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Religion/Spirituality, Stress, and Resilience among Sexual and Gender Minorities: The Religious/Spiritual Stress and Resilience Model

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Abstract: Although many sexual and gender minorities (SGMs) consider themselves religious/spiritual, the impact of this religiousness/spirituality on their health is poorly understood. We introduce the Religious/Spiritual Stress and Resilience Model (RSSR) to provide a robust framework for understanding the variegated ways that religiousness/spirituality (RS) influences the health of SGMs. The RSSR bridges existing theorizing on minority stress, structural stigma, and RS-health pathways to articulate the circumstances under which SGMs likely experience RS as health promoting or health damaging. The RSSR makes five key propositions: (a) minority stress and resilience processes influence health, (b) RS influences general resilience processes, (c) RS influences minority-specific stress and resilience processes, (d) these relationships are moderated by a number of variables uniquely relevant to RS among SGMs such as congregational stances on same-sex sexual behavior and gender expression or an individual's degree of SGM and RS identity integration, and (e) relationships between minority stress and resilience, RS, and health are bidirectional. In this manuscript, we describe the empirical basis for each of the five propositions focusing on research examining the relationship between RS and health among SGMs. We conclude by describing how the RSSR may inform future research on RS and health among SGMs.

Keywords: Religion, Spirituality, LGBTQ, Minority Stress, Resilience

Religion/Spirituality, Stress, and Resilience among Sexual and Gender Minorities: The Religious/Spiritual Stress and Resilience Model

Over the past 20 years, researchers, policymakers, and advocates have made progress in understanding and reducing health disparities experienced by sexual and gender minorities (SGMs; i.e., individuals who experience some degree of same-sex sexual attraction, engage in same-sex sexual behavior, experience their gender in ways that do not align with expectations based on sex assigned at birth and/or identify as lesbian, gay, bisexual, transgender, or queer/questioning [LGBTQ]; Lefevor, Park et al., 2021). However, SGMs continue to experience stigma and discrimination, which negatively affects their health (Meyer et al., 2021).

Historically, many religious organizations and individuals have opposed legislation protecting SGMs from discrimination (Todd et al., 2020). Perhaps consequently, many SGMs have reported substantial harm from religious organizations and individuals, ranging from interpersonal rejection and discrimination to sexual orientation/gender identity change efforts (Lefevor, Huffman et al., 2020; Ream, 2021). Because of the prevalence of these reports, the dominant narrative in the psychological literature about religiousness/spirituality (RS; see *Table 1* for a complete definition of RS and other key terms)[1] among SGMs has been characterized by themes of oppression and conflict (cf. Anderton et al., 2011; Rodriguez, 2010).

Researchers have explained how RS impacts SGMs' health with theoretical frameworks emphasizing individual and sociocultural factors, including cognitive dissonance theory (Festinger, 1957; Lefevor, Blaber et al., 2020), minority stress theory (Brewster et al., 2016; Meyer, 2003), and intersectionality theory (Crenshaw, 1989; Sherry et al., 2010). Collectively, studies rooted in these frameworks have often suggested that RS has a negative effect on the

[1] For the sake of brevity, we use "RS" to refer to both "religiousness/spirituality" (noun) and "religious/spiritual" (adjective).

health of SGMs (Sowe et al., 2017; Wolff et al., 2016). However, this singular and deficit-centric narrative does not speak to the complexity and nuance in SGMs' relationships with RS. Recently, the first meta-analysis examining the relationship between RS and health among sexual minorities was published, finding that the relationship between RS and health among sexual minorities was small but positive (r = .05) with substantial variation between studies (95% of studies reported effect sizes between r = -.31 and r = .41; Lefevor, Davis et al., 2021). This relationship was moderated by a number of factors (including whether participants were recruited from SGM venues and how RS was defined), highlighting the need for a more nuanced framework of how RS relates to health for SGMs. This call has been echoed by several researchers who have drawn attention to the way that the current narrative about RS among SGMs is primarily deficit-oriented and harm-focused (Etengoff & Rodriguez, 2021).

To fill this need, we present the Religious/Spiritual Stress and Resilience Model (RSSR). The RSSR builds on extant theories such as structural stigma (Hatzenbuehler, 2014) and minority stress theories (Brooks, 1981; Meyer, 2003) that describe how stigma and discrimination undermine health, additionally attending to the unique ways that RS can promote and contribute to health among SGMs. Though the RSSR is a general model, we note that, like the theories it leans on, the RSSR draws primarily on the experiences of American and Western European SGMs with RS. The RSSR integrates and applies many disparate strands of research. The vast majority of research addresses SGM health and the link between RS and health as separate areas of investigation (Lefevor, Davis et al., 2021); therefore, we begin by separately describing extant research related to (a) SGM health, (b) RS and health, and (c) RS among SGMs. We describe key concepts, definitions, and research findings in each area, providing a glossary of all key terms in Table 1.

Sexual and Gender Minority Health

Researchers have consistently documented a wide range of poorer health outcomes among SGMs relative to their heterosexual and cisgender peers (Institute of Medicine, 2011; Krueger & Upchurch, 2019; Lefevor, Boyd-Rogers et al., 2019; Liu et al., 2020). Researchers have noted disparities across a range of health outcomes including blood pressure (Lamb et al., 2020), cortisol (Lick et al., 2013), psychological distress (Ross et al., 2018; Russell & Fish, 2016), suicidal thoughts and behaviors (Chang et al., 2021; Lefevor, Boyd-Rogers et al., 2019), and substance use (Drabble et al., 2016). These health disparities can be attributed, at least in part, to a) structural stigma (Hatzenbuehler, 2014) as well as b) experiences of SGM-specific distal and proximal stressors that accompany a stigmatized social status (Meyer, 2003).

Structural Stigma. Many of the disparities experienced by SGMs can be explained by structural stigma (i.e., "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized"; Hatzenbuehler & Link, 2014, p. 2) toward SGMs. Often structural stigma is codified into laws that legalize discrimination against SGMs (Hatzenbuehler, 2014) or is reflected in a lack of laws protecting SGMs from hate crimes, employment discrimination, or other forms of discrimination (Hatzenbuehler et al., 2009).

Minority Stress. Where structural stigma explains disparities through an institutional lens, minority stress theory (Meyer, 2003) explains disparities by focusing on the interpersonal stressors experienced by SGMs (Ream, 2020). General stress theory (Lazarus & Folkman, 1984), suggests that life stressors and decreased social support lead to diminished health. Building on this framework, minority stress theory posits that SGMs experience both the same kinds of life

stressors that heterosexual and cisgender individuals experience as well as minority-specific stressors (i.e., distal and proximal stressors) and reduced access to social support.

Distal and Proximal Stressors. Meyer (2003) suggested that SGMs experience both "objectively stressful events and conditions" (i.e., distal stressors; Meyer, 2003, p. 681) and "internally stressful events" (i.e., proximal stressors; Meyer, 2003, p. 681) related to their experience as an SGM. Distal stressors include experiences of discrimination, victimization, and rejection. Meta-analytic evidence suggests that over half of SGMs have experienced some sort of verbal harassment, and 41% report SGM-based discrimination (Katz-Wise & Hyde, 2012). Proximal stressors include internalized negative self-views, hypervigilance, and concealment. Studies consistently document significant associations between these stressors and health among SGMs (Austin et al., 2013; Burks et al., 2018; Denton et al., 2014; Flentje et al., 2020).

Resilience Processes. Like their heterosexual and cisgender counterparts, SGMs engage in resilience processes both in the face of minority-specific stress and in the face of general life stress (Zautra et al., 2010; Table 1). Meyer (2003) suggested that typical resilience processes may be interrupted due to minority stress. Indeed, stigma and discrimination may make it more difficult for SGMs to access support from family and friends (Ehlke et al., 2020; Shilo & Savaya, 2012). Consequently, SGMs have responded by developing group-specific coping resources to provide belonging, connection, and practical information (i.e., RS support networks; Meyer, 2003; Meyer, 2015).

Religiousness/Spirituality (RS) and Health

The results of over 100 meta-analyses and systematic reviews indicate that among people generally, RS is consistently but modestly associated with better health (Davis et al., 2021, Appendix 18.S2), with an average correlation of $r = .15$ (Lefevor, Davis et al., 2021). This

finding has been replicated across a variety of populations, cultures, developmental periods, and methodologies (Hodapp & Zwingmann, 2019; Jim et al., 2015). Conversely, when people experience RS struggles ("tensions, conflicts, and negative emotions concerning RS"; Wilt et al., 2019), longitudinal meta-analytic evidence suggests these RS struggles lead to decreased psychological health (Bockrath et al., 2021). Paradoxically (yet perhaps predictably), the people who are most likely to experience both the positive and negative psychological effects of RS are people who are highly RS (Wilt et al., 2019).

RS Causal Pathways Theory: Linking RS and Health

RS causal-pathways theory (Koenig, 2012; Koenig et al., 2012) posits that RS enhances health via psychological, behavioral, and social pathways. Psychologically, RS may enhance health by helping them cope with stress and adversity (Pargament, 2007), cultivate a sense of meaning in life (Park, 2010), and fulfill psychological needs for predictability and self-coherence (Davis et al., 2021). Psychologically, RS may also help sustain positive emotions (Van Cappellen et al., 2021a), diminish negative emotions (Van Cappellen et al., 2021b), and provide a basis for meaning making and purpose (Mahoney et al., 2021). RS can enhance people's health via several behavioral mechanisms including participating in public and private RS practices, aligning with religiously proscribed or prescribed behaviors, and enacting character virtues that are motivated by RS beliefs and values (Davis et al., 2021; Koenig et al., 2012). RS can also enhance people's health via social mechanisms, including relationships with other people and/or supernatural entities, providing social support, belonging, and a sense of significance (Krause, 2006, 2010; Pargament, 2007; VanderWeele, 2017).

Research on RS Among SGMs

A small handful of systematic reviews and one meta-analysis have described research on RS among SGMs (Hamblin & Gross, 2013; Lassiter & Parsons, 2016; Lefevor, Davis et al., 2021; Rodriguez, 2010; Wilkinson & Johnson, 2020). Most reviews have described how SGMs may simultaneously experience stressors and support from RS (Hamblin & Gross, 2013; Wilkinson & Johnson, 2020) and that whether RS is experienced as helpful or harmful may depend on how RS is conceptualized and measured (Hamblin & Gross, 2013; Lefevor, Davis et al., 2021). No overarching, guiding theory has emerged from these reviews, but this literature can be divided into studies that examine ways in which RS has perpetuated harms among SGMs and ways in which RS has promoted resilience among SGMs.

Many SGMs have reported (both quantitatively and qualitatively) substantial harms related to their RS identities, experiences, and communities (Dehlin et al., 2014; Hall, 2018; Jacobsen & Wright, 2014). Across the globe, SGMs have faced religiously based violence, prejudice, stigma and interventions/therapies (American Psychological Association, 2009; Etengoff & Rodriguez, 2020, 2021). These harms are most pronounced in the context of religiousness (rather than spirituality; Rodriguez et al., 2016; Rosik et al., 2021) and may be moderated by the level of conflict SGMs experience between RS and SGM identities, SGMs' current RS beliefs, practices and motivations, and the degree to which SGMs experience support for their RS and SGM identities (Hamblin & Gross, 2013; Lefevor, Davis et al., 2021).

SGMs have also reported resilience to religiously based harms as well as benefits related to their RS identities, experiences, and communities (Skidmore et al., 2022c). SGMs have used RS in a variety of ways to cope with minority stress including undertaking scriptural exegesis (Etengoff & Rodriguez, 2017, 2020), seeking divine support through prayer (Etengoff, 2021; Etengoff & Rodriguez, 2020), engaging in spiritual development (Rodriguez et al., 2016;

Etengoff et al., In Press), finding supportive congregations (Rodriguez & Ouellette, 2000; Rodriguez, 2010), and seeking out online support groups for SGMs who are RS (Etengoff & Rodriguez, 2016). Further, some SGMs report that RS may facilitate minority stress-related growth (i.e., coming out growth; Rodriguez & Vaughan, 2013; Vaughan & Rodriguez, 2014). In addition, SGMs report benefits of using RS to navigate developmental challenges including understanding changing parent-child relationships in emerging adulthood (Etengoff & Daiute, 2014), navigating parenthood, (Rostosky et al., 2017) and creating fulfilling romantic relationships (Rostosky et al., 2008).

Why Do We Need a New Model?

There are at least two compelling reasons why a model explaining how RS relates to health among SGMs is needed. First, existing theoretical frameworks are unable to provide or have not fully provided an account of the multifaceted ways that RS relates to health among SGMs. Minority stress theory (2003) and its adaptations (Hatzenbuehler, 2009; Lefevor, Boyd-Rogers et al., 2019; Testa et al., 2015) provide a clear account of the ways in which RS may undermine health but have relatively little to say about how RS may promote health. Conversely, causal pathways theory (Koenig, 2012) concisely articulates the ways in which RS may lead to health but does not fully explain how RS may undermine it. Further, because extant health frameworks focus on RS or SGM identities independently, these theories obscure the unique nuances in the experiences of SGMs who are/were RS (Crenshaw, 1989). These frameworks also consequently fail to capture the unique ways that RS relates to health among SGMs as distinct from heterosexual and cisgender individuals. In sum, a novel model, specific to SGM individuals, is needed to simultaneously acknowledge the potential for SGM's RS to both positively and negatively impact their health

Second, much of the quantitative research examining RS among SGMs is conducted by researchers for whom RS among SGMs is not a primary focus. For example, of the 67 authors whose work was cited in Lefevor, Davis et al.'s (2021) meta-analysis, only 4 of those authors published multiple studies that were included in the analysis. Because subject expertise is built over time, researchers new to this area may not be familiar with the multifaceted relationships between RS and health among SGMs. Further, research examining SGM health and research examining the relationship between RS and health has largely been conducted in relative isolation from each other, with 95% of studies examining sexual orientation or RS failing to include a measure of the other (Lefevor, Davis et al., 2021). A coherent model of the relationship between RS and health among SGMs is thus particularly important to provide an accessible way for emerging researchers to become fully versed in two largely disparate bodies of research.

Introducing the Religious/Spiritual Stress and Resilience Model

We introduce the religious/spiritual stress and resilience model (RSSR) as a descriptive framework for understanding how RS positively *and* negatively relates to health among SGMs who are currently, formerly, and never identified as RS. The RSSR integrates many of the arguments made by structural stigma (Hatzenbuehler, 2014), minority stress (Meyer, 2003), and casual pathways theories (Koenig, 2012), specifically for SGM individuals. Conceptually, the RSSR is a descriptive model in which the relationship between RS and health is thought to be mediated by stress and resilience processes and moderated by variables unique to SGMs RS experiences.

The RSSR makes five primary assertions regarding the relationship between RS and health among SGMs, which are depicted graphically in Figure 1:

1. Minority stress and resilience processes influence health (pathways a, b, c)

2. RS influences general resilience processes (pathway d)
3. RS influences minority-specific stress and resilience processes (pathways d, e)
4. These relationships are moderated by a number of variables uniquely relevant to RS among SGMs such as congregational stances on same-sex sexual behavior and gender expression, an individual's degree of SGM and RS identity integration, and how the individual engages with RS (pathways f, g)
5. Relationships between minority stress and resilience, RS, and health are bidirectional (pathways a – e)

INSERT FIGURE 1 ABOUT HERE

Minority Stress and Resilience Processes Influence Health

First, we posit that minority stress and resilience processes directly and indirectly influence health, as demonstrated by pathways a, b, and c in Figure 1. Drawing on Virginia Brooks initial theorizing (1981), Ilan Meyer popularized these propositions in 1995; since then, hundreds of studies have corroborated Meyer's initial propositions. We summarize the central tenets and their support here but refer the interested reader to several more thorough reviews of minority stress theory (Durrbaum & Sattler, 2019; Katz-Wise & Hyde, 2012; Meyer, 2003; Meyer et al., 2021; Newcomb & Mustanski, 2010; Thoma et al., 2021).

Distal Stressors

Distal stressors directly influence health (pathway a). Distal stressors include both experiences and perceptions of prejudice events within a person's social environment (Meyer, 2003) and include physical violence, housing or employment discrimination, verbal harassment, and sexual assault (Katz-Wise & Hyde, 2012). Such experiences are linked to poorer health for SGMs. For example, experiences of victimization are highly associated with poorer health

outcomes such as increased depression and anxiety as well as heightened suicidal ideation and behaviors (Katz-Wise & Hyde, 2012; Lick et al., 2013; Meyer et al., 2021; Pascoe & Smart Richman, 2009; Thoma et al., 2021). Rejection is also associated with higher overall psychological distress for SGMs, including increased depressive symptoms, anxiety symptoms, disordered eating, and suicidality (Austin et al., 2013; Durrbaum & Sattler, 2019; Robinson et al., 2013).

Proximal Stressors

Proximal stressors also directly influence health (pathway a). Similar to distal stressors, proximal stressors have been linked to worse health for SGMs, including increased depression, anxiety, general physical health problems, and suicidality (Durrbaum & Sattler, 2019; Meyer et al., 2021). Meta-analytic findings suggest that there is a small to moderate overall effect size for internalized homonegativity predicting internalizing mental health problems, including depression and anxiety (Newcomb & Mustanski, 2010). SGMs who conceal their sexual orientation or gender identity consistently report higher psychological distress and depressive symptoms (Leleux-Labarge et al., 2015; Riggle et al., 2017; Thoma et al., 2021). Concealing one's SGM identity or experience is often used to protect oneself from exposure to distal stressors, but it may inadvertently reduce feelings of belonging as individuals perceive themselves to be inauthentic and disclose less information about themselves (Newheiser & Barreto, 2014). Proximal stressors may be more strongly associated with adverse health outcomes than distal stressors, particularly among adolescents, bisexual individuals, women, and ethnic/racial minorities (Durrbaum & Sattler, 2019; Lucassen et al., 2017; Marshal et al., 2011; Martin-Storey & Crosnoe, 2012).

Resilience

Resilience may both directly influence health and moderate the relationship between stressors and health outcomes (pathways b, c). Given the chronic and unavoidable nature of many minority stressors for SGMs, building minority-specific resilience is necessary in order to reduce the impact of these stressors (Feinstein & Marx, 2016). Resilience is thus not the antithesis or absence of minority stress but rather a process by which individuals actively buffer stress and its associated effects. Individual (i.e., finding hope) and community level (i.e., belonging) resilience factors can interactively help reduce the impact of minority stressors (Hall & Zautra, 2010; Meyer, 2015; Zimmerman, 2013). For example, SGMs who report higher levels of hope and personal responsibility for their lives experience less depressive and anxiety symptoms than those with lower levels (Russell & Fish, 2016). Relatedly, feelings of belongingness in SGM communities (i.e., LGBTQ+ affirming faith groups) have been associated with decreased depressive and anxiety symptoms, and have been shown to moderate the relationship between both distal (e.g., victimization, discrimination) and proximal stressors (e.g., concealment, internalized homonegativity) on health outcomes (Barr et al., 2016; Krause & Bastida, 2011; Wong et al., 2006).

RS Influences General Resilience Processes Among SGMs

We assert that RS may influence general resilience processes among SGMs (pathway d in Figure 1). A recent meta-analysis found that RS is positively related to health among sexual minorities (Lefevor, Davis et al., 2021), suggesting that this effect occurs along psychological, social, and behavioral pathways (Koenig, 2012).

Psychological Pathways

RS may promote resilience among SGMs through psychological pathways including the ways that SGMs (a) use RS to cope with stress, (b) use RS to make meaning, (c) experience

emotions while practicing RS, and (d) conceptualize specific beliefs and develop cognitive structures related to RS that may influence health (Koenig, 2012). The primary ways that RS promotes general resilience among SGMs, at least vis-à-vis psychological pathways, appear to be through encouraging meaning making, providing a space for positive emotions, and supporting a personal connection with the divine (Lefevor, Davis et al., 2021). Although many SGMs reject RS beliefs and worldviews, it appears that SGM's voluntary engagement with RS may promote resilience through an increased sense of meaning (Moscardini et al., 2018; Rosenkrantz et al., 2016), positive affective and cognitive experiences (Dahl & Galliher, 2010). Further, when SGMs report experiencing a personal relationship with a higher power (i.e., spirituality), this belief appears to buffer stress and promote health (Alessi et al., 2021; Dahl & Galliher, 2010; Dangerfield et al., 2019; Lassiter et al., 2019; Lefevor, Davis et al., 2021; Porter et al., 2019). SGM's spiritual beliefs may promote a sense of connectedness, self-cohesion, and emotion regulation that may support health (Dean et al., 2021; Lassiter et al., 2019; Lassiter & Mims, 2021; Lefevor, McGraw et al., 2021).

R/S coping strategies can be both helpful/positive or harmful/negative. Generally, positive religious coping (e.g., turning to deity or beliefs for support) tends to be an effective coping strategy among cisgender/heterosexual individuals (Ano & Vasconcelos, 2005), but there are mixed findings about the effectiveness of positive religious coping for SGMs (Lassiter et al., 2019; Lauricella et al., 2017). SGMs may have more complex relationships with their religious beliefs and deity, which may make turning to these beliefs and deity much less reliable than it would be for cisgender/heterosexual individuals (Lefevor, McGraw et al., 2021). At the same time, when SGMs experience support from their beliefs and deity, turning to these supports may be helpful in coping with distress. Although many aspects of RS relate to health differently for

SGMs and cisgender/heterosexual individuals, meta-analytic results suggest that when SGMs conceptualize RS as spirituality, they experience the same degree of health-protective effects from RS that cisgender/heterosexual individuals do (Lefevor, Davis et al., 2021).

Social Pathways

RS may promote general resilience among SGMs through social pathways including social connection, belongingness, and meaningful relationships. The efficacy of social pathways for RS resilience among SGMs has mixed empirical support (i.e., approximately half of the 57 studies in Lefevor et al.'s meta-analysis reported positive effects and about half reported negative effects; Lefevor, Davis et al., 2021). Part of the reason that the empirical literature on social pathways is mixed is because RS has also been noted to facilitate ostracization, alienation, and loneliness for SGMs (see section below on how RS can influence minority stressors). Nonetheless, at least some SGMs report that RS facilitates social connection and belonging (Rosenkrantz et al., 2016; Rostosky et al., 2017; Tan, 2005; Zarzycka et al., 2017), and that this engagement can lead to resilience and positive health (Kralovec et al., 2014; Scroggs et al., 2018), potentially because it increases self-acceptance or self-cohesion (Dean et al., 2021).

Behavioral Pathways

RS may also promote general resilience among SGMs by encouraging or discouraging specific behaviors. Behavioral pathways include (a) the RS behaviors engaged in as part of worship or practice (e.g., service attendance, meditation, study), (b) prosocial behaviors that are encouraged by a RS tradition (e.g., charity and community service work), and (c) harmful behaviors that are discouraged by a RS tradition (e.g., violent behaviors, risky sexual behaviors, substance misuse). Like social pathways, there is mixed empirical support that RS influences health among SGMs through behavioral pathways (i.e., approximately half of the 70 studies in

Lefevor et al.'s meta-analysis reported positive effects and about half reported negative effects; Lefevor, Davis et al., 2021).

For example, religious service attendance—particularly when other aspects of RS are controlled for—does not particularly appear to promote resilience among SGMs (Cranney, 2017; Dahl & Galliher, 2010; Lefevor, Davis et al., 2021), and some suggest that attending services may lead to adverse health outcomes, including increased hypertension (Lamb et al., 2021) and depression (Escher et al., 2018). Only a handful of studies report positive associations between service attendance and resilience (Lauricella et al., 2017; Wilkerson et al., 2013), possibly suggesting that the reported benefits of service attendance may be better explained by other associated RS behaviors (Etengoff & Lefevor, 2020; Garofalo et al., 2015; Lefevor, Sorrell et al., 2021). Alternatively, at least some research suggests that individuals may be more likely to attend religious services *because* they experience distress (i.e., guilt), making it more complicated to understand the true nature of this relationship (Abu-Raiya et al., 2015; Pargament, 1997).

Alternatively, the literature is a bit clearer that RS may promote resilience among SGMs by encouraging certain behaviors and discouraging other behaviors. For example, RS messaging about substance abuse and sexual safety appears to lead to less frequent substance use and risky sex in some SGMs (Drabble et al., 2016; Eliason et al., 2011; Garofalo et al., 2015; VanderWaal et al., 2017). Similarly, RS messaging about viewing one's body as an extension of the divine may lead SGMs to invest more in their physical health (Lassiter & Mims, 2021). RS may also effectively promote prosocial behaviors such as compassion, forgiveness, or love among SGMs, which in turn may lead to resilience (Job & Williams, 2020).

RS Influences Minority Stress and Resilience Processes

In addition to influencing general resilience processes, RS has been shown to influence SGM-specific stress and resilience processes. These relationships are depicted graphically in pathways d and e in Figure 1. We note that SGMs vary in how and whether they experience each of the following examples as stressful or resilience inhibiting.

RS Increases Exposure to Distal Stressors

The sociohistorical relationship between RS and prejudice toward SGMs is indisputable (Etengoff & Lefevor, 2020; Herek & McLemore, 2013; Whitley, 2009). The teachings within many religious traditions have often been used to support both discrimination and prejudice (Adamczyk, 2017). Moreover, multinational studies confirm that the relationship between RS and prejudice toward SGMs persists in all major religious traditions as well as when prejudicial attitudes are measured as country-level variables (Hoffarth et al., 2018; Janssen & Scheepers, 2019). Although more and more places of worship are publicly expressing their openness and acceptance of SGMs (Murphy, 2015), particularly within Western contexts, most places of worship have or have had policies/practices that are experienced by SGMs as homo/transnegative (Barringer, 2019). While it is beyond the scope of the present paper to explore theological positions, the present paper aims to explore the psychological impact of SGMs' diverse RS experiences. Below, we expand upon the distal stressors of: religiously based discrimination, cis- and hetero-normative messaging, sexual orientation and gender identity change efforts, and interpersonal rejection. Subsequently, we explore and expand upon RS resilience.

Religiously Based Discrimination. The most obvious manifestation of prejudicial attitudes involves overt discrimination, including violence and harassment. Some of the worst hate crimes committed against SGMs have been religiously motivated (Barka, 2006). SGMs who

live in more religious environments report discrimination (Moscardini et al., 2018), verbal abuse (Craig et al., 2017), physical abuse (Sowe et al., 2017), and harassment (Ho & Hu, 2016). This discrimination directly affects SGM's health, particularly if SGMs themselves are RS (Moscardini et al., 2018).

Cis- and Hetero-Normative Messaging. Many SGMs also report a subtler version of discrimination that is based in cis- and hetero-normativity (i.e., the expectation that all individuals are or ought to be heterosexual and cisgender). Cis- and hetero-normativity include pressure to conform to cisgender norms of presentation as well as expectations of heterosexual relationships and family structures (Mavhandu-Mudzusi & Sandy, 2015). As many as 91% of SGMs report hearing cis- and hetero-normative messages at places of worship (Gibbs & Goldbach, 2020; Kubicek et al., 2009; Woodyard et al., 2000). For example, many religious dominations have policies that prevent SGM individuals in same-sex relationships or whose gender expression does not match expectations based on their sex assigned at birth from being members and/or holding leadership positions (Lefevor, Sorrell et al., 2021). Religious community systems may also encourage conformity to cis- and hetero-normative conceptions of family (Barnes, 2013; Lefevor, Sorrell et al., 2021; Lefevor, Milburn et al., 2020). When SGMs attend religiously based colleges/universities, the welcomeness or unwelcomeness of these views can be magnified (Craig et al., 2017; Etengoff, 2021; Heiden-Rootes, Wiegand et al., 2020; Steward et al., 2008; Wilkinson & Pearson, 2009; Wolff et al., 2016). SGM individuals have reported varying responses to cis- and hetero-normative religious messages. For some SGMs, these views are experienced as jarring and distressing (Sowe et al., 2014; Sowe et al., 2017; Woodyard et al., 2000) and for other SGMs these views are consistent with their perception of an optimal way to engage with life as an RS individual (i.e., celibacy outside of cis-marriage, living

life as the gender typically associated with the sex assigned at birth; Yarhouse & Zaporozhets, 2019).

Sexual Orientation and Gender Identity Change Efforts. SGMs may also experience religiously motivated efforts to change gender identity or sexual orientation change efforts (Beckstead & Morrow, 2004; Freeman-Coppadge & Horne, 2019). Change efforts include individual-led efforts (e.g., cognitive reframing, "trying" to change), religiously based efforts (e.g., fasting, prayer), therapist-led efforts (e.g., conversion therapy), and group efforts (e.g., group retreats, support groups; Bradshaw et al., 2015). While many RS SGMs appear to engage in change efforts at some point in their life (Dehlin, Galliher et al., 2015b), a very small minority (as few as 4%) report that these efforts are successful in changing core experiences of sexuality or gender for even a short length of time (Bradshaw et al., 2015). Much more frequently, SGMs report harms resulting from change efforts (American Psychological Association, 2009).

Interpersonal Rejection. Religiously motivated prejudice can also result in interpersonal rejection for SGMs. This rejection can happen in religious contexts (e.g., formal excommunication, ostracization from a congregation), family contexts (e.g., parents reject SGM children because of their RS beliefs), and general interpersonal contexts (e.g., RS beliefs motivate an individual to socially distance themselves from an SGM). Rejection by fellow congregants or clergy is associated with increased anxiety, more identity conflict, and less social support (Hamblin & Gross, 2013; Zarzycka et al., 2017). Rejection may have long-lasting effects, with RS SGMs evidencing increased rejection sensitivity even if not currently attending services (Gandy et al., 2021; Lassiter, Saleh et al., 2019). RS may also be cited by SGMs' families as the grounds for decreased family support (Etengoff & Daiute, 2014; Etengoff & Rodriguez, 2021; Heiden-Rootes et al., 2019). Generally, RS SGMs report less family support

than SGMs who are not religiously affiliated (Hamblin & Gross, 2013; Henrickson, 2007; Shilo & Savaya, 2012), with as many as 2/3 of SGMs reporting experiencing some degree of parental rejection (VanderWaal et al., 2017). SGMs' perceptions of parental rejection is a powerful predictor of poor health among SGM youth (Shearer et al., 2018), with their psychologically damaging effects often extending to adulthood (Heiden-Rootes et al., 2019; Ream, 2021).

RS Increases Proximal Stressors

RS may also influence SGM's health by creating an environment that perpetuates or worsens proximal stressors. Specifically, RS may encourage concealment or foster internalized stigma among SGMs. For SGMs raised in some religious traditions which prohibit same-sex relationships, RS may also instigate identity conflict. We further acknowledge that in some cases, the gap between RS and secular views on SGM identities and behaviors may be particularly challenging for SGM individuals to navigate.

Concealment. SGMs are much more likely to conceal their sexual orientation or gender identity if they are RS (Kubicek et al., 2009; Lefevor, McGraw et al., 2021; Lefevor, Sorrell et al., 2019; Shilo & Savaya, 2012; Woodyard et al., 2000). Some studies suggest that over half of SGMs who attend religious services conceal their sexual orientation/gender identity from their RS community (Jeffries et al., 2014; Shilo et al., 2016; Suen & Chan, 2020), often due to concerns about rejection from others (Lassiter et al., 2019). Concealment may thus lead SGMs to have less relational intimacy (Itzhaky & Kissil, 2015) and may make it more difficult for SGMs to feel comfortable in RS spaces. Ultimately, this religiously motivated concealment may lead to greater loneliness, depression, substance abuse, and general emotional turmoil (Corbin et al., 2020; Escher et al., 2018; Itzhaky & Kissil, 2015; Shilo et al., 2016). Despite these general trends, at times, SGMs conceal their sexual orientation or gender identity due to situational

awareness (e.g., disclosing could be more harmful than concealing) or to a sense of autonomy/control (e.g., not disclosing in situations where a straight or cisgender person would not feel the need to disclose), making the relationship between concealment and health less straightforwardly negative (Pachankis et al., 2020).

Internalized Stigma. SGMs may also internalize cis- and hetero-normative messaging. This internalized stigma (i.e., internalized homonegativity, internalized transnegativity) includes beliefs that one is fundamentally flawed, unlovable, or unacceptable because of one's sexuality or gender (Szymanski et al., 2008). Dozens of studies have linked RS to internalized stigma, typically understanding this link to be the result of cis- and hetero-normativity inherent in most faith traditions (Barnes & Meyer, 2012; Foster et al., 2017; Kubicek et al., 2009; Wright & Stern, 2016). Ultimately, internalized stigma seems to be associated with depression, substance use, and suicide (Alessi et al., 2021; Kralovec et al., 2014; Newcomb & Mustanski, 2010), though at least a handful of studies suggest that this relationship is less strong among individuals who are RS (Brewster et al., 2016; Crowell et al., 2015; Kralovec et al., 2014), potentially due to conceptual overlap between measures of RS and internalized stigma (Rosik et al., 2021; i.e., measures of internalized stigma assess attitudes/behaviors that a RS individual would endorse, regardless of their degree of internalized stigma; although see Lefevor, Larsen et al., 2022 though for a recent meta-analysis that suggests this may not be the case). Many studies have suggested that RS ultimately affects SGMs' health negatively because SGMs who are RS experience less SGM identity affirmation and more religiously based conflict than those who are not RS (Heiden-Rootes et al., 2020; Jacobsen & Wright, 2014; Page et al., 2013; Stern & Wright, 2018; Szymanski & Carretta, 2019). The relationship between internalized stigma and poor health may

be mediated by spiritual struggles (i.e., blaming God or the Devil for problems; Bourn et al., 2018; Brewster et al., 2016).

Identity Conflict. Although some or even many SGMs do not experience identity conflict (Rodriguez, 2010), many SGMs report conflict between their RS and SGM identities (Gibbs & Goldbach, 2020; Hamblin & Gross, 2013; Nielson, 2016; Rodriguez, 2010; Rodriguez & Ouellette, 2000; Rodriguez et al., 2019; Wolff et al., 2016). This conflict may be enhanced as SGMs engage with *either* their RS or SGM identities and may manifest as uncertainty around their ideal gender expression or sexual behavior, confusion as to their religious beliefs, and/or difficulty reconciling their SGM and RS identities. Regardless of the source, identity conflict is clearly linked to poor health including low self-esteem, depression, anxiety, self-harm, isolation, and risky sexual behavior (Gibbs & Goldbach, 2020; Hamblin & Gross, 2013; Nielson, 2017; Rodriguez et al., 2019).

RS Influences In-Group Coping and Resilience

RS may create barriers for SGMs to access in-group coping resources and alternatively, facilitate the creation of unique ways of coping (see pathway d in Figure 1). In his initial delineation of minority stress theory, Meyer (2003) suggested that group solidarity and cohesiveness were primary resilience processes for SGMs. This thinking follows Jones et al.'s (1984) argument that participating in minority communities improves health in two primary ways: (a) providing a space free of discrimination and (b) providing a new reference group for individuals to reinterpret minority stressors as aspects of hetero- and cis-sexist societies rather than because of personal defects. However, RS may also interfere in each of these processes. Conversely, or perhaps consequently, SGMs who identify as RS may also seek and access group-specific resources unique to RS SGMs to cope with minority stress.

RS May Make it More Difficult for SGMs to Connect to SGM Individuals and Communities. Historically, SGM communities have been a place of support for SGMs to connect with others like them. These spaces can be particularly helpful for SGMs processing harmful experiences from RS and may provide access to others who have experienced similar experiences, helping the healing process (Lefevor, Huffman et al., 2020). Particularly if the SGM ultimately disaffiliates religiously, SGM communities may be experienced as a safe haven.

However, many RS SGMs report that SGM communities do not feel welcoming of their RS (Beagan & Hattie, 2015) and consequently that it is more difficult to connect with secular SGM communities (Craig et al., 2017). A recent meta-analysis confirmed that SGMs sampled from SGM communities had more negative views toward RS than SGMs generally (Lefevor, Davis et al., 2021). Engagement with SGM communities may thus not be as related to health for RS SGMs as it is for secular SGMs because RS SGMs may not feel as strong of a sense of belongingness in SGM spaces (Scroggs et al., 2018; Skidmore et al., 2022a). At its extreme, some RS SGMs may experience discrimination or rejection in SGM spaces because of their intersectional identities (Beagan & Hattie, 2015).

RS may also keep SGMs from connecting to SGM communities. SGMs with a RS background tend to come out later (Bradshaw et al., 2015; VanderWaal et al., 2017) and experience less support surrounding their SGM identity (Kralovec et al., 2014). RS is associated with fewer contacts with other SGMs (Shilo & Savaya, 2012), potentially because of RS cis- and hetero-normative teachings (Woodyard et al., 2000). Further, RS teachings may promote stereotypes that SGMs and SGM communities are sexually focused, unhappy, and otherwise unhealthy. Thus, RS SGMs may be more hesitant to connect with SGM communities, leading

them to be more isolated and preventing them from accessing the health-promoting benefits of community connection (Shilo & Savaya, 2012; Zeidner & Zebulun, 2018).

Unique Resilience of RS SGMs

Like other individuals with multiple marginalized identities, RS SGMs often form their own tightknit groups based on their shared, intersecting identities. These groups may serve the two functions identified by Jones et al. (1984) in that they provide a space free from discrimination of either identity and they provide a space for RS SGMs to normalize and validate their experiences. Many RS traditions and denominations are creating spaces for these groups to emerge by altering and/or dialoguing about theological positions to no longer discourage same-sex sexuality or gender expansive expressions. SGMs from more conservative RS traditions often form their own support groups such as Courage and Dignity (SGM Catholics), North Star and Affirmation (SGM Mormons), Q Christian Fellowship and Spiritual Friendship (SGM Christians), and the Muslim Alliance for Sexual and Gender Diversity (SGM Muslims). At least some research suggests that these groups may provide the same kind of buffering effects that SGM communities may provide for non-RS SGMs (Barringer & Gay, 2017; Scull & Mousa, 2017). Both affiliation with denominations that do not discourage same-sex sexuality or gender expansive expression (Foster et al., 2015; Rodriguez, 2010) as well as connection to communities of SGMs from conservative faith backgrounds (Lefevor, McGraw et al., 2021; Shilo et al., 2016) have been demonstrated to be health promoting for RS SGMs.

Some SGMs may also evidence unique resilience by integrating RS and SGM identities. Although RS SGM identity integration appears uncommon from the limited data available (Dehlin, Galliher et al., 2015a; Lefevor, Skidmore et al., 2021), SGMs who integrate their religious and SGM identities often report positive health outcomes (Dehlin, Galliher et al.,

2015a). These SGMs may engage more often with RS and see their faith as a larger part of who they are, which may ultimately be beneficial (Dean et al., 2021; Scroggs et al., 2018). Some have even reported that their RS involvement helps them cope with the unique minority stressors experienced as an SGM such as internalized stigma or discrimination (Barbosa et al., 2020).

RS-Specific Moderators

We posit that the relationship between RS and stress or resilience is moderated by a handful of variables particularly pertinent to SGMs and RS (see paths f and g in Figure 1). These include the congregational stances on same-sex sexual behavior and gender expression of the congregations RS SGMs attend, the degree to which an SGM's world is permeated by RS, where an individual is in their SGM identity development, how an individual conceptualizes their RS, relationship status, and individuals' other social identities. This list is not meant to be exhaustive but rather a starting point to encourage future research.

Congregational Stance on Gender/Sexuality

For SGMs who are RS, the degree to which their congregation holds theological positions that enable a variety of life pathways for SGMs affects whether RS will be experienced as a stressor or resilience factor. Some congregations have adopted formal statements welcoming SGMs or that allow SGMs to hold all of the same leadership positions that heterosexual and cisgender congregants hold (Jeffries et al., 2008; Rodriguez & Ouellette, 2000; Rodriguez et al., 2019). In contrast, other congregations expect sexual celibacy outside of marriage between a cisgender man and a cisgender woman and discourage gender expansive presentation. SGMs participate in and value both kinds of congregations, and SGMs in both kinds of congregations have reported health and satisfaction (Lefevor, Beckstead et al., 2019).

Nonetheless, when SGMs attend congregations that encourage a variety of life pathways for SGMs, attending worship services appears to be more likely to be experienced as a resilience factor and may even reduce minority stressors experienced. Studies have found that the effects of discrimination on depression are attenuated when SGMs attend congregations that do not have strict expectations about their sexual behavior or gender expression (Gattis et al., 2014). Attending such a congregation may also mitigate the effects of minority stressors by reducing identity conflict (Fuist, 2016), providing a space to address institutionalized and internalized cis- and hetero-normativity (Barbosa et al., 2020), and acceptance and emotional healing (White et al., 2019).

When SGMs who attend congregations that discourage same-sex sexual behavior or gender expansive presentation, attending worship services is more likely to be experienced as a stressor and lead to anxiety (Hamblin & Gross, 2013). Early experiences of attending a theologically conservative congregation may make adult SGMs more prone to sexual risk-taking behaviors (Nielson, 2017). Attending theologically conservative congregations may also enhance the degree of sexual identity conflict and reduce the degree of social support experienced by an SGM (Hamblin & Gross, 2013). Nonetheless, at least some SGMs who attend theologically conservative congregations may find support among fellow congregants to whom they may be open about their SGM identity and/or experience (Lefevor, McGraw et al., 2021)—which may lead to health and satisfaction (Lefevor, Beckstead et al., 2019). Likely, the extent to which SGMs experience theologically conservative congregations as health-promoting is attributable to the degree to which SGMs evidence both self-acceptance around their SGM identity and religious alignment with the congregation (Dean et al., 2021).

How an Individual Experiences RS

How SGMs conceptualize RS may alter the way that RS influences their experience of minority stressors and resilience, ultimately influencing their health. In particular, the degree to which an SGM holds orthodox or fundamentalist views, the degree to which an SGM's worldview is permeated by RS, and the degree to which an SGM separates religion and spirituality may alter the way that RS influences their experience of minority stress and resilience.

Religious Conservativism. SGMs who hold more conservative religious views experience their RS differently than those who do not (Etengoff & Lefevor, 2020). Conservative views may lead SGMs to engage more frequently and intensely with religious services, which may make them more likely to internalize negative views about their same-sex sexual attractions or gender expansive experiences (Rickard & Yancey, 2018; Sherry et al., 2010; Warlick et al., 2021). At the same time, holding conservative views may help SGMs find support, belonging, and congruence, as being more engaged in these beliefs may facilitate stronger social ties to likeminded congregants and family members (Lefevor, McGraw et al., 2021). Conservatively religious SGMs may thus experience increased family support but decreased SGM-identity support (Kissil & Itzhaky, 2015; Lefevor, Sorrell et al., 2019). These trends may be amplified when SGMs attend faith-based colleges/universities, with RS SGMs experiencing both enhanced stress and enhanced support (Dean et al., 2021; Etengoff, 2021; Heiden-Rootes et al., 2020; Yarhouse et al., 2009).

RS Identity Salience. How much an SGM's environment and worldview is characterized by RS (i.e., RS identity salience) will also impact the way in which RS influences health. For SGMs whose worldview is characterized by RS—as may often be the case among SGM Mormons, Muslims, Evangelical Christians, or Orthodox Jews—RS may be experienced as a

way of life rather than as a choice. RS may inform how family relationships ought to be carried out, which foods or drinks are acceptable, how one should spend their leisure time, and even the focus of one's private thoughts (Alvi & Zaidi, 2021; Scull & Mousa, 2017). For SGMs whose worldview is characterized by RS, coming out may be experienced by self and others as a rejection of a prescribed way of life (Alvi & Zaidi, 2021). While maintaining the RS identity may lead to fewer interpersonal RS struggles, it could increase the damage done by interpersonal RS conflict (Lefevor, McGraw et al., 2021). Conversely, rejecting a RS identity may involve a reworking of many aspects of life, which may not be "worth it" for some SGMs (Longo et al., 2013; Skidmore et al., 2022b). Indeed, rejecting a RS identity experienced as a worldview may lead to greater struggles, less family support, and suicide attempts (Cranney, 2017; Gibbs & Goldbach, 2015; Joseph & Cranney, 2017; Kralovec et al., 2014; Lefevor, McGraw et al., 2021). At least some SGMs may find a way to "hold" both an SGM and religious identity and have reported benefits of doing so (Rodriguez et al., 2019; Yarhouse et al., 2018). Concealment and internalized stigma may serve to maintain the status quo and ensure family support—consequently reducing distress—even if concealment and internalized stigma ultimately feed conflict (Kralovec et al., 2014; Scull & Mousa, 2017). For these SGMs, RS may thus increase both stressors and support.

Religion vs. Spirituality. Most SGMs differentiate between religiousness and spirituality (Johnston & Stewart, 2011). Generally, holding spiritual beliefs (rather than religious) is more definitively linked to increased support and resilience (Meanley et al., 2016). Among SGMs who are religious, also identifying as spiritual is linked to better health, possibly because of the sense of connection inherent in spirituality (Lassiter, Saleh et al., 2019). Though many SGMs leave organized religion (Lefevor, Park et al., 2018), many also appear to reclaim a sense of spirituality

over time (Lamb et al., 2021; McGlasson & Rubel, 2015). These trends are borne out in the results of a recent meta-analysis that found when SGMs conceptualized RS as spirituality, they experienced the same health-protective benefits that heterosexual and cisgender individuals do from RS (Lefevor, Davis et al., 2021). Thus, for SGMs, spirituality may have a more uncomplicated and positive relationship with health because it does not increase stressors while increasing resilience.

SGM Identity Development/Integration. RS may be experienced as a stressor or resilience factor based on how an SGM is navigating their identity development. While early research characterized SGMs' identity development as following sequential, hierarchical stages (e.g., confusion, tolerance, acceptance, pride, and synthesis; Cass, 1979), more recent work has argued the SGM identity development is more often a fluid and socioculturally contextualized process (Rodriguez, 2010). Relatedly, while many SGMs' RS identity development has been characterized by conflict, trying to change, disengaging from religion, and redefining faith and values, these stages may not be linear or hierarchical (Dahl & Galliher, 2012; McGlasson & Rubel, 2015). In this vein, Rodriguez (2010; et al., 2019) introduced the framework of SGM RS identity integration as a process more so than a final destination.

Relationship Status. SGMs may experience RS as a stressor or resilience factor based on the SGM's single/relationship status. Lefevor, Beckstead and colleagues (2019) suggested four primary single/relationship statuses pursued by SGMs from conservative religious backgrounds: single and committed to celibacy, single but pursuing sexual relationships, in a mixed orientation relationship where one partner is cisgender and heterosexual and the other partner is an SGM, or in a same-sex relationship. Research on these statuses suggest that religiously conservative SGMs may be more likely to pursue celibacy or mixed orientation relationships and that these

SGMs may experience their RS as a resilience factor (Freeman-Coppadge & Horne, 2019; Lefevor, Schow et al., 2021). For these individuals, RS may provide support and reification of SGMs' life choice (Lefevor, Beckstead et al., 2019). Because of their commitments to partners and RS values, many of these SGMs seek to remain within their partnership, sometimes at a great personal cost (Dehlin et al., 2014).

Conversely, other SGMs may experience RS as a stressor because RS may inhibit SGMs from forming intimate same-sex relationships that could otherwise help buffer minority stress. Because many RS traditions discourage same-sex sexual relationships, SGMs coming from RS backgrounds who desire same-sex sexual relationships may experience difficulties entering in these relationships due to delayed sexual activity (Beagan & Hattie, 2015), being overly sexually cautious (Woodyard et al., 2000; Severson et al., 2014), feeling conflicted about finding same-sex partners (Zeidner & Zevulun, 2018), and/or experiencing internalized negative attitudes toward same-sex sexual partners (Dangerfield et al., 2019). All of these processes could potentially make it more difficult for SGMs to find satisfying relationships that might otherwise help foster a sense of acceptance, belonging and freedom from discrimination (cf. Jones et al., 1984).

Individuals' Intersectional Social Identities

SGMs' other social identities may also affect the way that RS influences stressors or support. Race/ethnicity, age, and gender and sexuality—as well as the unique ways in which these identities intersect—may be particularly salient.

Gender and Sexual Identity. SGMs may experience RS, minority stress, and resilience differently based on their specific sexual and gender identities (Barringer, 2020; Scroggs & Faflick, 2019). Often, research on sexual minorities is presumed to apply to gender minorities

without a substantive representation of gender minorities in this work (Tebbe et al., 2016). This thinking can be problematic as sexual and gender minorities differ in many important respects. The majority of the work cited in this manuscript focuses on sexual minorities, though we have intentionally included gender minority-specific citations where possible. A small but growing body of research focuses specifically on RS in gender minority samples (see review in Rodriguez & Follins, 2012; Etengoff & Rodriguez, 2020). Notably, a recent study documented associations between RS struggles and gender minority stress (Exline et al. 2021), however much research remains to be done. Further, both cisgender and transgender women have been historically oppressed in RS spaces (Barrow & Kuvalanka, 2011), which may lead SGM women to have more positive experiences with RS when they construct their experience as more individually motivated rather than relying on authority (Ali et al., 2021; Eliason et al., 2011).

Race/Ethnicity. SGMs of color are much more likely to be RS than their White counterparts (Lefevor, Smack et al., 2020). This RS also may take a different form as SGMs of color may be both more likely to prefer theologically conservative places of worship and to find alternative spaces to express their same-sex sexuality or gender expansive expression, such as the ballroom and house culture (White et al., 2019). RS may be a more common and effective source of coping with distress among SGMs of color, even when the RS promotes cis- and hetero-normative views (Lefevor, Smack et al., 2020; Schmitz & Woodell, 2018; Walker & Longmire-Avital, 2013). RS may thus be engaged with as a cultural practice, which may alter how it relates to stress or resilience (Lassiter & Mims, 2021). SGM communities may also be less likely to be welcoming and positive places for SGMs of color (Mitha et al., 2021), potentially leading SGMs of color to rely more heavily on RS communities.

Age. SGMs relationships with RS may change as they age (Westwood, 2017). Further, cohort differences may impact the way that SGMs of various ages relate to RS. Older SGMs may be more likely to identify as RS (McGlasson & Rubel, 2015) and to have experienced more discrimination, oppression, and distress in RS spaces (Escher et al., 2018). Younger SGMs are less likely to affiliate religiously (Lefevor, Park et al., 2018) and may not have experienced the same kind of discrimination and oppression in RS spaces. As such, RS may be experienced as less stressful but also less supportive by younger SGMs relative to older SGMs.

Relationships between Minority Stress and Resilience, RS, and Health are Bidirectional

Up to this point, we have presented the model linearly, which is how we posit that the relationships are most frequently experienced. However, consistent with relational developmental systems metatheory (Overton, 2010, 2015)—the predominant metatheoretical framework of lifespan development—it is likely that these causal pathways operate bidirectionally, at least some of the time. Below, we present the logic behind the possible bidirectionality of the pathways of the RSSR. We stress, however, that we see the pathways as predominantly occurring from RS to stress/resilience to health.

Health may Influence Perceptions of Minority Stress and Resilience

At least some research suggests that health may affect perceptions of mental stress (paths *a* and *b* in Figure 1). Much of the research supporting minority stress theory is correlational rather than longitudinal (Bailey, 2020), and some longitudinal research has suggested that increases in anxiety are not always related to increases in proximal or distal stressors (Pachankis et al., 2018). It may be that when SGMs experience worse health, they are more likely to perceive distal and proximal stressors, as both are related to trait neuroticism (Lippa, 2005; Mineka et al., 1998).

Stress and Resilience May Influence RS

Stress and resilience may also influence RS (indirect paths that include paths *d* and *e* in Figure 1). RS SGMs have noted that their mental and physical health have affected their spiritual consciousness (Lassiter & Mims, 2021). Similarly, experiencing high degrees of distress may lead SGMs to engage with RS as a way to cope (see Abu-Raiya et al., 2015; Pargament, 1997). Theoretical, correlational, and longitudinal research have all supported claims of bidirectionality between RS and health in heterosexual and cisgender populations (Davis et al., 2021; Dew et al., 2020; Hardy et al., 2020; Kim-Spoon et al., 2014; King et al., 2020; Sallquist et al., 2010).

Implications, Limitations, and Future Directions

The RSSR is built on decades of empirical research on the influence of RS on health among SGMs. This novel model suggests that the relationship between RS and health varies depending on how SGMs understand and interact with RS. The RSSR provides a descriptive framework to guide the study of RS and health among SGMs. We now turn to discuss the limitations, implications, and future directions of this framework.

Limitations

The RSSR integrates RS and SGM scholarship to introduce an intersectional, theoretical model and add explanatory value to the study of SGM's RS lives. However, the RSSR is also limited by the content and scope of the current body of research on RS SGMs, which has largely relied on Western perspectives and samples. The predominance of Western perspectives makes it difficult to discriminate the ways that SGMs who live in Western countries experience RS distal stressors (e.g., likely through microaggressions, verbal harassment) from SGMs who live in other parts of the world (e.g., likely through more overt aggression, more physical harassment). The Abrahamic religions, have dominated the research, leaving large gaps in our knowledge of other

RS communities and practices (i.e., Hinduism, Buddhism). In addition, extant RS research has focused primarily on White, sexual minorities, thus our assumptions that the RSSR model applies to People of Color and gender minorities await further empirical testing. However, we do direct the reader's attention to an emerging body of work on LGBTQ+ Muslims' positive and negative RS experiences that are often assessed outside of Western contexts and with POC groups (Etengoff & Rodriguez, 2021). Finally, the focus of this model is on psychological and physical health outcomes and additional facets of health may benefit from further discussion. For example, RS pathways to relational health and RS health need further conceptual and empirical work using SGM samples.

Implications and Future Directions

The RSSR suggests several fruitful avenues for future research. First, although the RS → resilience → health link has been studied extensively in general populations, this link has been less explored among SGMs. Future research could expand our understanding of the ways in which this pathway *operates differently* for SGMs than for cisgender and heterosexual individuals. For example, research may qualitatively examine how SGMs engage with prayer similarly to and differently from cisgender and heterosexual individuals; research may also examine whether RS coping is as effective of a resource for SGMs as it is for cisgender and heterosexual individuals. Much of the current research examining the relationship between RS and health among SGMs relies on broad measures of RS such as service attendance or self-reported religiosity. These single-item, broad-domain measures often only allow for only broad conclusions about RS and health. We encourage researchers to use multi-faceted or multiple measures of RS that distinguish psychological, behavioral, and social pathways. We further urge

future researchers to incorporate multiple methods of assessment to try to disentangle the correlates of RS.

Second, little research has nuanced between the way that RS may relate to both *general* and *minority-specific* resilience processes among SGMs. Most research examines how RS affects general processes such as coping, social support, or mindfulness. Because of their unique histories with RS, many SGMs have reclaimed RS in nuanced ways that may affect minority-specific resilience. For example, congregations that hold nonrestrictive stances on same-sex sexual behavior and gender expression may enhance minority-specific resilience (e.g., providing a community that understands stressors as a systemic rather than individual problem) as well as general resilience (e.g., providing additional social contact). Understanding the unique ways that RS affects both of these processes is important in being able to fully characterize the relationship between RS and health.

Finally, although research has identified some variables that moderate the relationship between RS and stressors/resilience, it is likely that many more moderators exist. Understanding the specific variables that affect whether RS becomes a stressor or resilience factor for SGMs has clear social and health implications and ought to be undertaken. For example, the degree to which an individual's social context holds cis- or hetero-normative attitudes may fundamentally change how an individual experiences RS in that context. Better understanding of which variables moderate the relationships between RS and stressors/resilience and the function of these variables is critical to understanding how RS ultimately relates to health among SGMs.

Conclusion

SGMs experience stress and stigma that ultimately harms their health. For some SGMs, RS intensifies or directly causes the stress and stigma that undermines their health. For other

SGMs, RS primarily buffers the stress and stigma received in other places, ultimately promoting health. For most SGMs perhaps, RS simultaneously undermines and promotes health through a variety of mechanisms. The RSSR provides an initial framework to understand both *how* and *why* RS may promote and hinder health among SGMs. It suggests that RS largely influences health by influencing both *general* and *minority-specific* stress processes. It further holds that these processes are likely moderated by a number of variables unique to RS among SGMs such as the congregational stances on same-sex sexual behavior and gender expression of RS SGMs' congregations or the degree to which an SGM's environment is permeated by RS.

In a field that is often marked by extreme claims of RS either undermining or enhancing health, we argue that a more moderate position is more scientifically defensible. We strongly urge researchers to test the claims of the RSSR and to continue to identify variables that moderate the relationship between RS and health among SGMs rather than assessing the omnibus relationships between RS and health among SGMs. Ultimately, we believe that this nuance in when and how RS relates to health among SGMs is the key to understanding and effectively addressing the health disparities experienced by SGMs.

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Table 1.

Glossary of Key Terms.

Term	Definition
Cis-/hetero-normative	Relying on the assumption that all individuals are cisgender or heterosexual and privileging cisgender and heterosexual identities above other forms of sexual or gender identity (Worther, 2016).
Community-based Resilience	Ways in which communities may help build individuals' capacities for health (Hall & Zautra, 2010).
Distal Stressors	Objectively stressful events and conditions (e.g., discrimination, violence, rejection) (Meyer, 2003).
Gender	Comprised of gender identity, gender expression, and sex assigned at birth (Lefevor, Park et al., 2020). Some individuals experience incongruence between their gender identity and the sex they were assigned at birth but do not identify as transgender or genderqueer (Mansfield, 2017).
Health	Includes physical health (e.g., blood pressure, number of sick/well days), mental health (e.g., psychological distress, anxiety, suicidal ideation, problematic substance use), sexual health (e.g., use of protection during anonymous sexual encounters), and well-being (e.g., flourishing, life satisfaction; Lefevor, Davis et al., 2021).
Identity Integration	Navigating RS and SGM identities in a way that the two are not perceived as conflicting (Rodriguez & Ouellette, 2000; Rodriguez et al., 2019).
Internalized Stigma	Beliefs that one is fundamentally flawed, unlovable, or unacceptable because of one's sexuality or gender (Szymanski et al., 2008).
Proximal Stressors	Internally stressful events that are often related to self-identity as an SGM (e.g., internalized stigma, hypervigilance, hiding/concealing) (Meyer, 2003, p. 681).
Religiousness/Spirituality (RS)	RS is comprised of a person's unique constellation of thinking, feeling, relating, and behaving in relation to what they perceive as sacred (Davis et al., 2021). This constellation is multidimensional and includes aspects that are psychologically, socially and behaviorally focused.
Religiously/Spiritually Promoted Resilience	Coping process by which individuals use RS to make meaning and increase positive emotional outcomes (Pargament, 1997).
Religiousness	People's search for sacred meaning and connection in the context of culturally sanctioned codifications, rituals, and institutions (Davis et al., 2021, p. 4).
RS Struggles	Tensions, conflicts, and negative emotions concerning RS (Wilt et al., 2019).
Sexual and Gender Minority	Individuals who self-identify as lesbian, gay, bisexual, queer/questioning; experience a significant degree of same-sex attraction; and/or engage in significant same-sex sexual behavior (Herek & McLemore, 2013, p. 310). Gender minority individuals include those who identify as transgender, gender nonbinary, gender nonconforming, or genderqueer as well as individuals whose gender identity or internal experience of gender does not conform to what is typically associated with their sex assigned at birth, regardless of the degree to

	which they have engaged in physical, social, or medical efforts to achieve congruence (APA, 2015).
Sexual Orientation	Comprised of sexual attraction, behavior, and identity (Lefevor, Park et al., 2020). Many individuals who experience some degree of same-sex attraction or engage in some same-sex behavior identify as lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) but others do not (Lefevor, Park et al., 2020). Those who do not identify as LGBTQ describe themselves in a variety of ways, including as same-sex attracted, same-gender loving, child of God, or ex-gay/lesbian/trans (Lassiter, 2015; Lefevor, Sorrell et al., 2019).
Spirituality	People's search for meaning and connection with whatever they perceive as sacred (Davis et al., 2021, p. 4).
Stigma	Cooccurrence of labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001, p. 377).
Structural Stigma	Societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized (Hatzenbuehler & Link, 2014, p.2).

Figure 1

The Religious/Spiritual Stress and Resilience Model.

SEE ADDITIONAL DOCUMENT FOR FIGURE

Note: The lists underneath aspects of the model are illustrative and nonexhaustive.