WORKING PAPER:

Religion, Mental Health, and the Latter-day Saints: A Review of Literature 2005-2022

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Abstract

The objective was to review all peer-reviewed, scholarly articles on the mental health of members of The Church of Jesus Christ of Latter-day Saints from 2005 to 2022. Forty-six studies were identified. Research findings were consistent with the general research on RS and mental health which typically finds RS related to better mental health. When comparisons are made, Latter-day Saints are typically found to have better mental health than those of other religions or no religion. It was found that in the last 10 years, research on sexual minorities has dominated the research on Latter-day Saint mental health. Although findings are nuanced, sexual minorities tend to have worse mental health when they are only somewhat enacting either a Latter-day Saint and/or sexual minority identity. The research literature on Latter-day Saint mental health is in its infancy with few studies utilizing a high degree of methodologic rigor. More longitudinal and representative research is needed to better understand Latter-day Saint mental health. Further, more theoretical work is needed to provide a framework for explaining findings and guiding future research.

Although the relationship between religion and spiritualty (R/S) and mental health has long been controversial (Bergin, 1983; Dawkins, 2011; Ellis, 1980; Freud, 1928; James, 1902), research has predominantly found R/S related to better mental health (see Rosmarin & Koenig, 2020). Still, aspects of R/S may be risk factors such as when fellow religionists or religious leaders are critical or demanding (Schieman et al., 2013), when God is viewed as having little or no interest in individuals' problems (Ellison et al., 2014), when divine favor is viewed "legalistically" (Judd et al., 2020), or when a religion is rejected by society (Koenig, 2018).

However, the relationship between R/S and mental health is likely moderated by denominational differences (e.g., Oh et al., 2022). More than a century ago Durkheim (1897) examined whether Catholics or Protestants had higher suicide rates, basing his rationale on theological differences possibly leading to differences in social integration and suicide rates. Despite some flaws in his work (Stark et al., 1983), it is significant that Durkheim posited that differences in theology and/or practices would lead to different outcomes. Understanding differences can lead to better understanding of protective and risk factors within a religion and provide direction for denominations in enhancing protective and reducing risk factors.

Over the past two decades, one denomination receiving increased attention regarding the mental health of its members is The Church of Jesus Christ of Latter-day Saints. Debate over the mental health of Latter-day Saints has recently emerged, particularly relating to sexual and gender minorities (SGMs) (Prince, 2019). Questions have arisen over whether this more "high-demand" (Busby & Dollahite, 2020) and sexually conservative religion may, on average, create dissonance for its SGMs, leading to poorer mental health (McGraw, Chinn, et al., 2021).

Prior reviews have found the predominantly positive associations between R/S and mental health also apply to Latter-day Saints (de Diego Cordero & Badanta Romero, 2017; Judd,

1986, 1998; Overton, 2005). However, these reviews require an update to include the most recent findings. Given the rise in mental health concerns over the last decade (Twenge, 2017), it is important to examine whether prior research on Latter-day Saints holds in more recent samples, including for SGMs. The last review of Latter-day Saint mental health was in 2005 (Overton, 2005). Though a more recent study examined overall Latter-day Saint health (de Diego Cordero & Badanta Romero, 2017) a review that specifically targets mental health research since 2005 is needed to more fully outline the landscape of this research. Therefore, the current review on mental health of Latter-day Saints is from 2005 through November 2022.

Previous Research

The first review of studies focusing on Latter-day Saints and mental health was by Judd in 1986 and later expanded through 1995 (Judd, 1998). Of the fifty-five studies (examining 73 outcomes) from 1925 to 1995 that included at least one measure of mental health and one measure of Latter-day Saint affiliation, belief, or practice; 70% indicated a positive relationship (meaning greater mental health), 4% were negative, 24% neutral, and 1% curvilinear.

Overton (2005) reviewed the literature from 1995 through 2005. Overton's review yielded 37 studies examining 95 outcomes focusing on the relationships between Latter-day Saint religiosity and variables such as family life, child sexual-abuse, sexuality, eating disorders, depression, suicide, racial prejudice and ethnocentrism, and social competence. Latter-day Saint affiliation, belief, or practice was positively related to mental health in 71% of the studies, with 17% finding a negative relationship, and 12% finding no significant relationship.

Methodology

The studies reviewed in the current paper update the research on the relationship between Latter-day Saint affiliation, belief, or practice, and mental health from January of 2005 through

November 2022. The method for identifying studies in this area was:

1. Using EBSCO, databases PsychInfo and Academic Search Premier were searched for the period between January 2005 and November 2022 to identify peer reviewed journal articles that included Latter-day Saint affiliation, beliefs, practices, or other aspects of R/S. Samples or sub-samples had to be clearly identified as being the majority Latter-day Saint. Search terms were: Latter-day Saint, LDS, and Mormon.
2. Studies included one or more measures of mental health or well-being. Combined with search terms of affiliation, the mental health search terms included: mental health, mental illness, anxiety, alcohol abuse, body-image, coping, delinquency, depression, divorce, drugs, drug abuse, drug use, eating disorder, obsessive-compulsive disorder, perfectionism, psychopathology, self-esteem, scrupulosity, sexuality, shame, social support, substance abuse, suicide, and well-being.
3. In addition to this search, we also employed the "ancestry method" which included examining the reference citations of articles identified for related studies that may not have been captured in the database search.

Results

By employing the search methods using the key terms as described above, the initial search resulted in 748 studies. After further examination, studies that examined "LDS" that were not studying Latter-day Saints (keywords including "latent different scores" or "learning disabilities") were then excluded from the search results, leaving 355 studies. Studies were exclude if they did not report original research or if they were qualitative (although important, for comparability we selected only quantitative research) resulting in 44 studies. In the final stages manuscript preparation, we became aware of two more recent studies that were also included resulting 46 studies to be included in this literature review.

Of the 46 studies, only five were longitudinal. This raises important questions of the direction of effects. When in distress, individuals may reach out to religion for support and the association between religiousness and negative mental health may be positive. On the other hand, the ample documentation of religion's mental health benefits suggest that those practices may reduce mental health problems (Oman & Syme, 2018). Only longitudinal work examining reciprocal influences can determine the degree to which mental health difficulties may increase religiousness and religiousness may decrease mental health difficulties. Unfortunately, none of the studies reviewed examine such reciprocal effects.

Since 2014 there has been a substantial interest in SGM Latter-day Saints. In fact, of the 33 studies on Latter-day Saints since 2014, 21 (64%) focus on SGM issues. None of these studies on SGM have been longitudinal and 33% (7) used no controls and only 19% (4) used representative samples. We are therefore left with few studies of high methodological rigor. At the same time, these studies have broken important ground in this area, providing a much needed baseline from which to formulate the future of this research.

In our summary, we emphasize findings from more rigorous methods over those from less rigorous methods. For example, we emphasize a study on Latter-day Saint depression that controlled for background factors over a study that used no controls. Table 1 contains a list of the studies with some of their attributes.

Substance Use/Abuse

Given the Church of Jesus Christ of Latter-day Saints' teachings on health (The Church of Jesus Christ of Latter-day Saints, n.d.-b), it is unsurprising studies find Latter-day Saints are less likely to use alcohol, tobacco, or illicit drugs and are the least likely to experience the urge to drink alcohol in response to negative emotion (see Dulin et al., 2006; Dyer et al., 2022; Dyer &

Goodman, 2022; Merrill et al., 2005; Michalak et al., 2007a; Sandberg & Spangler, 2007). Greater religious activity for Latter-day Saints also predicts less substance use (Dulin et al., 2006; Merrill et al., 2005).

Depression and Anxiety

In our review, the earliest studies on depression are from Norton and colleagues (Norton et al., 2006, 2008) examining elderly (65 years+) in a rural Utah county. Their 2008 longitudinal study finds Latter-day Saints at greater risk for new onset of major depression, though they also found going to church more than once a week related to better mental health. Thus, while being a Latter-day Saint is a risk, if one is a Latter-day Saint, attending church is better than not (there was no significant interaction between the two). This seemingly odd finding may have to do with the imbalance in the sample. Of the 2,804 participants, only 6.6% were non-Latter-day Saints. Further, given none of the comparison group had new onset depression (which was rare), the study is likely not estimating the true proportion of non-Latter-day Saints experiencing new onset depression, perhaps contributing to some of the counter intuitive findings.

Three studies using representative data on Utah adolescents (Dyer et al., 2022, in press; Dyer & Goodman, 2022) are the exception in that they have large numbers of non-Latter-day Saints and make comparisons to those of other religions and no religion. At the bivariate level, Latter-day Saint adolescents had significantly lower rates of depression than those of other religions or no religion, though, in two of these studies, significant differences largely disappeared when controlling for family conflict and adolescent and family substance use (Dyer et al., 2022; Dyer & Goodman, 2022). However, in both of these studies, after other variables were added to the model, Latter-day Saints had lower levels of depression than those of no religion. And, in one of the studies (Dyer et al., 2022), Catholics and Protestants had lower levels

of depression than Latter-day Saints. One of the studies (Dyer et al., in press) found lower rates of depression for Latter-day Saints associated with lower rates of COVID-19 stressors.

Other studies examining depression and anxiety use primarily Latter-day Saint samples and do not compare Latter-day Saints to others. In these studies, positive religiousness (e.g., intrinsic religiosity, self-transcendence, religious commitment) and religious practices were either unrelated to depression/anxiety (Allen & Heppner, 2011; Kane et al., 2021) or related to lower levels of depression (Allen et al., 2019; Judd et al., 2020; Sanders et al., 2015). In contrast, Ogletree and colleagues found male private religious practices related to greater depression (Ogletree et al., 2019). However, the lowest depression levels were for males with authoritative fathers and high family religious practices. Certain negative aspects of religiousness commonly found to relate to poorer mental health (e.g., scrupulosity, legalism, abandonment by god, maladaptive perfectionism) were positively related to depression for Latter-day Saints (Allen & Wang, 2014; Judd et al., 2020; Ogletree et al., 2019; Sanders et al., 2015).

Suicidality

"Suicidality" includes suicide thoughts, plans, and attempts; we also included non-suicidal self-injury here (NSSI). The earliest study reviewed was Thomas et al. (2011) whose sample was drawn from an inpatient treatment facility, comparing Latter-day Saints to non-Latter-day Saints. At intake, Latter-day Saints were more suicidal, though by discharge there were no differences. The next study of Latter-day Saint suicidality was nine years later (Dyer et al., 2020) using a sample of primarily Latter-day Saints (87%). Shame was related to an increase in suicidality over time whereas church support and family flexibility were related to a decreases over time. More recently, five studies (Angoff et al., 2021; Dyer et al., 2022, in press; Dyer & Goodman, 2022; McGraw, Docherty, et al., 2021) have used representative data on Utah

adolescents to examine suicidality or NSSI in adolescents. In general, Latter-day Saints had lower levels of suicidality and NSSIs though some of these differences disappeared when controlling for family and substance use factors (see Dyer et al., 2022; Dyer & Goodman, 2022).

Body Esteem/Appearance/Image

Four studies examined what Latter-day Saints' think about their bodies. Three were female only samples (Fischer et al., 2013b; Sandberg & Spangler, 2007; Steffen, 2011) with the fourth being 82.1% female (Coyne et al., 2022). Three were Latter-day Saint only samples (Coyne et al., 2022; Fischer et al., 2013b; Steffen, 2011) and one was primarily Latter-day Saint (68.6%; Sandberg & Spangler, 2007). Although it was a Latter-day Saint only sample, Fischer, et. al. compared eating disorders of their sample to national statistics. Thus, there has been little work on male Latter-day Saints and little work on how Latter-day Saints compare to others. The comparative research found that Latter-day Saint women had more positive views about their bodies and were less likely to have eating disorders than other women (Fischer et al., 2013b; Sandberg & Spangler, 2007). Spiritual strength was negatively related to concern about appearance (Steffen, 2011) and body esteem was positively related to positive church culture (e.g., acceptance; diversity) and negatively related to negative church culture (e.g., comparison; pressure to conform Coyne et al., 2022). Overall, research finds Latter-day Saint women, on average, have more healthy attitudes and behaviors towards their bodies and the more connected they are with religious belief and activity the better their attitudes. Two studies examined whether living in Utah were predictive of body image with Sandberg and Spangler (2007) finding Utah females having greater concern with body shape whereas Coyne et al. (2022) found no association with body esteem and living in or outside Utah.

Perfectionism, Scrupulosity, and Shame

Several studies examined some combination of perfectionism, scrupulosity, and shame. We therefore summarized these together. Perfectionism can be divided into adaptive perfectionism (attitudes that lead individuals to excel in healthy ways) and maladaptive perfectionism (attitudes that create fear and anxiety about performance). Scrupulosity is a form of obsessive-compulsive disorder manifest in a religious context (e.g., intense fear of God or fear of sinning). Shame often includes making "internal, stable, global attributions about one's self, which lead to negative feelings about the global self" (Cohen et al., 2011, p. 948).

Allen and Wang (2014) classified nearly half of their all Latter-day Saint sample (47.2%) as adaptive perfectionists with 30.3% being maladaptive perfectionists, and 22.5% non-perfectionists. Adaptive perfectionism was related to greater intrinsic religiosity (Rasmussen et al., 2013), experiencing God's grace, and less legalism (Judd et al., 2020). Maladaptive perfectionism was unrelated to intrinsic or extrinsic religiosity (Rasmussen et al., 2013; with no controls, Allen et al., 2021 found intrinsic spirituality related to less maladaptive perfectionism) but was significantly related to experiencing God's grace less, higher legalism (Judd et al., 2020), higher scrupulosity, lower self-esteem, and higher anxiety about God (Allen et al., 2021).

Scrupulosity was related to less religious commitment (Allen et al., 2015) and greater guilt, personal-discrepancy, and God-discrepancy (Wang et al., 2018). For females, scrupulosity was negatively related to experiencing grace and positively related to legalism (Judd et al., 2020). At the bivariate level, scrupulosity was related to lower intrinsic spirituality, lower self-esteem, greater avoidance from God, and greater anxiety from God (Allen et al., 2021). Shame was related to less religious commitment, greater scrupulosity (Allen et al., 2015), experiencing less grace from God, and greater legalism (Judd et al., 2020). Allen et al. (2015) also found that the relationship between legalism and shame was mediated by scrupulosity and that family

perfectionism intensified the link between scrupulosity and shame. In the one comparative study, Dyer et al. (2020) found at ages 12-14, Latter-day Saints had lower levels of shame. However, they were no different from others two years later.

Sexual and Gender Minority Latter-day Saints

The relationship between religion and wellbeing for SGMs has received much attention over the past few decades. Much of the literature conceptualizes religions as often creating "homophobic environments" (Sherry et al., 2010a, p. 113) which create conflict for SGMs. Like many conservative leaning religions, The Church of Jesus Christ of Latter-day Saints considers sexual relations appropriate only between opposite sex married couples (situations of biological ambiguity about sex are handled on a case by case basis; The Church of Jesus Christ of Latter-day Saints, n.d.-a). Minority stress theory is often invoked with hypotheses suggesting that SGMs face additional stressors within The Church of Jesus Christ of Latter-day Saints (Crowell et al., 2015). Over the last few years, research on SGMs has come to dominate the research on Latter-day Saints and mental health. Of the 25 studies of Latter-day Saint mental health published in the last 5 years, 16 of them (64%) have focused on SGMs.

In 2021, McGraw and colleagues (2021) identified 33 studies (19 quantitative or mixed method, 14 qualitative) on Latter-day Saints SGMs. There were three categories of studies: 1) those with Latter-day Saint only samples exploring the experiences of SGMs, 2) those examining the differences between current and former Latter-day Saints SGMs, and 3) those comparing SGM Latter-day Saints to SGMs of other religions or no religion. Some studies may have contained elements of more than one of these categories. Studies examining the experiences of SGM Latter-day Saints often describe difficulties navigating their sexuality and religious identity (Bradshaw et al., 2015; Dehlin et al., 2014; Dehlin et al., 2015). Resolving identity conflict is

likely important in better mental health (Dehlin et al., 2015; Grigoriou, 2014a). In the same vein, feeling resolved about conflicts between religion and sexuality and being more moderate in one's views was also positively related to well-being (Lefevor, Blaber, et al., 2020).

Studies that examined differences between current and former SGM Latter-day Saints are few. Bridges and colleagues (Bridges et al., 2020) found current Latter-day Saints had better mental health than former Latter-day Saints. Joseph and Cranney (2017) found no difference between current and former SGM Latter-day Saints on self-esteem. Examining depression, Crowell and colleagues (2015) found significant interactions where being an active Latter-day Saint buffered against the effects of internalized homophobia and identity confusion. However, Lefevor et al. (2021) found internalized homophobia related to depression for Latter-day Saints (unrelated for non-Latter-day Saints) though it was unrelated to life satisfaction for Latter-day Saints (it was related for non-Latter-day Saints). Lefevor, Meter, et al. (2022) categorized their sample as engaged Latter-day Saint, moderately engaged Latter-day Saint, and lapsed Latter-day Saint, finding no differences in depression or life satisfaction across these group, but greater meaning of life and fewer alcohol problems for engaged Latter-day Saints.

Another study found SGM Latter-day Saint who either attended church regularly and those who did not attend church had greater life satisfaction than those who attended only sporadically (Lefevor, Blaber, et al., 2020). Skidmore, Lefevor, Golightly, et al., (2022) found the influence of belongingness to either The Church of Jesus Christ of Latter-day Saints or to various SGM groups seemed to be moderated by religious activity and one's connection with religion and sexuality. Whereas belongingness to The Church of Jesus Christ of Latter-day Saints was related to better mental health when church attendance and internalized homophobia were high, belongingness to SGM groups was related to better mental health when church attendance was

low and internalized homophobia low (see also Skidmore, Lefevor, & Dillon, 2022). They also found when active concealment of sexual orientation was low, mental health tended to be better (see also Skidmore, Sorrell, & Lefevor, 2022).

Other studies found former SGM Latter-day Saints have better mental health than current Latter-day Saint SGMs (Bradshaw et al., 2022; Dehlin, Galliher, Bradshaw, & Crowell, 2014a; Ison et al., 2010) or that those in same-sex relationships had better mental health (Bradshaw et al., 2022): though these studies employed no statistical controls (see also Crowell et al., 2015). One study that did use controls found former SGM Latter-day Saints had less depression and more life satisfaction and flourishing than current SGM Latter-day Saints (Lefevor, Blaber, et al., 2020). Lefevor and colleagues (2022) conducted more nuanced analyses finding (among other things) "religious struggles" had a stronger negative relationship with suicide ideation for active Latter-day Saints than for nonactive/former Latter-day Saints and that sexual identity affirmation was negatively related to suicide ideation for nonactive/former Latter-day Saints but unrelated to suicide ideation for active Latter-day Saints.

Of the studies comparing SGM Latter-day Saints to SGMs of other religions or no religion, some find SGM Latter-day Saints report better mental health (Cranney, 2017; Dyer et al., 2022; Dyer & Goodman, 2022; McGraw, Docherty, et al., 2021). One study found SGM Latter-day Saint to have greater negative sexual identities and more religious incongruence that those of other religions, though there were no difference in their mental health (Wolff et al., 2016). Finally, Angoff et al.'s (2020) findings are somewhat unclear, though it appears SGM Latter-day Saints may have fewer non-suicidal injury (NSSI) (or are not any different) than SGMs of other religions or no religion. Some research finds family support predictive of better mental health for SGM Latter-day Saints (Grigoriou, 2014a; Mattingly et al., 2016). Two studies

found no difference in depression or life-satisfaction across Latter-day Saint and non-Latter-day Saint SGMs (Lefevor, Skidmore, et al., 2021; Skidmore, Lefevor, & Dillon, 2022).

Sex differences regarding feelings towards The Church of Jesus Christ were also examined for same-sex attracted (SSA) men and women. Bradshaw et al., (2020) found that SSA women experienced greater alienation from the Church, were more likely than SSA men to express negative sentiments about their church experiences, and were less likely to subscribe to Church beliefs. Even though more women than men identified as bisexual, bisexuality facilitated continued activity in the Church for both sexes, but less so for women.

Some studies have examined how identity may play a role in sexual minority Latter-day Saint's mental health. Grigoriou (2014a) found that individuals who said their Latter-day Saint or SSA identity was more important than those who could not decide which was more important had lower levels of depression and anxiety. Dehlin et al., (2015) found integrating religious identity with sexual identity was related to the most optimal outcomes. It is likely that those who have identity conflicts are at increased risk of mental health difficulties. Lefevor et al. (2020) compared Latter-day Saints who indicated they were SSA to those who adopted a LGBQ label. SSA Latter-day Saints had higher religiousness, placed greater value on child-centered family, and were more likely to be celibate or in a mixed orientation marriage than those who identified as LGBQ. Results indicate that SSA Latter-day Saints who were either consistently engaged or more disengaged from their religious identity experienced better well-being and better mental health than participants who were not resolved in their religious and sexual identities. LGBQ Latter-day Saints reported feeling more contentedness with their sexual feelings and less homonegativity. However, there were no mental health differences between these groups.

Although a different construct from sexual orientation, gender identity is an important

area to include in research. Only one study examined the mental health of transgender individuals as a unique group, finding Latter-day Saint transgender individuals had the same level of mental health as those of other religions or no religion (Dyer & Goodman, 2022).

Discussion

The research on Latter-day Saints and mental health fits relatively well within the overall research on religion and mental health. In studies examining only Latter-day Saints, those who are more active in their faith and/or have positive religious attributes (e.g., intrinsic religiosity, religious commitment) tend to have better mental health. Those less active and those with negative religious attributes (e.g., legalism, scrupulosity, feeling abandoned by God) tend to have worse mental health. Further, when comparing to those of other religions or no religion, Latter-day Saints appear to have better mental health, though few studies examined this and, as will be discussed, the picture is more nuanced for sexual minorities.

Studies that examined why Latter-day Saints may have better mental health suggest their lower likelihood of alcohol use and stronger family connection is likely important (Dyer et al., 2022; Dyer & Goodman, 2022). However, few studies examined this and more research is needed to explain why difference may exist. Although identifying denominational differences is important, when the risk/resilience factors which give rise to those differences are understood, we are better able to capitalize on the processes that undermine or promote mental health.

Sexual minority Latter-day Saints

Much of the research on SGM Latter-day Saints begins with the premise that Latter-day Saint SGMs will have worse mental health than disaffiliated Latter-day Saints or those of other faiths. Findings for this, however, were mixed. Some studies found current Latter-day Saints had better mental health (Bridges et al., 2020), some found no differences in mental health (Joseph &

Cranney, 2017), and others found former Latter-day Saints with better mental health (Bradshaw et al., 2022). Some studies find SGM Latter-day Saints have better mental health than non-Latter-day Saint SGMs (Dyer & Goodman, 2022; McGraw, Docherty, et al., 2021). It is relevant to note that studies with samples that are generalizable find better outcomes for SGM Latter-day Saints. This likely overlaps with results of a meta-analysis that found that when samples of SGMs were drawn from sexual minority venues (such as gay bars), the relationship between mental health and religiousness tended to be non-significant or more negative (Lefevor, Davis, et al., 2021). However, when the sampling method was more general and representative, there tended to be a positive relationship between religiousness and mental health. Riess (2022) compared a more representative sample of disaffiliated Latter-day Saints (a Qualtrics panel was used) with a sample of disaffiliated Latter-day Saints drawn from a survey advertised online with snowball sampling. They found the snowball sample was less diverse (more white) and more likely to have left religion and belief in God altogether. Disaffiliated Latter-day Saints in the snowball sample were more educated, 70% college educated compared to only 21% of the disaffiliated from the more representative sample. Given education is related to mental health (Araya et al., 2003; Assari et al., 2018), snowball studies comparing former and current Latter-day Saints that do not account for education may confound education and affiliation.

In reviewing the research on SGM Latter-day Saints, one consistent finding is that identity confusion relates to worse mental health. For mental health, it appears more optimal to be either connected or, conversely, disconnected from religiousness as a Latter-day Saint than to have mid-level involvement or experience identity conflict (e.g., Lefevor, Blaber, et al., 2020; Skidmore, Lefevor, Golightly, et al., 2022). Resolution of identity conflicts are likely central to maintaining healthy religious connections. Future research should examine the various processes

of identity development to provide direction for those experiencing identity confusion.

Much of the SGM Latter-day Saints research, however, needs additional nuance and more theorizing. Theories such as minority stress theory have not been employed granularly enough to theorize how affiliation or disaffiliation may differentially relate to outcomes (e.g., how might affiliation affect depression or anxiety differently) or what specific processes may be involved. An example of more granular research is Skidmore, Lefevor, Golightly, et al., (2022) who test moderators of the relationship between church belongingness and mental health. However, even this research could benefit from more initial theoretical model building and testing, helping to improve our mid-range theories about SGM Latter-day Saints and mental health. This need for additional theorizing also applies to research on Latter-day Saint mental health in general.

Methodology

To a rather striking degree, a substantial proportion of the 46 studies reviewed have used methodologies that substantially limit what can be concluded. For instance, because few studies are longitudinal (only three studies controlled for prior levels), the direction of effects is unknown. No studies of Latter-day Saints of which we are aware examine religiosity as an outcome of mental health. Given research suggests mental health problems may reduce individuals' engagement with religion (see Koenig, 2018), it is unknown if more religious Latter-day Saints score better mental health measures because those who have worse mental health are more likely to disengage. Although one study that adjusted for the effect of disaffiliation found affiliated Latter-day Saints still likely have better mental health (Dyer et al., 2022), more research regarding reciprocal effects is needed. Further, several studies controlled for no confounding factors. This substantially limits whether we can attribute affiliation or religiousness to better mental health or whether confounds may explain the relationship. In addition, the

majority of research relies on convenience samples. It is also important to note that all studies reviewed were conducted in the United States with Utah being heavily drawn from. We have no peer-reviewed research of Latter-day Saints and mental health internationally. Given religiousness may have differential impacts based on culture (e.g., Stack & Kposowa, 2011), cross-country and cross-cultural studies are needed. In the end, much of what we know about Latter-day Saints and mental health is based on the most basic types of statistics with non-representative samples. Conclusions drawn should be made with this crucial caveat and the more methodologically advanced studies should be given more weight.

Limitations

Inclusion criteria for this review only included studies that used quantitative measures. Qualitative research may help generate new research questions and provide rich descriptions of Latter-day Saint mental health. We also did not include studies that have a small percentage of Latter-day Saints and/or for whom Latter-day Saints is not a focus. For example, several studies using the National Study of Youth and Religion (Smith, 2005, 2009) find Latter-day Saints to be more devoted and that those who are devoted are more likely to have better mental health.

Implications and Future Research

While keeping the methodologic limitations of the studies in mind, finding that religiousness is generally related to better mental health for Latter-day Saints is valuable. For clinicians, this knowledge could be used in therapy with Latter-day Saints by working to incorporate a client's faith and religiosity, which could potentially be helpful in improving the client's mental health. For example, clinicians may help their Latter-day Saint clients by leveraging certain beliefs that may promote healthy coping (e.g., the belief that working through trials/opposition is part of the purpose of life). Latter-day Saint parents may also leverage

information about what aspects of their religion may be particularly helpful to mental health. For instance, knowing their religion may increase mental health by promoting strong family relationships and reducing drug use can help parents focus on these aspects of their faith.

Regarding SGM Latter-day Saints, resolving identity concerns may be an important priority for clinicians. Some studies suggest that those Latter-day Saints who are "caught in the middle" identities and beliefs are at greatest risk for mental health difficulties (Lefevor, Blaber, et al., 2020; Skidmore, Lefevor, Golightly, et al., 2022). This research also suggests it should not be assumed that SGM Latter-day Saint will or will not struggle. Findings here fit well with what Sherry and colleagues concluded: "A therapist should not, as the authors initially did, make assumptions that a client who identifies as both spiritual or religious, as well as LGB is necessarily dealing with a conflict in negotiating their identities. As the current study has shown, many LGB people have successfully negotiated the integration of these two aspects of identity in a way that allows them to feel congruent and free from identity conflict" (Sherry et al., 2010b, p. 117). However, as they also note: "for those individuals who are not able to reconcile their sexual and spiritual identities, the conflict is particularly strong" (p. 117). Regarding the general research on R/S, some suggests that those who are "all in" or "all out" have better outcomes than those in the middle (Nadal et al., 2018). It is therefore crucial to continue work on how SGM Latter-day Saints can successfully navigate their religious identity.

In the end, current research provides a base from which to launch research agendas regarding Latter-day Saint mental health that is more rigorous theoretically and methodically. The better Latter-day Saint mental health is understood the better able ecclesiastical leaders, clinicians, and the religious will be able to accentuate the protective factors that may be found (or developed) within the faith.

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Table 1. *List of studies in chronological order*

Author & Title	Sample	Measures	Mental Wellbeing Outcomes
(Merrill et al., 2005)	n=1,333 80.9% LDS 55.4% Male Mean age: 22.8 (range: 17-35)	-Religious preference -Family religiosity during adolescence -Relationship quality with parents -Substance use -Reason for abstaining from substances	Alcohol, Tobacco, and Illicit Drug Use -LDS had lowest use of tobacco, alcohol, illicit drugs (*no controls*). -Family church attendance and parents' religiosity were protective against substance use only for LDS.
(Dulin et al., 2006)	n=986 54.8% LDS 47.3% Male Mean age: 22.2 (SD=3.5)	-Social Provisions Scale: Social support -Religious preference -Religious activity -DSM-IV-TR alcohol abuse criteria	Alcohol Abuse -LDS reported the least alcohol abuse. -Greater religious activity predicted less alcohol abuse.
(Michalak et al., 2007b)	n=7,370 1.9% LDS 45.6% Male Age range: 18-60	-Religious importance -Religious proscription from alcohol use -Religious preference -Drinking abstention vs. heavy drinking	Alcohol Abuse -LDS are most likely to be abstainers of alcohol and were high on religiosity. -Of LDS, only 3.2% were heavy drinkers compared to the national average of 5.2%.
(Norton et al., 2006)	n=4,468 91.9% LDS 43% Male Mean age: 75.0 (range: 65-100)	-DSM-IV: Major depression, -Religious affiliation -Church attendance -Substance use -Health status -Social support.	Major Depression -LDS were at greater risk of major depression. -While women who attended services regularly were less likely to have major depression, men who attended regularly were more likely to have major depression.
(Sandberg & Spangler, 2007)	n=153 68.6% LDS 100% Female Mean age: ~20.5 (range: 18-40+)	-The Emotional Eating Scale-Revised for Substance Use -The Beliefs About Appearance Scale -The Multidimensional Body-Self Relations Questionnaire -The Body Appreciation and Respect Scale -The Attention to Body Shape Scale -The Body Shape Questionnaire	Urges to use substances, Body Image -Compared to LDS, non-LDS were more likely to experience increased urges to use substances in response to negative emotion -LDS reported more positive feelings toward their bodies and more satisfaction with their bodies and body shape. -Non-LDS females endorsed greater preoccupation with being overweight and more negative feelings about the body than LDS females.

			-LDS females residing inside Utah report greater concern with body shape and greater preoccupation with becoming overweight than Latter-day females residing outside Utah.
(Norton et al., 2008)	n=2,989 93.8% LDS 42% Male Mean age: 73.8 (range: 65-100)	DSM-IV measure of major depression, church attendance, health status, social support.	<u>New-Onset Major Depression</u> -LDS were at greater risk of new-onset major depression. -Church attendance more than once a week was related to a lower likelihood of new-onset major depression.
(Bartz et al., 2010)	n=53 100% LDS 45% Male Median age 35, 36 *No controls* *Longitudinal*	-Minnesota multiphasic personality inventory-2 -Religious Orientation Scale -Closeness to God/church -Emotional well-being	<u>Psychopathology</u> -LDS were similar to normative samples in psychopathology. -Between 1984 and 2001 all indices of psychopathology except hypochondriasis and depression decreased. Depression increased during that time. -Religious devoutness was not correlated with psychopathology.
(Allen & Heppner, 2011)	n=94 100% LDS 39% Male Mean age: 31.5 (range:18-75)	-Religious Commitment Inventory–10 -Collectivistic Coping Styles -Psychological Well-being Scale -Brief Symptom Inventory–18	<u>Self-Acceptance, Purpose in Life, Anxiety, Depression</u> -Religious commitment positively related to self-acceptance and purpose in life. -Religion/Spirituality positively related to purpose in life. -Religiousness variables unrelated to anxiety and depression.
(Steffen, 2011)	n=218 100% LDS 100% Female Mean age: 55 (SD=5)	-Women's Health Questionnaire - Functional Assessment in Chronic Illness Therapy-Spirituality -Measure of Body Apperception -The Brief COPE	<u>Body Appearance</u> -Spiritual strength was negatively correlated with concern about appearance but was not correlated with perceived body integrity.
(Thomas et al., 2011)	n=298 37.6% LDS 67% Male Mean age: 37.1 (range 17-86). *Longitudinal*	-The Brief Psychiatric Rating Scale	<u>General Pathology</u> -At admission, LDS patients presented with higher levels of suicidality and guilt. -By discharge, LDS had a greater symptom reduction, resulting in no statistical difference between LDS and non-LDS patients. -LDS were somewhat protected from unusual thought content.

			-Female non-LDS presented with the higher levels of symptoms at admission.
(Fischer et al., 2013a)	n=1,926 primarily LDS 100% Female Mean age: 18.2 (range 18-24).	-The Eating Attitudes Test (EAT-40) -Body Shape Questionnaire (BSQ)	Body Image, Eating Disorder Risk -Brigham Young University students had the same level of body image and a lower risk for eating disorders compared to other populations of college students.
(Rasmussen et al., 2013)	n=119 96.6% LDS 38.7% Males Mean age: 20.02 (range 17-37)	-Religious Orientation Scale-Revised: intrinsic and extrinsic religiosity -Frost's Multidimensional Personality Scale: perfectionism	Adaptive and Maladaptive Perfectionism -Intrinsic religiosity was related to adaptive perfectionism. Extrinsic religiosity was not. -Intrinsic and extrinsic religiosity were unrelated to maladaptive perfectionism.
(Allen & Wang, 2014)	n=267 100% LDS 40% Males Mean age: 23.6 (range 18-68)	-Religious Commitment Inventory-10 -Almost Perfect Scale -Penn Inventory of Scrupulosity -Depression Anxiety Stress Scale-21 -Rosenberg Self-Esteem Scale -Satisfaction With Life Scale	Adaptive and Maladaptive Perfectionism, Self-esteem, Anxiety. and Depression -Discrepancy and scrupulosity predicted lower life satisfaction, and greater anxiety and depression. -126 participants were classified as adaptive perfectionists, 81 as maladaptive perfectionists, and 60 as nonperfectionists
(Dehlin, Galliher, Bradshaw, & Crowell, 2014b)	n=1,612 100% current or former LDS 75.9% Male Mean age: 36.9 (range: 18-70+) *No controls* *Sexual Minorities*	-Views of same-sex attraction etiology -LDS activity status (e.g., frequency of attendance, affiliation status) -Sexual activity -Relationship status -Quality of Life Scale -The Rosenberg Self-Esteem Scale -Sexual Identity Distress scale -Lesbian, Gay, Bisexual identity scale -Counseling Center Assessment 0f Psychological Symptoms-34	Self-esteem, Quality of life, Sexual identity distress, Depression -Differences were found in mental health (self-esteem, quality of life, internalized homophobia, sexual identity distress, depression) across categories of: 1) church affiliation, 2) relationship status, and 3) sexual activity. In general, those who were active LDS, those who were single, and those who were celibate (particularly not by choice) had worse mental health.

(Grigoriou, 2014b)	n=142 100% LDS 75% Males Mean Age: 40.37 (range: 18+) *Sexual Minorities*	-Importance of Sexual Identity OR Mormon identity. -Stigma-Consciousness Questionnaire–Same-Sex Attracted Mormons (SCQ-SSAM) -Social Constraints Scale–LDS Family and Friends (SCS-LDS) -The Hopkins Symptoms Checklist Anxiety and Depression Scales	<u>Anxiety and Depression</u> -Compared to those who could not chose an identity, those who indicated their LDS identity was more important, had lower levels of anxiety and depression. Those whose sexual identity was more important (compared to those who could not chose) had lower levels of anxiety. -Higher scores on the Social Constraints Scale were related to greater anxiety. -The Stigma-Consciousness Questionnaire was unrelated to mental health.
(Allen et al., 2015)	n=421 100% LDS 49.4% Male Mean age: 23.0 (range:18-63)	-Religious Commitment Inventory-10 -Graceful Avoidance of Personal Legalism -Penn Inventory of Scrupulosity -Family Almost Perfect Scale -State Shame and Guilt Scale	<u>Shame, Guilt, Scrupulosity, Perfectionism</u> -Religious commitment was related to less shame, guilt, and scrupulosity. -Scrupulosity was related to more shame and guilt. -Legalism was related to greater scrupulosity. -The relationship between legalism and shame/guilt was mediated by scrupulosity. -Family perfectionism intensified the link between scrupulosity and shame.
(Crowell et al., 2015)	n=634 100% current or former LDS 72% Male Mean age: 26.41 (range: 18-33) *No controls* *Sexual Minorities*	-Lesbian/Gay Identity Scale -Counseling Center Assessment of Psychological Symptoms – 34	<u>Depression</u> -Unaffiliated LDS had lower depression than active LDS. No differences between unaffiliated and less active or between less active and active. -For inactive and unaffiliated LDS, need for acceptance and internalized homonegativity were predictive of depression. -For active LDS, need for acceptance was related to greater depression and identity confusion was related to less depression. -At high identity confusion or high internalized homophobia, active LDS had the lowest levels of depression.
(Dehlin et al., 2015)	n=1,493 100% current or former LDS 76% Male	-Sexual orientation -Sexual orientation disclosure -Origins of same-sex attraction attitudes -Attempts to cope with same-sex attraction -The Sexual Identity Distress Scale	<u>Identity confusion, Sexual identity distress, Depression, Self-esteem, Quality of life</u> -Those who integrated their religious and LGBTQ identity had the best mental health across sexual identity distress, depression, self-esteem, and quality of life. They had

	Mean age: 36.8 (range: 18+) *No controls* *Sexual Minorities*	-The Quality of Life Scale -Rosenberg Self-Esteem Scale -Lesbian, Gay, Bisexual Identity Scale -Counseling Center Assessment of Psychological Symptoms – 34 -Current status as LDS -Religious beliefs	greater sexual identity distress than those who rejected their religious identity. -Those who rejected a LGBTQ identity and those who compartmentalized their religious and LGBTQ identities had particularly low mental health.
(Sanders et al., 2015)	n=898 100% LDS 58.3% Male Mean age: 20.9 (Age range: 17-46)	-The Religious Orientation Scale -The Christian Orthodoxy Scale -The Religious Fundamentalism Scale -The State-Trait Anxiety Inventory -The Beck Depression Inventory -The Burns Perfectionism Scale -The Test of Self-Conscious Affect -Religious Status Inventory -Multidimensional Self-Esteem Inventory -The Self-Transcendence Questionnaire -The Eating Attitudes Test -The Meaning in Life Questionnaire -The Schedule for Meaning in Life Evaluation -The Brief Symptom Inventory	<u>Depression, Global self-esteem, Global psychological distress, Depression, Anxiety, Disordered eating</u> -Intrinsic religiosity and fundamentalism were negatively related to depression. -No relationship between Christian orthodoxy and depression -Intrinsic religiosity negatively related to anxiety. -Fundamentalism and orthodoxy unrelated to anxiety. -Global self-esteem was positively related to Acceptance of God's grace and love, involvement in organized religion, awareness of God, being repentant. In the presence of these other religiousness variables, global self-esteem was negatively related to affirming openness in faith and experiencing fellowship. -Extrinsic religiosity was positively related to: global psychological distress, depression, and anxiety. Unrelated to obsessive compulsive. -Self-transcendence was negatively related to: global psychological distress, depression, anxiety, obsessive compulsive, and disordered eating.
(Mattingly et al., 2016)	n=587 100% current or former LDS 70.5% Male Mean age: 24.9 (range 18-30) *No controls* *Sexual Minorities*	-Family support for sexual orientation diversity -Quality of life scale -Positive aspects of nonheterosexuality questionnaire -Lesbian, gay, bisexual identity scale -Counseling Center Assessment of Psychological Symptoms – 34	<u>Depression, Anxiety, Social Anxiety, Quality of life</u> -Family support of GLBTQ individuals was related to less depression for women and men. For men only, family support was related to less social anxiety and better quality of life.

(Joseph & Cranney, 2017)	n=348 100% current or former LDS 69.0% Male Mean age: ?? *Sexual Minorities*	-Church affiliation and activity -Social Support from Family and Friends Scale -Gay or SSA identity -Gay identity acceptance -Agreement with church policy -Rosenberg Self-Esteem Scale	Self-esteem -Both active and former LDS reported similar levels of self-esteem. -These similar levels appear to be related to active individuals having higher family support but lower Gay/SSA identity whereas former members had less family support but higher acceptance of Gay/SSA identity.
(Wang et al., 2018)	n=420 100% LDS 50.3% Male Mean age: 23.56 (SD=5.21)	-Perceived perfectionism from God scale -Short Almost Perfect Scale -Religious Commitment Inventory-10 -Graceful Avoidance of Personal Legalism -Penn Inventory of Scrupulosity -Positive and Negative Affect Schedule -Satisfaction with Life Scale -State Shame and Guilt Scale	Scrupulosity -Guilt, personal-discrepancy, and God-discrepancy were related to higher levels of scrupulosity.
(Allen et al., 2019)	n=110 100% LDS 35.5% Male Mean age: 22.1 *No controls*	-Religious Commitment Inventory -Big Five Personality Inventory -Social Interaction Anxiety Scale -Clinical Anger Scale	Social interaction anxiety, Clinical anger -Social interaction anxiety and clinical anger were negatively correlated with extraversion, agreeableness, and religious commitment. Social interaction anxiety was also negatively correlated with openness.
(Bridges et al., 2019)	n=272 100% LDS 69% Male Mean age: 41 (range: 18-79) *Sexual Minorities*	-Sexual orientation -Sexual satisfaction -Patient Health Questionnaire depression scale -Generalized Anxiety Disorder Scale -Sexual attraction and behavior -Partner sexual attraction and aversion -Relationship communication -Frequency of attending religious activities. -Religious conservativism	Depression, Anxiety -Homosexual attractions and behaviors were positively associated with depression. -Relationship communication and being religiously conservative were negatively associated with both depression and anxiety. -Sexual attraction and sexual aversion were unrelated to depression and anxiety.
(Ogletree et al., 2019)	n=796 100% LDS 54% Male Mean age: 14.21 (range: 11-17)	-Center for Epidemiological Studies Depression Scale for Children—10 -National Institute on Aging/Fetzer Religion and Spirituality Scale: Daily spiritual experiences -Positive and negative religious coping	Depression -Depression was positively related to: living in Utah (compared to Arizona), private religious practices for males, and abandonment by God.

		-Parenting Styles and Dimensions Questionnaire—Short Version -Private religious practices -Church support	-Depression was negatively related to: father authoritativeness for females, peer support at church, and being heterosexual. -There was an interaction between authoritative fathering and family religious practices such that males with authoritative fathers and whose family had high religious practices had the lowest depression compared to males with other configurations of authoritative fathering and family religious practices.
(Bridges et al., 2020)	n=530 100% individuals raised LDS (43% currently affiliated) 73.6% Male Mean age: 36.4 (range: 18-79) *Sexual Minorities*	-Satisfaction with Life Scale -Generalized Anxiety Disorder Scale -Thoughts of self-harm/suicide (suicidality) -Internalized homonegativity -LGB self-acceptance -Outness -Sexual identity support -Connection needs support -LGBT community support	<u>Life Satisfaction, Anxiety, Suicidality</u> Direct effects: -Life satisfaction was positively associated with sexual identity support, connection needs support, LGB self-acceptance, and education. Anxiety was negatively associated with all of these. Suicidality was negatively associated with these except for sexual identity support and education. Indirect Effects: -Sexual identity support, connection needs support, and LGBT community support were positively associated with life satisfaction and negatively associated with anxiety and suicidality through higher levels of LGB self-acceptance. -Sexual identity support and LGBT community support were positively associated with anxiety and suicidality through greater outness. -LDS affiliation was negatively associated with anxiety and suicidality through less outness.
(Judd et al., 2020)	n=635 96% LDS 36.4% Male Mean age: 20.5 (range: 17–25)	-Dimensions of Grace Scale: Experiencing God's grace and Legalism -Patient Health Questionnaire-9: Depression -General Anxiety Disorder Scale -The Penn Inventory of Scrupulosity -Almost Perfect Scale Revised -Guilt and Shame Proneness Scale	<u>Anxiety/Depression, Shame, Fear of God, Fear of Sin, Perfectionism: Discrepancy, Standards, Order</u> For Females: Experiencing grace was negatively related to anxiety/depression, fear of God, and perfectionism discrepancy. Experiencing grace was positively related to perfectionism standards and order. Legalism (total effect) was positively associated with shame, fear of God, fear of

			sin, perfectionism discrepancy and negatively related to perfectionism standards. For Males: Experiencing grace was negatively related to shame and positively related to perfectionism standards and order. Legal is (total effect) as positively associated with anxiety/depression, shame, perfectionism discrepancy and negatively associated with perfectionism standards and order.
(Lefevor, Sorrell, et al., 2020)	n=1,128 100% current or former LDS 69.6% Male Mean age: 37.46 (range:18-70+) *No controls* *Sexual Minorities*	-Sexual minority identity -Patient Health Questionnaire: Depression -Generalized Anxiety Disorder scale -Flourishing Scale -Satisfaction With Life Scale -Physical health -Substance use -Current religious affiliation -Religious behaviors	<u>Anxiety, Depression, Flourishing, Life Satisfaction, Physical Health, Substance Use</u> -No differences found in health outcomes between those who identified as LGBQ and those who identified as SSA (same-sex attracted).
(Lefevor, Blaber, et al., 2020)	n=1,128 100% current or former LDS 69.6% Male Mean age: 37.46 (range:18-70+) *Sexual Minorities*	-Patient Health Questionnaire: Depression -Generalized Anxiety Disorder scale -Flourishing Scale -Satisfaction With Life Scale -Current religious affiliation -Religious behaviors -Beliefs about the etiology of same-sex attraction, same-sex sexuality, and sexual activity	<u>Anxiety, Depression, Flourishing, Life Satisfaction</u> -The “confused” viewpoint was associated with the most anxiety and depression and the least life satisfaction and flourishing. The “moderate” viewpoint was associated with less anxiety and depression and more flourishing than other viewpoints. -Attending religious services very frequently or very infrequently was associated with the least depression, and most life satisfaction and flourishing. -Former LDS had less depression and more life satisfaction and flourishing than current LDS. -Greater resolution of conflict between religious and sexual identities was associated with lower anxiety and depression and increased life satisfaction and flourishing.
(Dyer et al., 2020)	n=617 87% LDS 53% Male	-FACES IV: Family Flexibility -Brief RCOPE: Positive and negative coping (abandonment by God)	<u>Shame, Suicide Ideation</u>

	Mean age: 13.14 (range: 11–15) *Longitudinal*	-Church support -Parenting Styles and Dimensions Questionnaire-Short Version: Parent verbal hostility -Faith Activities in the Home Scale -Internalized Shame Scale -Passive suicide ideation	-The following were longitudinally related to suicide ideation: shame (+)[a], church support (-), and family flexibility (-). -The following were longitudinally related to shame: private religious practices (+), family flexibility (-), and depression, (+).
(Angoff et al., 2021)	n=49,425 59.5% LDS 47.3% Male 8th, 10th, and 12 grade adolescents. *Sexual Minorities*	-Non-suicidal self-injury (NSSI) -Past-year suicide attempt -Sexual orientation -Religious identification	<u>Non-suicidal self-injury (NSSI)</u> -Likelihood of NSSI was greater for sexual minorities, especially gay and bisexual. -Likelihood of NSSI was greatest for European Americans. -Likelihood of NSSI was lower for LDS youth. However, LGB LDS and LGB non-LDS were at equal likelihood. "Unsure" non-LDS had greater likelihood of NSSI than "Unsure" LDS. -Likelihood of NSSI was greater in transgender non-LDS than transgender LDS.
(Allen et al., 2021)	n=547 100% LDS 36% Male Mean age: 20.8 (range: 17-57) *No controls*	-Almost Perfect Scale -Penn Inventory of Scrupulosity -Attachment to God -Intrinsic Spirituality Scale -Rosenberg Self-Esteem Scale	<u>Maladaptive perfectionism, Scrupulosity, Self-esteem, Anxiety from God</u> The following were significant pairwise correlations: Between maladaptive perfectionism and: scrupulosity (+)[a], intrinsic spirituality (-), self-esteem (-), and anxiety about God (+). Between scrupulosity and: intrinsic spirituality (-), self-esteem (-), avoidance from God (+), and anxiety from God (+). Between self-esteem and: avoidance from God (-) and anxiety from God (-). Between anxiety from God and avoidance of God.
(Kane et al., 2021)	n=627 93% LDS 40% Male Mean Age: 29 (range: 18-76) *No controls*	-Religious Commitment Inventory -Multicultural Ethnic Identity Measure-Revised -Gratitude Questionnaire -Trait Forgivingness Scale -Rosenberg Self-Esteem Scale -Depression Anxiety Stress Scale -Satisfaction with Life Scale	<u>Self-esteem, Depression, Anxiety, Stress</u> -Gratitude and forgiveness meditated the relationship between religious commitment (both intrapersonal and interpersonal) and self-esteem. -Depression, anxiety, and stress were not significantly correlated with religious commitment.

(Lefevor, Skidmore, et al., 2021)	n=1,083 61% LDS 66.1% Male Mean Age: 35.94 (range: 25-50) *Sexual Minorities*	-Patient Health Questionnaire: Depression -Satisfaction with Life Scale -Service attendance -Religious Commitment Inventory -Interpersonal Religious Struggles Scale -Sexual orientation change efforts -Concealment Behavior Scale -Internalized Homonegativity Inventory (IH) -LGBTQ community connectedness	<u>Depression, Life Satisfaction (LS)</u> -Full sample: greater LS was related to being heterosexual, not being LDS, having higher religious commitment, and fewer interpersonal religious struggles. -Full sample: greater depression was related to greater interpersonal religious struggles. -For LGBT: greater LS was related to greater LGBT connectedness. For LDS, IH was unrelated to LS where it was positively related to LS for non-LDS. -For LGBT: greater depression was related to greater concealment. For LDS, IH was related to greater depression whereas it was unrelated for non-LDS. -For LGBT: LS and depression where unrelated to being LDS.
(McGraw, Docherty, et al., 2021)	n=73,982 59% LDS 48% Male Subsample of 6,137 LGBTQ individuals used in primary analyses. Mean Age: 15.2 (range: 6th-12th grade) *Sexual Minorities*	-Parental closeness -Family conflict -Depression symptoms -Substance misuse -Self-harm -Suicidal thoughts and behaviors -Bullied for sexual orientation	<u>Suicidal Thought and Behaviors (STBs)</u> - LDS and cis-gender heterosexuals had fewer STBs than non-LDS and LGBTQ individuals (*no controls*). -The relationship between family (closeness to parents and family conflict) and STBs was mediated through depressive symptoms, self-harm, and substance misuse. -The indirect effect of family conflict to STBs through substance misuse was non-significant for LDS.
(Skidmore, Lefevor, & Dillon, 2022)	n=302 42.9% current LDS 50.6% Male Mean age: 29.96 (SD=12.54) *Sexual Minorities*	-Patient Health Questionnaire: Depression -LGBT Community Connectedness scale: (belongingness with LGBQ groups and The Church of Jesus Christ of LDS) -Internalized homonegativity	<u>Depression</u> -Current and former LDS did not differ in depression. -Belongingness with the Church of Jesus Christ of LDS was related to less depression. Internalized homonegativity was related to greater depression. -Belongingness with LGBQ groups was unrelated to depression.

(Skidmore, Lefevor, Golightly, et al., 2022)	N=602 100% current or former LDS 68.6% Male Mean age: 30.83 (range: 18-40) *Sexual Minorities*	-Suicide ideation -LGBT Community Connectedness Scale -Religious commitment scale -Internalized Homonegativity Inventory -Concealment Behavior Scale -Duke University Religious Index: Service attendance -Christian Orthodoxy Scale	<u>Suicide ideation (SI)</u> -Church Belongingness was related to lower SI when: concealment was low, internalized homonegativity was high, and service attendance was high. -Church Belongingness was related to greater SI when: concealment was high, internalized homonegativity was low, and service attendance was low. -LGBTQ Belongingness was related to less SI when: concealment was low and service attendance was low. -LGBTQ Belongingness was related to greater SI when service attendance was high.
(Skidmore, Sorrell, & Lefevor, 2022)	N=602 100% current or former LDS 68.6% Male. Mean age: 30.83 (range: 18-40) *Sexual Minorities*	-Attachment style -Patient Health Questionnaire: Depression -Satisfaction with Life Scale -Concealment Behavior Scale -Internalized Homonegativity Inventory	<u>Depression, Life Satisfaction</u> -Depression was related to greater concealment, internalized homonegativity, and an insecure attachment. -Life satisfaction was highest for those with a secure attachment who also had low concealment or low internalized homonegativity.
(Coyne et al., 2022)	n=1,333 100% LDS 17.9% Male Mean Age: 32.9 (range: 18-80)	-Religious beliefs and practices -Body esteem -Church congregation culture	<u>Body Esteem</u> -There were no differences between Utahans and participants in other locations on body esteem. -Body esteem was positively related to positive church culture whereas it was negatively related to negative church culture.
(Lefevor, McGraw, et al., 2022)	n=602 100% current or former LDS 68.6% Male Mean age: 30.83 (range: 18-40) *Sexual Minorities*	-Suicide ideation -Religious Commitment Inventory -Christian Orthodoxy Scale -Positive religious coping -Religious and Spiritual Struggles Scale -Internalized Homonegativity Inventory -Concealment Behavior Scale -LGBT Community Connectedness Scale -Lesbian, Gay, or Bisexual Identity Salience Scale: Identity affirmation -Sexual identity/Religion conflict resolution	<u>Suicide Ideation (SI)</u> -Religious commitment negatively related to SI for nonactive/former LDS but was unrelated to SI for active LDS. -Orthodoxy was negatively related to SI for active LDS but unrelated to SI for nonactive/former LDS. -Positive religious coping had a stronger relationship with SI for nonactive/former LDS than for active LDS. -Religious struggles had a stronger negative relationship with SI for active LDS than for nonactive/former LDS. -Concealment was positively related to SI.

		-Multidimensional Scale of Perceived Social Support	-Sexual identity affirmation was negatively related to SI for nonactive/former LDS but unrelated for active LDS. -Friend support was negatively related to SI.
(Dyer et al., 2022)	n=86,346 51.7% LDS 48.5% Male Mean age: 14.49 (range: 10-19) *Sexual Minorities*	-Suicidality -Depression -Religious denomination preference -Family connections -Drug use -Sexual orientation -Communication connections	Suicide Ideation (SI), Suicide Attempts (SA), Depression - LDS LGBQ individuals were not significantly different in SI or SA than those of other religions or no religion, though were lower than no religion in depression. -LDS heterosexuals were significantly higher than Catholics and Protestants in depression and lower than those of no religion. LDS were higher in SI than Catholics and no different from other religions in SA. -Poor mental health was related to: youth drug use and family drug problems, family conflict, not feeling safe at school, and being bullied either for sexual orientation or religion.
(Dyer & Goodman, 2022)	n=46,562 61% LDS 47% Male Mean age: 15.5 (range: 12-19) *Sexual Minorities*	-Suicidality -Depression -Religious denomination preference -Family connections -Drug use -Sexual orientation -Communication connections -COVID-19 Stressors	Suicide Ideation (SI), Suicide Attempts (SA), Depression -There was no significant association between religious preference and SI or SA. Nones were higher than LDS in depression. The effect of affiliation did not vary by sexual orientation. -When there were significant differences across genders, males were lower than females and trans and females were lower than trans. -For trans, suicidality and depression were the same comparing Latter-day Saints and those of other religions or no religion.
(Bradshaw et al., 2022)	n=1612 100% current or former LDS	-Kinsey Scale: Sexual orientation (behavior, attraction, and identity) -Status in the Church of Jesus Christ of LDS	Depression, Anxiety, Self-esteem, Quality of life, Sexual identity distress

	75.9% Male Mean age: ?? *No controls* *Sexual Minorities*	-Counseling Center Assessment of Psychological Symptoms: Depression, Anxiety -Rosenberg Self-Esteem Scale -Quality of Life Scale -Sexual Identity Distress Scale	-Compared to all other LDS statuses combined, women who were active had greater sexual identity distress. -Compared to all other LDS statuses combined, men who were active had greater depression and greater sexual identity distress. -Women in same-sex relationships had lower depression, greater self-esteem, and lower sexual identity distress than those in mixed-orientation relationships. -Men in same-sex relationships had lower depression, greater quality of life, and lower sexual identity distress than those in mixed-orientation relationships.
(Lefevor, Meter, et al., 2022)	n=815 100% current or former LDS 64.9% Male Mean age: 31.07 (range: 18-75) *No controls* *Sexual Minorities*	-Alcohol Use Disorder Identification Test -Patient Health Questionnaire-9 (depression) -Meaning in Life Questionnaire -Satisfaction with Life Scale -Christian Orthodoxy Scale -Religious Commitment Inventory -Duke University Religion Index - Lesbian, Gay, or Bisexual Identity Salience scale -Outness -Sexuality support	<u>Depression, Alcohol use disorder, Meaning of life, Life satisfaction</u> -Across three categories (engaged LDS, moderately engaged LDS, and lapsed LDS) there were no differences in depression or life satisfaction, though engaged LDS had greater meaning of life and a lower alcohol use disorder.
(Dyer et al., in press)	n=71,001 56.2% LDS 50% Male Mean age: 14.56 (range: 10-19)	-Religious affiliation -Suicidality -Depression -COVID-19 Stressors	<u>Depression, Suicide ideation, Suicide attempts</u> -Compared to other groups (Catholics, Protestants, those of no religion, and those of all other religions), overall, LDS were lower in depression, ideation, and attempts except LDS were no different from Protestants in ideation. -Differences were partially accounted for by LDS experiencing fewer COVID-19 stressors. Except, Latter-day Saints were more likely to become sick with COVID-19 symptoms increasing ideation.

[a] + = positive relationship, - = negative relationship

NOTE: In some studies, their primary statistics were pair-wise correlations, t-test, or one-way ANOVAs. When this was the case, we report these findings. However, when studies followed up with more rigorous tests (e.g., regressions that included controls) we do not report the more basic statistics such as pair-wise correlations.