Religion and Suicide Risk in Lesbian, Gay, and Bisexual Austrians

Karl Kralovec, M.D.,[1,2,4] Clemens Fartacek, M.Sc.,[1,2,3] Reinhold Fartacek, M.D.[1,2], and Martin Plöderl, Ph.D.[1,2,3]

[1] Suicide Prevention Research Program, Paracelsus Medical University, Salzburg, Austria

[2] Department of Suicide Prevention, University Clinic of Psychiatry and Psychotherapy, Christian-Doppler-Klinik, Salzburg, Austria

[3] University Institute for Clinical Psychology, Paracelsus Medical University and Christian-Doppler-Klinik, Salzburg, Austria

[4] To whom correspondence should be addressed at Sonderauftrag für Suizidprävention, Christian-Doppler-Klinik, Ignaz-Harrer-Straße 79, 5020 Salzburg, Austria, e-mail: k.kralovec@salk.at

RUNNING HEAD: Religion and Suicide Risk in LBG Austrians

Correspondence and galley proofs:

Karl Kralovec
Sonderauftrag für Suizidprävention
Christian-Doppler-Klinik
Ignaz-Harrer-Straße 79
5020 Salzburg
Austria
Phone: +43 662 4483 4345
Fax: +49 662 4483 4344
E-mail: k.kralovec@salk.at

Abstract

Religion is known to be a protective factor against suicide. However, religiously affiliated sexual minority individuals often report a conflict between religion and sexual identity. Therefore, the protective role of religion against suicide in sexual minority people is unclear. We investigated the effect of religion on suicide risk in a sample of 358 lesbian, gay and bisexual Austrians. Religion was associated with higher scores of internalized homophobia, but with fewer suicide attempts. Our data indicate that religion might be both a risk and a protective factor against suicidality in religiously affiliated sexual minority individuals.

Keywords: suicide, religion, homosexuality, internalized homophobia

Religion and Suicide Risk in Lesbian, Gay, and Bisexual Austrians

During recent years, numerous studies investigating the relationship between religion and suicide risk were published, with most of them presenting indications of religion as a protective factor (Colucci & Martin, 2008; Gearing & Lizardi, 2009). Several theories have been developed to explain the protective effect of religion against suicidality. Some authors stressed the role of social support (Robins & Fiske, 2009). Other studies suggested the importance of religious beliefs and moral objections to suicide (Dervic et al., 2006; Dervic et al., 2004). Dervic et al. (2004) also discussed that a lower aggression level in religiously affiliated depressed individuals may function as a protective factor against suicidality. Additionally, religion might have an indirect preventive effect on suicide by proscribing substance abuse (Hilton et al., 2002).

A minority group supposed to be at high risk for suicide are lesbian, gay and bisexual (LGB) individuals. They report more suicidal ideation and suicide attempts than heterosexual people (Haas et al., 2011; Plöderl et al., 2010; King et al., 2008; McDaniel et al., 2001; Plöderl & Fartacek, 2006). However, studies investigating the effect of religion on suicide risk in LGB people are sparse. On the one hand, many LGB individuals have active religious lives (Rodriguez, 2010) and previous data showed the importance of spirituality for LGB individuals with existential well-being predicting stronger self-esteem (Tan, 2005; Yakushko, 2005). On the other hand, many religions proscribe same-sex sexual activities and view such activities as sinful or unnatural. Such beliefs might induce “internalized homophobia” in religious LGB individuals, which describes the internalization of beliefs that view same-sex sexual attraction and/or activities negatively. Internalized homophobia in turn is reported to be associated with negative mental health outcomes (Newcomb & Mustanski, 2010), and the conflict between religious and sexual identities might result in shame, depression and even

suicidal ideation (Schuck & Liddle, 2001). So, as for suicide risk, it remains an open question if religion has a protective, neutral, mixed or even harmful effect in LGB individuals.

The clarification of this question was the goal of this study. We analyzed religious affiliation, the sense of belonging to a religious community, suicide ideation, suicide attempts in the past and general suicide risk factors in the whole sample, and internalized homophobia and other minority specific risk factors in LGB participants.

Method

Data analyzed in our study were collected in line with a previous study comparing suicidality and associated risk factors of LGB adults with matched heterosexual controls in Austria (Plöderl & Fartacek, 2005).

Participants

LGB individuals were sampled via the address lists of LGB organizations throughout Austria. Sexual orientation was assessed with three items: " In your sexual fantasies there are ... ?" and "You would like to have sex with ... ?", with five multiple choice answers (*only women, mostly women, men and women, mostly men, only men*); and "How do you describe yourself?" with seven multiple choice answers (*heterosexual, mostly heterosexual, bisexual, mostly homosexual, homosexual, transsexual, not sure*). Participants were classified as bisexual if they answered all three items not on the exclusive heterosexual or homosexual end. Cronbach's alpha for the three items was $r = .88$. Of 899 potential participants contacted, 391 (44%) returned the questionnaire with $n = 358$ appropriate for analysis. Exclusion included heterosexual orientation, being transgendered, incomplete or obvious joking answers or responses past the deadline. A heterosexual control group was matched to the LGB sample with respect to sex, age and degree of education. Participants in the control group were recruited from organizations such as fire departments, the Red Cross or the University of Salzburg. Of 848 people contacted, 303 (36%) returned the questionnaire. After

exclusion of non-heterosexual participants and those who were not comparable to LGB participants, n = 267 remained for final analysis. This provided a total N of 625 participants. The mean age of the total sample was 36.2 years (SD = 11.8), 67% of which were male.

Measures

Participants who reported a certain religious affiliation were asked for their specific denomination in the questionnaire. The sense of belonging to a religious community was assessed by the item "Do you feel a sense of belonging to your religious community?", with four response options (*very, probably, probably not, not*).

Suicidal ideation during the last 12 months was assessed using the questions from Paykel, Myers, Lindethal, and Tanner (1974) covering death wishes ("Have you ever wished you were dead [for instance that you could get to sleep and not wake up]?"), suicide ideation ("Have you ever thought of taking your life, even if you would not really do it?"), and serious suicide ideation ("Have you ever reached the point, where you seriously considered taking your life, or perhaps made plans how you would go about doing it?"). Current suicidal ideation was measured with the question "Do you think that you will make a suicide attempt in the near future?" using 5 items (*definitely not, quite not, perhaps, quite sure, I do not know*). For the analysis, the last four categories were collapsed into one because of infrequent appearance. Suicide attempts were assessed using the question "Have you ever made a suicide attempt?"

We measured depression and hopelessness, which are supposed to be associated strongly with suicidal ideation and suicide planning (Mann et al., 1999). Depressive mood was assessed using the Allgemeine Depressionsskala (Hautzinger & Bailer, 1993), a German version of the CES-D scale (Radloff, 1977). Hopelessness was measured using the Skalen zur Erfassung der Hoffnungslosigkeit (Krampen, 1994), a German short form of the Beck Hopelessness Scale (Beck et al., 1974).

Further suicide risk/protective factors we assessed were social support and victimization. To measure perceived social support, participants were asked to name up to seven persons — besides father and mother, who were already given - they judged as important. Four items measured social support (e.g. “I can contact him/her when I’m in trouble” / "I am appreciated by him/her" / "I have a satisfying relationship with him/her" / "The relationship with him/her is free of conflicts"), with a mean score ranging from one (nonsupportive) to four (supportive). For the analysis, perceived support from all stated persons (.78), from family (parents and siblings) (.79), and from friends (.67) were used (reliability as measured with Cronbach's alpha in brackets). Questions recommended by Herek (1990) were translated to assess victimization in the last year and in previous years covering verbal insults; being threatened with physical violence; property damage; being thrown at with objects; being chased, spat upon, kicked/beaten; threat with a weapon; assault with a weapon; sexual harassment with and without assault; and school/work abstinence because of fear. Participants had to state yes/no if such an incidence occurred in the last year, and with a separate item, if in previous years ($r = .65$ [last year], $r = .81$ [previous years]).

We assessed minority specific risk factors according to the minority stress model by Meyer (2003), which suggests that in addition to general stressors that affect everyone, stressors that are unique for sexual minorities might cause mental health problems, including suicidality: As for perceived social support, LGB participants were given three additional items about social support specific to their sexual orientation: "I can talk with him/her about my homosexuality or bisexuality"; "The first reaction to my homo-/bisexuality was positive"; and "The current reaction to my homo-/bisexuality is positive" with similar scoring as described above. Internalized homophobia was assessed with a German version of the Internalized Homophobia Scale (Wagner, 1998). Finally, victimization based on sexual

orientation, age of awareness, age of coming out, degree of openness and gay community involvement were assessed with further details of methods see Plöderl & Fartacek (2005).

Statistical Methods

Data were analyzed with R 2.14.1 (R Development Core Team, 2008). Odds ratios and 95% median unbiased confidence intervals were calculated with the "epitools" package, using the mid-*p* significance level (Aragon, 2007). All reported associations are Spearman rank correlations. Wilcoxon rank sum tests were used for group differences for ordinally scaled variables, with the first and third quartile given in brackets after the median.

Results

Descriptive Data

Suicide attempts were more frequently reported by LGB (14%) compared to heterosexual individuals (1%) (see Table I). Similar differences were found for current suicidal ideation and suicide ideation in the past 12 months (17% vs. 10%, and 18% vs. 7%, respectively). All these sexual orientation differences are statistically significant (p .01) and reported elsewhere in detail (Plöderl & Fartacek, 2005). Significantly more heterosexual than LGB participants endorsed a religious affiliation (81% vs. 61%, $OR = 2.62$, $CL = 1.82\text{-}3.81$, $p < .001$). The most frequent denominations were Catholicism, followed by Protestantism and other religious affiliations; denominations did not differ significantly by sexual orientation (see Table I). Among the religiously affiliated subsample, LGB individuals reported less sense of belonging to their religious community compared to their heterosexual counterparts [$M = 2.26$, Median = 2.00 (1, 3) vs. $M = 2.47$, Median = 3.00 (1, 3), $W = 25511$, $p < .05$].

Insert Table I about here

Association of Religion with suicidality and related risk or protective factors

Religiously affiliated participants reported fewer suicide attempts than those without religious affiliation both in the whole sample (6% vs. 15%, *OR* = 2.92, *CL* = 1.65 - 5.18, $p < .001$) and in the LGB group (11% vs. 20%, *OR* = 1.95, *CL* = 1.07 - 3.58, $p < .05$) (see Table II). The association between religious affiliation and suicide attempts did not reach significance in the heterosexual group, probably due to the low number of suicide attempts (0% versus 4%, *OR* = 7.93, *CL* = .63 - 252.02, *n.s.*) (see Table III).

Insert Table II about here

There was no significant association between religious affiliation and current suicidal ideation or suicidal ideation during the last 12 months in both groups. The sense of belonging to one's religious community was not significantly associated with suicide attempts or current suicide ideation in both groups, but with significantly less suicidal ideation during the last 12 months in LGB individuals ($r = -.14$, $p < .05$).

Insert Table III about here

Both religious affiliation and the sense of belonging to one's religious community were significantly associated with increased internalized homophobia (see Table II). Internalized homophobia, in return, was associated with significantly higher levels of current suicidal ideation ($r = .23$, $p < .001$) and suicidal ideation during the last 12 months ($r = .16$, p .01). However, no significantly different levels of internalized homophobia were found with respect to suicide attempt status. To analyze the independent contribution of the sense of belonging to religious community and internalized homophobia on past year suicidal

ideation, both variables were entered as predictors in an ordinal regression analysis. Both belonging (B = -.48, $SE\ B$ = .20, $Walds$-z = 2.41, p = .02) and internalized homophobia (B = .05, $SE\ B$ = .02, $Walds$-z = 3.05, p = .002) remained independently significant predictors of past year suicide ideation.

Correlations of religious affiliation and sense of belonging to a religious community with suicide related risk/protective factors (except for internalized homophobia) among LGB participants revealed only significant results for some social support variables and for experienced victimization in previous years, but not for other variables such as depression or hopelessness or for the minority specific risk/protective factors victimization based on sexual orientation, age of awareness, age of coming out, degree of openness and gay community involvement (see Table II). Religiously affiliated LGB participants reported significantly more social support in general and from family, compared to LGB participants without a religious affiliation (see Table II). However, in contrary to general social support, a higher sense of belonging to a religious community was significantly associated with less social support specific to sexual orientation issues, i.e. not being able to talk about homosexuality with one´s family (parents and siblings), and negative first-reactions to coming out (in general and from family), with all correlations being statistically significant ($p < .05$) (see Table II).

Among the heterosexual subsample only family support and victimization in previous years were significantly associated with religious affiliation. No other significant differences or correlations were found (see Table III). Questions covering victimization during the last year did not reveal a significant difference between religiously affiliated and not affiliated people in both samples. However, significantly less victimization in previous years was reported among those who were religiously affiliated both in the LGB and in the heterosexual group (see Table II and III).

Discussion

The main result of this study was that being part of a religious community was associated with fewer suicide attempts among the LGB group as well as in the whole sample. The effect of religion on suicidal ideation, however, was mixed: On the one hand, sense of belonging to a religious community was associated with less suicidal ideation in the last 12 months in LGB participants. On the other hand, both religious affiliation and sense of belonging to a religious community were associated with higher levels of internalized homophobia, which was in turn associated with higher levels of suicidal ideation. Therefore, religion might be both a risk factor (via internalized homophobia) and a protective factor against suicidality in LGB individuals. This was also stressed by the regression analysis results where both internalized homophobia and religion remained independent significant predictors for suicide ideation.

The question arises how religion might prevent suicidal behaviour despite its possibly mixed effect on suicidal ideation. Henrickson (2007) reported about LGB individuals reporting no religion and experiencing more support from their families compared to those raised Christian. Yet, and although the sense of belonging to a religious community was significantly associated with less social support specific to sexual orientation issues, in our study religiously affiliated LGB individuals reported more social support in general and from family compared to religiously unaffiliated LGB people. These findings suggest that maybe social cohesion and support might mediate the protective effect of religion on suicidal behavior. In our study, both among heterosexual and LGB individuals, religiously affiliated subjects reported significantly less violent experiences in previous years compared to their religiously unaffiliated counterparts. So, alternatively, the protective effect of religion against suicidal behavior might also be due to less victimization, which would agree with the Interpersonal Psychological Model by Joiner (2005). This suicide model suggests that failed

belongingness and feeling of burdensomeness explain the desire to kill oneself. However, only few among those who desire suicide are able to actually follow through on their intentions, and the capability for suicide is acquired by "provocative events" such as violent experiences.

As already mentioned, another result of our study was, that religious affiliation and sense of belonging to a religious community were associated with higher levels of internalized homophobia, which, in turn, was associated with more suicidal ideation. In order to prevent suicidality in LGB individuals, we must think about what in religion might be responsible for this effect. Most religions condemn homosexuality as being unnatural or perverse (Rodriguez 2010). So it seems to be no surprise that religious LGB people often experience a conflict between religious and gay identity (Schuck & Liddle, 2001; Rodriguez & Ouellette, 2000). Causes for such conflicts can come both from outside of the individual, e.g. depending on the acceptance by others. They also can come from within the individual, when religious LGB individuals internalize values of their religious community which view same-sex sexual attraction and/or activities negatively (Rodriguez, 2010). In addition, having a strong commitment to two incompatible identity components (Baumeister et al., 1985) might result in shame, depression and even suicidal ideation (Schuck & Liddle, 2001).

The denominations among the heterosexual group in our study quite match the official statistical distribution of denominations among Austrians with the vast majority being Roman Catholic (Statistik Austria, 2001). However, in the LGB group, significantly more individuals reported no religious affiliation compared to controls, and religiously affiliated LGB participants also reported less sense of belonging to their religious community compared to their heterosexual counterparts. This affirms previous data by Schuck and Liddle (2001), who reported conflicts between religious beliefs and sexual orientation in nearly two thirds of LGB participants and solutions like identifying as spiritual rather than religious, remaining

religious, but not attending, or abandoning religion altogether. So, rejecting one`s religious identity seems to be one way to alleviate the identity conflict described above (Schuck & Liddle, 2001; Hamblin & Gross, 2011). Rodriguez and Ouellette (2000) described another three strategies of how to deal with the conflict between religious and sexual identity: Some religious LGB individuals reject their homosexual identity. Others keep the two conflicting identities completely separate, which is called compartmentalization (Rodriguez & Ouellette, 2000). Again other religious LGB people manage to apply a different strategy for solving this conflict by integrating their religious beliefs and homosexuality, so that they can maintain both a positive gay and a positive religious identity (Rodriguez & Ouellette, 2000). As previous data suggest, being involved in a gay positive church can help religious LGB individuals to integrate these two identities (Rodriguez & Ouellette, 2000). Because such identity conflicts possibly result in depression and even suicidal ideation (Schuck & Liddle, 2001), a religious community´s view of homosexuality might be of importance for LGB individuals´ suicidality.

Nugent and Gramick (c.f. Yakushko, 2005) analyzed the different ways how religious communities approach homosexuality: The rejecting-punitive view, and the rejecting-nonpunitive view, the latter describing the rejection of homosexual behavior but not of the homosexual person. Furthermore, there is the qualified acceptance position, that considers homosexuality acceptable but inferior to heterosexual orientation, and finally the full-acceptance view, considering homosexuality to be equal to heterosexual orientation. Yakushko showed the importance of a religious community's approach to homosexuality for LGB individuals` mental well-being in her study of 82 predominantly Christian non-heterosexual participants: Religious LGB people who participated in a faith community practicing full-acceptance view of homosexuality reported lower stress over their sexual

orientation and higher self-esteem compared to those who had not experienced a "full-acceptance" religious community (Yakushko, 2005).

Our study has some limitations. Recruiting LGB individuals via the address lists of LGB organizations may cause the sample to be not representative. Religion is a complex construct and using only two variables ("religious affiliation" and "sense of belonging to a religious community") may provide insufficient information. It has been repeatedly common so far to use only one single question to assess religion as a protective or risk factor against suicidality (Colucci & Martin, 2008). However, for further research it will be important to use measures both reflecting the complexity and multidimensionality of religion and possibly adapted especially to the needs of LGB people who might experience religion and spirituality differently than their heterosexual peers (Wilkerson, 2012). Finally, with the vast majority of our sample being Roman Catholic, results of our study can not be applied to other denominations.

The findings of our study point out some important implications for clinical practice and suicide prevention. On the one hand, they suggest that there is a protective effect of religion against suicidal behavior in LGB people. Therefore, religious aspects should be considered when treating LGB people suffering from suicidality. On the other hand, our data showed higher levels of internalized homophobia in religiously affiliated LGB individuals compared to those without religious affiliation. In addition, there were higher levels of internalized homophobia among those reporting more sense of belonging to their religious community. Finally, our data showed that internalized homophobia was associated with significantly higher levels of suicidal ideation. Future studies are needed to explore if there might be a causal relationship between approaches to homosexuality by specific religious communities and the LGB individual's internalized homophobia and suicidal ideation. Given

such a relationship, the way how religions approach homosexuality could be of importance for suicide prevention among LGB people.

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Table I.

Religious and Clinical Characteristic by Sexual Orientation

	Homosexual/Bisexual $n = 358$		Heterosexual $n = 267$	
	M or *n*	(*SD* / %)	*M* or *n*	(*SD* / %)
Gender (% women)	114	(32)	90	(34)
Age	36.41	(11.66)	35.86	(12.10)
Religious Affiliation (% yes)	219	(61)	215	(81)
Catholic	183	(51)	193	(72)
Protestant	29	(8)	18	(7)
Other	7	(2)	4	(2)
Sense of belonging to a Religious Community	$n = 214$[a]		$n = 210$[a]	
Not strong (%)	56	(26)	37	(18)
Probably not strong (%)	75	(35)	60	(29)
Probably strong (%)	55	(26)	90	(43)
Very strong (%)	28	(13)	23	(11)
Suicide Attempt (% lifetime)	51	(14)	3	(1)
Suicide Ideation (past 12 months)	$n = 356$[a]		$n = 265$[a]	
Never (%)	291	(82)	247	(93)
Rarely (%)	37	(10)	13	(5)
Sometimes (%)	20	(6)	2	(1)
Often (%)	8	(2)	3	(1)
Current Suicide Ideation (%)	62	(17)	27	(10)

Table I *(Continued)*

	Homosexual/Bisexual		Heterosexual	
	M or *n*	(*SD* / %)	*M* or *n*	(*SD* / %)
Depression	7.79	(2.65)	7.12	(2.39)
Hopelessness	25.29	(7.63)	23.49	(5.52)
Internalized Homophobia	25.59	(9.67)	-	-
Social Support				
Overall	3.07	(0.44)	3.15	(0.43)
Family	2.73	(0.67)	3.01	(0.58)
Friends	3.41	(0.41)	3.39	(0.41)
Being able to Talk about Homosexuality			-	-
Overall *n* = 336	3.34	(0.56)	-	-
Family *n* = 262	2.64	(0.99)	-	-
Friends *n* = 297	3.77	(0.44)	-	-
First Reaction to Coming Out			-	-
Overall *n* = 336	3.36	(0.60)	-	-
Family *n* = 260	2.63	(0.98)	-	-
Friends *n* = 297	3.78	(0.44)	-	-
Current Reaction to Coming Out			-	-
Overall *n* = 336	3.67	(0.46)	-	-
Family *n* = 261	3.32	(0.79)	-	-
Friends *n* = 297	3.89	(0.32)	-	-
Violent Experiences (past year)	0.54	(1.18)	0.45	(0.92)
Violent Experiences (earlier)	2.36	(2.70)	2.43	(2.50)
Sexual Orientation based Violence	1.05	(1.90)	-	-

Age of Awareness	18.89	(6.88)	-	-
Age of Coming Out	22.61	(6.75)	-	-
Degree of Openness	0.86	(0.21)	-	-
Gay Community Involvement	26.71	(4.81)	-	-

Note. [a]differs from total n due to missing data

Table II.

Association of Religion with Suicidality and Related Risk Factors among Homosexual and Bisexual Participants.

	Religious Affiliation				Test		Correlation with	
	Yes		No		*OR* (95%-*CI*) or		Sense of Belonging to	
	M / *n*	(*SD* / %)	*M* / *n*	(*SD* / %)	*t*(*df*)	*p*	the Religious Community	*p*
Sucide Attempt (lifetime)	24	(11)	27	(20)	1.95 (1.07-3.58)	*	-.03	
Suicide Ideation (past 12 months)	1.32	(0.71)	1.23	(0.61)	1.24 (326.46)		-.14	*
Current Suicide Ideation	36	(17)	26	(19)	1.16 (0.66-2.02)		.09	
Depression	7.72	(2.63)	7.91	(2.67)	-0.67 (288.06)		.02	
Hopelessness	25.68	(7.66)	24.68	(7.57)	1.22 (296.41)		-.04	
Internalized Homophobia	26.92	(9.79)	23.52	(9.15)	3.31 (306.27)	**	.26	**
Social Support								
Overall	3.11	(0.42)	2.99	(0.46)	2.32 (262.48)	*	-.08	
Family	2.81	(0.62)	2.62	(0.73)	2.40 (231.74)	*	-.07	
Friends	3.43	(0.41)	3.36	(0.41)	1.39 (241.71)		.02	

Table II. *(Continued)*

	Religious Affiliation				Test		Correlation with	
	Yes		No		*OR* (95%-*CI*) or		Sense of Belonging to	
	M / *n*	(*SD* / %)	*M* / *n*	(*SD* / %)	*t*(*df*)	*p*	the Religious Community	*p*
Being able to Talk about Homosexuality								
Overall	3.34	(0.56)	3.34	(0.57)	-0.01 (277.85)		-.13	
Family	2.58	(0.98)	2.72	(0.99)	-1.08 (221.29)		-.25	**
Friends	3.77	(0.43)	3.78	(0.46)	-0.07 (225.68)		.01	
First Reaction to Coming Out								
Overall	3.35	(0.58)	3.38	(0.56)	-0.49 (287.49)		-.17	*
Family	2.59	(1.01)	2.70	(0.95)	-0.86 (234.57)		-.25	**
Friends	3.79	(0.43)	3.76	(0.46)	0.62 (229.42)		-.05	
Current Reaction to Coming Out								
Overall	3.65	(0.49)	3.70	(0.42)	-0.82 (307.35)		-.09	
Family	3.29	(0.80)	3.60	(0.79)	-0.68 (227.98)		-.13	
Friends	3.89	(0.34)	3.90	(0.27)	-0.28 (275.75)		.00	
Violent Experiences (past year)	0.60	(1.30)	0.45	(0.96)	1.25 (348.45)		-.04	

Violent Experiences (earlier)	2.13	(2.61)	2.73	(2.82)	-2.02 (277.49) *	-.05
Sexual Orientation based Violence	0.91	(1.68)	1.27	(2.19)	-1.67 (238.81)	.04
Age of Awareness	18.76		19.11		-0.48 (302.04)	.09
Age of Coming Out	22.41	(6.83)	22.93	(6.64)	-0.69 (282.19)	.11
Degree of Openness	0.85	(0.22)	0.80	(0.19)	-1.61 (309.60)	-.08
Gay Community Involvement	26.44	(4.65)	27.14	(5.04)	-1.30 (274.54)	.07

Note. All correlations were nonparametric Spearman rank correlations; *OR*: odds ratios, *CI*: Confidence Interval, *$p < .05$, **$p < .01$

Table III.
Association of Religion with Suicidality and Related Risk Factors among Heterosexual Participants.

	Religious Affiliation				Test		Correlation with	
	Yes		No		*OR* (95%-*CI*) or		Sense of Belonging to	
	M / *n*	(*SD* / %)	*M* / *n*	(*SD* / %)	*t*(*df*)	*p*	the Religious Community	*p*
Sucide Attempt (lifetime)	1	(0)	2	(4)	7.93 (0.63-252.02)			.11
Suicide Ideation (past 12 months)	1.11	(0.45)	1.06	(0.24)	1.12 (152.3)			-.07
Current Suicide Ideation	19	(9)	8	(15)	1.88 (0.73-4.47)			.00
Depression	7.18	(2.45)	6.87	(2.17)	0.91 (85.23)			-.10
Hopelessness	23.38	(5.56)	23.98	(5.39)	-0.72 (79.39)			-.09
Social Support								
Overall	3.17	(0.43)	3.04	(0.42)	1.94 (77.58)			-.03
Family	3.07	(0.58)	2.76	(0.56)	3.51 (73.04)	**		-.02
Friends	3.37	(0.43)	3.47	(0.32)	-1.63 (77.32)			.03
Violent Experiences (past year)	0.47	(0.92)	0.37	(0.93)	0.76 (77.08)			-.11
Violent Experiences (earlier)	2.21		3.31		-2.49 (67.26)	*		-.05

Note. All correlations were nonparametric Spearman rank correlations; *OR*: odds ratios, *CI*: Confidence Interval, *$p < .05$, **$p < .01$