> <ul style="list-style-type: none"> - Snowball sampling - Data collection 2016 - Open-ended questions 	<p>damnation and trauma</p> <ul style="list-style-type: none"> b) 75% report religious inconsistencies that led to negative opinion and departure from religious community c) 35% of respondents noted exceptions for religious people to be trans or bi+ inclusive
Vanderwaal, Sedlacek, and Lane (2017)	USA Non-specific	<p>Explore perceived levels of family acceptance/rejection of sexual orientation or gender identity during teen years</p> <p>TF – none identified</p>	<p>LGBT+ adults (18-35) raised in Seventh-Day Adventist church (n=310)</p> <p>Religious identity noted: Christian</p>	<p>Mixed Methods: Quantitative Questionnaires utilized:</p> <ol style="list-style-type: none"> 1) Family Acceptance Project (Ryan et al., 2009). 2) Rosenberg Self Esteem Scale (Rosenberg, 1965) 3) Multidimensional Scale of Perceived Social Support (PSS) (Zimet et al., 1988) 4) Patient Health Questionnaire (PHQ9) (Kroenke et al., 2001) 5) National Monitoring the Future Survey – substance abuse questions (Johnson et al., 2016) <ul style="list-style-type: none"> - Snowball convenience sampling - July-October 2016 data set via online modalities <p>Qualitative Questions:</p> <ol style="list-style-type: none"> 1) Compare current lives to teen years 2) Describe or clarify responses not captured in surveys <p>Independent variables: family acceptance and rejection Dependent variable: social support</p>	<ul style="list-style-type: none"> a) 69.5% reported parents disappointed with their sexual identity, 42.8% stated parents forbade them from disclosing orientation to others, 8.9% were disowned/became homeless. b) 81.9% stated that parents struggled to accept identity, 42.1% ridiculed by family. c) 60.4% prayed that God would change their child’s orientation and 57% used scripture to attempt to change their orientation/identity, 25% utilized spiritual leaders in sexual orientation change efforts d) 60-70% of respondents believe they have positive social support from friends, only 20-40% felt family provided available support, 9-20% identified support from religious community. e) Significant number of individuals continue to identify as spiritual and as members of the Seventh-Day Adventist religion despite negative responses to sexual identity. f) Mental health outcomes include weekly alcohol use (22.3%), marijuana use (10%), tobacco use (10%). High risk sexual behavior (26%), suicidal ideations (31.7%)

					and suicide attempt (29%).
Yadegarfar , Meinhold- Bergmann, and Ho (2014)	Thailand (Bangkok)	Influence of family rejection, social isolation, and loneliness on negative health outcomes among Thai MtF Transgender Adolescents TF – none identified	Transgender (Male to Female) (n=129) and cisgender males (n=131) ages 15-25 Religious identity noted: none identified	Quantitative (Correlational) Multivariate analysis, multiple regression analysis Measure constructs: 1. Demographics 2. Family Rejection 3. Social Isolation (Social Support Appraisals scale, Vaux et al., 1986) 4. Loneliness (UCLA Loneliness Scale, Russell et al., 1978) 5. Depression (Depression, Anxiety, and Stress scale DASS-21) (Lovibond & Lovibond 1995) 6. Suicidal thoughts and attempts (positive and negative suicide ideation inventory – PANSI Osman et al., 1998) 7. Sexual Risk behaviors – questions written by researchers	a) Transgender respondents reported: significantly higher levels of family rejection, loneliness, and depression, more negative risk factors related to suicidal behavior, lower social support, protective factors related to suicidal behavior and less certain in avoiding high risk sexual behaviors. b) In both transgender and cisgender groups, loneliness was found to be the most common predictor in levels of depression, suicidal thinking, and avoiding sexual risk behavior. c) In transgender respondents, family rejection was a significant predictor in levels of depression (higher level of family rejection correlated to higher depression levels) d) In transgender population, lower social supports correlated to higher frequency of negative risk factors related to suicidal behaviors