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Affirming and Nonaffirming Religious Beliefs Predicting Depression and Suicide Risk Among Latter-Day Saint Sexual Minorities

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Sexual minorities (SMs) who are current/former members of the Church of Jesus Christ of Latter-day Saints (LDSs) report high levels of depression and risk for suicide. Recent research has suggested that specific LDS religious beliefs may be related to these negative mental health outcomes. Using two independent online samples of current/former LDS SMs (Sample 1 = 403; Sample 2 = 545), we tested associations of affirming/nonaffirming LDS beliefs with depression and suicide risk cross-sectionally (Sample 1), and then longitudinally (Sample 2) tested if religious/spiritual struggles and internalized stigma mediated these relationships. Cross-sectionally, nonaffirming LDS beliefs were associated with higher depression, but effects disappeared when religious/spiritual struggles and internalized stigma were entered in the model. Affirming LDS beliefs were unrelated to depression and suicide risk. Longitudinally, after including earlier levels of internalized stigma, religious/spiritual struggles, depression, and suicide risk as controls, nonaffirming beliefs indirectly predicted more depression 2 months later (Time 3) through internalized stigma at 1 month (Time 2). These results suggest LDS beliefs may play an important role in the development and experience of depression for LDS sexual minorities.

Public Significance Statement
Latter-day Saint (LDS) sexual minorities often face unique challenges related to their sexual identities and religious beliefs. In this study, we found that when LDS sexual minorities hold nonaffirming religious beliefs about their sexual orientation, then they tend to believe other stigmatizing messages, which leads them to feel more depressed. Clinicians working with LDS, or other religious sexual minority clients, might benefit from targeting stigmatizing religious messages in therapy.

Keywords: Latter-day Saints, depression, suicide, sexual minority, stigma

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Despite increased access to mental health care and more social acceptance, sexual minorities (SMs; i.e., those who identify as lesbian, gay, bisexual, queer/questioning, or are same-sex attracted) continue to report higher levels of depression and suicide risk compared to their heterosexual counterparts (Hottes et al., 2016; King et al., 2008). One framework that has helped explain these disparities is minority stress theory, which posits that SM face unique external and internal stressors, which predicts greater psychopathology (Meyer, 2003). Over the last 20 years, research has confirmed that minority stressors predict worse mental health outcomes for SM (Argyriou et al., 2021; Fish et al., 2015; Langhinrichsen-Rohling et al., 2011; McLaren, 2016).

Religious/spiritual processes represent an understudied set of factors that may be related to minority stressors and ultimately negative mental health outcomes, such as depression and suicide risk. For example, many faith traditions teach *nonaffirming* religious/spiritual beliefs about SM, such as same-sex marriage is a sin or that same-sex attractions are a temptation from the devil (Kashubeck-West et al., 2017). As a result, SM within these spaces may experience two specific proximal (i.e., internal) minority stressors: (a) internalized stigma, which involves internalizing nonaffirming messages and viewing themselves as flawed, weak, or shameful (Barnes & Meyer, 2012; Gibbs & Goldbach, 2021) and/or (b) religious/spiritual struggles surrounding their sexuality, such as believing God does not love them, doubting their beliefs, or believing they are being judged by religious/spiritual people—all based on their sexual orientation or attractions (Beckstead & Morrow, 2004). Conversely, SM may utilize or hold religious/spiritual beliefs that they experience as *affirming* of their sexual orientation (e.g., God made me gay for a reason), which may protect them from internalized stigma and religious/spiritual struggles (Gibbs & Goldbach, 2021; Kubicek et al., 2009). Because both internalized stigma and religious/spiritual struggles are related to depression and suicide risk (Gibbs & Goldbach, 2015; King et al., 2008; Rosmarin et al., 2013), affirming and nonaffirming religious/spiritual beliefs may directly or indirectly predict depression and suicide risk.

SMs who are current or former members of the Church of Jesus Christ of Latter-day Saints (LDSs) provide an excellent case

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This study was not preregistered. Data and syntax are available upon request.
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example to test these pathways. Current and former LDS SM commonly report high levels of internalized stigma, religious/spiritual struggles, depression, and suicide risk (Bridges et al., 2020; Dehlin et al., 2014; Lefevor, McGraw, & Skidmore, 2022; Lefevor, Skidmore, et al., 2022; McGraw et al., 2021). Furthermore, nonaffirming religious/spiritual beliefs are noticeably central to the LDS theological worldview (McGraw et al., 2021). Likewise, similar to SM of other faith traditions (see Gibbs & Goldbach, 2021), some LDS SM describe focusing on religious beliefs that they experience to be *affirming* of their sexual identity in order to cope with difficulty (Beckstead & Morrow, 2004; Goodman, 1997). As such, we sought to use two independent samples of current/former LDS SM to cross-sectionally and longitudinally test the potential effects of affirming and nonaffirming LDS beliefs on two minority stressors (i.e., internalized stigma and religious/spiritual struggles about one's sexual orientation) and two specific negative mental health outcomes (i.e., depression and suicide risk).

LDS Beliefs

Nonaffirming LDS Beliefs

In general, many religious institutions teach nonaffirming beliefs about SM (Kashubeck-West et al., 2017). For example, SM among Evangelical or Catholic traditions report being taught that their sexual orientations are evil, represent the presence of a "demon inside of them," and that this will result in severe spiritual consequences (e.g., "Gay is bad. Gays go to hell" Kubicek et al., 2009, p. 6; see also Schuck & Liddle, 2001). Likewise, some SM from Orthodox Jewish communities have discussed the belief or message that there is no *tachlis* (i.e., purpose) in life for them or that a religious ritual, such as a *shiva*, which is commonly saved for the mourning of those who have died, would need to be performed because they were gay (Etengoff & Daiute, 2014).

Similarly, the Church of Jesus Christ of Latter-day Saints teaches unique doctrines meant to discourage same-sex sexuality in its congregations (Church of Jesus Christ of Latter-day Saints, 2017). For example, LDSs are taught that (a) God has ordained other-sex marriage as essential and divine and is himself in a marriage with a divine woman, referred to as Heavenly Mother (Church of Jesus Christ of Latter-day Saints, 1995, n.d.); (b) to reach the highest realms of heaven after death, members must enter into other-sex marriages that are sanctioned by an official LDS ritual (known as a "sealing"), which can only be performed in LDS temples (Church of Jesus Christ of Latter-day Saints, 2021a); and (c) any sexual behaviors outside of other-sex marriage are seen as moral violations that can lead to church discipline (e.g., disfellowship/excommunication; McGraw et al., 2021).

Current and former LDS SM are commonly exposed to nonaffirming beliefs by lay ecclesiastical leaders, family members, and peers. These beliefs include that SM are spiritually weak or flawed because of their attractions (Beckstead & Morrow, 2004; Mattingly et al., 2016); that their attractions are a temptation to be controlled, avoided, or changed (Simmons, 2017); that God disapproves of them, their attractions, and any same-sex sexual behaviors (Beckstead & Morrow, 2004; Jacobsen & Wright, 2014); that they must either live a celibate life or enter into a mixed-orientation marriage to be able to get into heaven (Legerski et al., 2017; Simmons, 2017); that they may be changed into heterosexuals in the afterlife (Simmons, 2017); or if they engage in same-sex sexual behaviors, then they will be forever separated from their families in the afterlife (Jacobsen & Wright, 2014; Mattingly et al., 2016). Perhaps as a result, samples of current/former LDS SM find increased adverse mental health outcomes including internalized stigma, religious/spiritual struggles, depression, and suicide risk (Dehlin et al., 2014; McGraw et al., 2021; Simmons, 2017).

Potentially Affirming LDS Beliefs

Despite official church doctrine, some SM may focus on LDS beliefs that they experience to be *affirming* of their sexual identity. For example, LDSs are taught that God is a loving Heavenly Father, who has a plan for each individual person (Church of Jesus Christ of Latter-day Saints, 2021a, 2021b). In addition, like other Christians, LDSs believe that Jesus Christ is their personal savior and that he sacrificed himself to show mercy and offer forgiveness of wrongdoing (Church of Jesus Christ of Latter-day Saints, 2000). Furthermore, LDSs believe that Christ also felt and suffered each individual person's own personal struggles and can offer individualized compassion and direction because of this (Bednar, 2013). Thus, SM can interpret these broader LDS teachings as being applicable to their own experiences such as saying God loves them, has a plan for them to be a SM, and that because of Christ's sacrifice for them, he knows what it is like to be a SM and can help them work through the specific challenges they face (see Schilaty, 2021). However, no research has yet examined the degree to which LDS SM endorse these beliefs or how they relate to internalized stigma, religious/spiritual struggles, depression, or suicide risk.

SM in other religious traditions also report engaging with more affirming religious beliefs. For example, some Evangelical or Catholic SM have reported beliefs such as "God creates everything for a reason" and specifically that God made them "gay for a reason" (Kubicek et al., 2009, p. 10; see also Gibbs & Goldbach, 2021). Similarly, others also report believing that their relationships are sacred and blessed by God (Phillips et al., 2017; Rostosky et al., 2008). In general, SMs from other faith traditions report these affirming beliefs provide them with greater meaning and purpose in their lives, as well as the ability to cope with negative experiences (Gibbs & Goldbach, 2021; Kubicek et al., 2009; Rosenkrantz et al., 2016).

How LDS Beliefs Fit Within a Minority Stress Framework

Meyer's (2003) minority stress theory posits that SM are exposed to unique forms of internal (proximal) and external (distal) stress that are not experienced by their heterosexual peers, thereby increasing depression and suicide risk. Distal stressors are typically understood as objective events of harm and stigmatization targeted toward SM, such as workplace discrimination, violence, or bullying (Meyer, 2003). Particularly relevant to the present study, however, are proximal stressors, which are internal processes where stigma is internalized and affects a SM person's self-concept, affect, cognition, and behavior (Meyer, 2003).

Affirming and nonaffirming LDS beliefs may relate to depression and suicide risk through two specific proximal minority stressors: internalized stigma and religious/spiritual struggles related to sexual orientation. Internalized stigma refers to the process whereby SM

internalize negative messages regarding same-sex sexuality as part of their own self-image, leading to devaluation of the self (e.g., internalized homonegativity; Frost & Meyer, 2009). Thus, holding nonaffirming LDS beliefs such as "God disapproves of same-sex sexual behaviors" may lead LDS SM to believe that their sexual orientation represents their own moral failings (i.e., internalized stigma). Furthermore, holding nonaffirming LDS beliefs may also increase the likelihood that LDS SM experience religious/spiritual struggles specifically related to their sexual orientation/attractions, such as believing that God hates them, that they are spiritually weak, or have no hope for the afterlife. These experiences of internalized stigma and religious/spiritual struggles about their sexual orientation/attractions may then go on to produce feelings of depression and risk for suicide. Conversely, although not yet tested among LDS SM samples, one could imagine that if a participant could counteract the nonaffirming beliefs with affirming ones (e.g., God loves me or God made me as a same-sex attracted person), then they might experience less internalized stigma, religious/spiritual struggles, and subsequent depression and risk for suicide.

Some scholars have suggested that specific LDS beliefs are implicated in the deaths by suicide of LDS SM (Barker et al., 2016), while others have called into question the lack of cross-sectional and longitudinal evidence to support such claims (Cranney, 2020). In light of these controversies, researchers have begun examining these processes cross-sectionally among current and former LDS SM samples. The results of such studies have revealed several important findings. First, believing that one's same-sex sexuality is caused because of a spiritual failure or weakness to "Satan's temptation" (i.e., nonaffirming beliefs) is related to higher levels of internalized stigma and depression (Dehlin et al., 2014). Second, holding orthodox Christian beliefs (e.g., "Jesus Christ was the divine Son of God" and "Through the life, death, and resurrection of Jesus, God provided a way for the forgiveness of people's sins") is related to less suicidal ideation (Lefevor, McGraw, & Skidmore, 2022). Third, internalized stigma and religious/spiritual struggles are related to more depression and/or suicide risk (Crowell et al., 2015; Lefevor, McGraw, & Skidmore, 2022; Lefevor, Skidmore, et al., 2022; Skidmore et al., 2022).

The Present Study

The present study aimed to advance our understanding of how specific affirming and nonaffirming LDS beliefs may be associated with and predict future internalized stigma, religious/spiritual struggles, depression, and suicide risk. First, whereas prior studies rely on a single item to assess religious/spiritual beliefs (e.g., same-sex sexuality is a spiritual weakness), we created a multi-item scale to assess both affirming and nonaffirming beliefs specific to LDS SMs. Second, using two independent samples of current/former LDS SMs, we cross-sectionally and longitudinally tested the potential effects of affirming and nonaffirming LDS beliefs on internalized stigma, religious/spiritual struggles, depression, and suicide risk. Specifically, in our first sample, we explore cross-sectionally the potential for internalized stigma and religious/spiritual struggles to mediate the relationship between affirming/nonaffirming beliefs and depression and suicide risk. In our second sample, we then test this hypothesis longitudinally by modeling direct and indirect pathways of influence of affirming/nonaffirming LDS beliefs after controlling for earlier statuses of the mediators (i.e., internalized stigma and religious/spiritual struggles) and criterion measures (i.e., depression and suicide risk). Previous research has also found some small differences in religiousness, internalized stigma, and depression by gender and former LDS status (Chakravarty et al., 2022; Dehlin et al., 2015). Thus, we included gender and former LDS status as control variables for our analyses.

Method

Participants

For both samples, participants were recruited online and had to be aged 18 or older, been a baptized member of the Church of Jesus Christ of Latter-day Saints, identify as a SM or someone who experiences same-sex attraction, and know the English language well enough to complete the survey instructions. In Sample 1, a total of 403 participants met these criteria, while a total of 545 participants met the criteria for Sample 2. This study was not preregistered.

Sample Characteristics for Sample 1

In Sample 1 (N = 403), participants' age ranged from 19 to 80 (M_{age} = 34.4; SD = 12.2). Most were White/European American (94.5%) with 5.5% reporting being racially/ethnically diverse (Latina [o]/Hispanic—0.7%, Native Hawaiian/Pacific Islander—0.5%, Asian/Asian American—0.3%, and multiracial/ethnic—4.0%). Approximately half (51.6%) identified as gay/lesbian, with others identifying as bisexual/pansexual (18.4%), same-sex attracted (6.5%), queer/questioning (7.7%), asexual (3.2.0%), or another label (e.g., mostly straight, fluid; 1.2%). Gender identification was as follows: 53.9% cisgender men, 26.1% cisgender women, and 20.1% transgender or gender diverse. Participants were generally assigned male-at-birth (64%) or 36% female-at-birth. Most were formerly LDS (61.5%), while others were currently LDS (38.5%). For education status, 42.9% held bachelor's degrees, 25.3% had professional or graduate degrees, 27.8% had some college, an associate degree, or vocational training, while 3.97 held a high school diploma or equivalent. Over half lived in Utah (53.1%), while a sizable portion lived in states with higher percentages of LDSs, such as California (7.7%), Arizona (5.2%), Idaho (4.0%), New York (3.5%), Texas (3.0%), or Wyoming (2.5%). Approximately 21% lived in other U.S. states or internationally. Half of the sample reported they were in a romantic relationship.

Sample Characteristics for Sample 2

In Sample 2 (N = 545), participants' age ranged from 18 to 78 (age M = 32.8; SD = 12.4). Most were White/European American (83%) with 17% reporting being racially/ethnically diverse (Latina [o]/Hispanic—7.0%, Native Hawaiian/Pacific Islander—0.8%, Asian/Asian American—2.8%, Middle Eastern—0.8%, Native American/Alaska Native—2.6%, multiracial/ethnic—0.5%, or other label—2.3%). Approximately half (49%) identified as gay/lesbian, with others identifying as bisexual/pansexual (28%), same-sex attracted (12%), queer/questioning (9.2%), or asexual (2.0%). Gender identification was as follows: 47% cisgender men, 36% cisgender women, and 12.5% transgender or gender diverse. Participants were generally assigned male-at-birth (55%), 43% female-at-birth, or 2.3% intersex. Most were currently LDS (72.3%), while others were formerly LDS (27.6%). For education status, 35% were college

graduates, 30% had professional or graduate degrees, 26% college experience (25.8%), and 6% high school (6.0%). Regarding place of residence, most lived in Utah (44.7%), or in other U.S. states with higher percentages of LDSs, such as California (10.4%), Arizona (8.0%), Idaho (4.4%), New York (0.6%), Texas (3.9%), or Wyoming (0.6%). Approximately 27.5% lived in other U.S. states or internationally. Last, 52% were in a romantic relationship. For more information about the demographic characteristics of both samples, see Table 1.

Sampling Procedures

Procedures for Sample 1

For Sample 1, data were collected in February 2022. The institutional review board at Utah State University approved study procedures prior to data collection. Participants were recruited using a variety of community sampling techniques. Initially, participants who had completed a previous wave of the research team's longitudinal study and agreed to be contacted regarding future research opportunities were emailed three times and invited to participate in the present study. Such participants were initially recruited for the longitudinal study primarily via postings in LDS SM social media groups and communities (e.g., North Star, encircle, affirmation), advertisements in relevant forums such as the annual North Star conference, and therapeutic organizations that tailor to LDS SMs in Utah (e.g., lesbian, gay, bisexual, transgender, and/or queer/questioning Therapist Guild of Utah).

Additional participants were recruited for the present study following similar procedures as those recruited for the longitudinal study. All participants accessed the survey through the research team's website and were offered $10 for participating. For a more complete description of sampling procedures and specific venues contacted, see Lefevor, Skidmore, et al. (2022). To be included in the study, participants had to be at least 18 years old, identify as an SM (e.g., gay, lesbian, bisexual, queer), and have completed the entirety of the survey. In total, 403 participants met eligibility criteria and were included in our final sample.

Procedures for Sample 2

For Sample 2, four waves of data were collected from April 2020 to December 2020. The first wave recruited participants on a rolling basis and those who volunteered their email addresses received additional survey items 1, 2, and 3 months after they completed the first wave. For this study, we only used data from the first three waves to conduct the mediation analysis. Participants who completed all four waves were entered into a raffle to win one of 10 $100 Amazon gift cards. This study was approved by the institutional review board of Bowling Green State University.

Measures

Given that two different research teams were involved in this study, not all variables for the present study used the same scales. When overlap was possible, both samples completed the same measures; however, we indicate below cases where Samples 1 and 2 were given different measures of the same variable.

Predictor Variables

SM Affirming and Nonaffirming LDS Beliefs. LDS beliefs about SM issues were assessed in both samples using 14-items created by the authors (see Table 2). The items were designed to fall into two categories: (a) affirming beliefs that express love, understanding, and purpose about SM and (b) nonaffirming beliefs that describe LDS theological, doctrinal, or social boundaries and prohibitions for SM. Items were developed in large part from Simmons (2017), which identified teachings that LDS SM reported being commonly taught about sexuality. Items differed slightly between the two samples, with items in Sample 2 being directed toward SMs specifically, while Sample 1 was inclusive of gender minorities (see Table 2). Participants indicated the degree they personally believed the belief true, using a 5-option Likert scale of *strongly disagree* to *strongly agree*.

In Sample 1, internal consistency was excellent for both the affirming ($a = .91$) and nonaffirming items ($a = .93$), and they were only weakly correlated ($r = .25$, $p < .001$). In Sample 2, the items were assessed at Time 1, and internal consistency for affirming items was good ($a = .87$) and excellent for the nonaffirming items ($a = .91$), while again being weakly correlated ($r = .20$, $p < .001$). A description of exploratory and confirmatory factor analyses as well as divergent/convergent validity regarding these items can be found in the Supplemental Materials.

Religious and Spiritual Struggles. In both samples, religious/spiritual struggles were assessed using items from Exline et al.'s (2014) Religious and Spiritual Struggles Scale (RSSS). The RSSS contains six subscales, including doubt, divine, demonic, and interpersonal oriented struggles, with the scale demonstrating excellent internal consistency upon development (Exline et al., 2014). In Sample 1, only the four-item doubt subscale was used (e.g., "felt troubled by doubts or questions about religion or spirituality" and "felt confused about my religious/spiritual beliefs"). Participants indicated the extent to which they experienced these doubts over the last month on a 1–5 Likert scale, from *not at all* to *a great deal*. Internal consistency was excellent ($a = .93$). In Sample 2, a total score using all the items on the RSSS was used. Participants at Times 1 and 2 indicated the extent to which they experienced these religious/spiritual struggles *surrounding their sexual orientation* over the last month on a 1–5 Likert scale, from *not at all* to *a great deal*. Internal consistency across waves was excellent ($a = .93$–$.94$).

Internalized Stigma. In Sample 1, the Internalized Homonegativity subscale of the Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011) was utilized to measure internalized homonegativity. Participants indicated their agreement to three items on a 6-point Likert-type scale was as follows: "I wish I were heterosexual," "If it were possible, I would choose to be straight," and "I believe it is unfair that I am attracted to people of the same sex." The authors of the scale reported good reliability and validity for the LGBIS as well as the Internalized Homonegativity subscale (Mohr & Kendra, 2011). Cronbach's α for the present study was good ($a = .89$). In Sample 2, internalized stigma was measured at Times 1 and 2 using the nine-item self-report Internalized Homophobia Scale (IHP) using a 5-point Likert scale (Frost & Meyer, 2009). We modified the IHP to be inclusive of SM identities rather than just gay/lesbian identities. Internal consistency across waves was excellent ($a = .91$–$.93$). The different measures used for

Table 1
Demographic Characteristics of Samples 1 and 2

Sample characteristic	Sample 1		Sample 2	
	N	%	*N*	%
Sexual orientation				
Lesbian/gay	208	51.6	268	49.2
Bisexual/pansexual	64	18.4	151	27.7
Queer/questioning	31	7.7	50	9.2
Same-sex attracted	25	6.5	61	11.2
Asexual	13	3.2	11	2.0
Other label[a]	5	1.2	—	—
Gender identity				
Man	229	56.8	260	48.2
Woman	116	28.8	201	37.3
Nonbinary/genderqueer	47	11.7	34	6.3
Other label[b]	11	2.7	44	8.2
Transgender status				
Transman	12	3.0	4	0.7
Transwoman	11	2.7	7	1.3
Sex assigned-at-birth				
Male	258	64.0	295	54.9
Female	145	36.0	230	42.8
Intersex	—	—	5	0.9
Latter-day Saint status				
Current	155	38.5	364	72.4
Former	248	61.5	139	27.6
Current religious affiliation				
Latter-Day Saint	155	38.5	—	—
None/unaffiliated	179	44.4	—	—
Catholic	2	0.5	—	—
Christian—mainline protestant	36	8.9	—	—
Christian—Evangelical or Pentecostal	5	1.2	—	—
Jewish	1	0.3	—	—
Other label[c]	25	6.2	—	—
U.S. state of residence				
Utah	214	53.1	151	44.7
California	31	7.7	35	10.4
Arizona	21	5.2	27	8.0
Idaho	16	4.0	15	4.4
New York	14	3.5	2	0.6
Texas	12	3.0	13	3.9
Wyoming	10	2.5	2	0.6
Other	85	21.1	93	27.5
Race/ethnicity				
White/European American	381	94.5	321	83.0
Latina(o)/Hispanic American	3	0.7	27	7.0
Native Hawaiian/Pacific Islander	2	0.5	3	0.8
Asian/Asian American	1	0.3	11	2.8
Middle Eastern	—	—	3	0.8
Native American/Alaska Native	—	—	10	2.6
Multiracial/ethnic	16	4.0	2	0.5
Other label	—	—	9	2.3
Education status				
Graduate/professional degree	102	25.3	115	29.7
Bachelor degree	173	42.9	134	34.6
Some college, associate degree, or vocational training/degree	112	27.8	111	28.7
High school degree or equivalent	16	4.0	23	5.9
Relationship status				
Single	183	50	179	46.4
In relationship	186	50	201	52.1
Married/civil partnership	—	—	118	58.7
Unmarried	—	—	81	40.3
Sex of partner				
Same-sex partnership	72	40.0	97	48.3
Opposite-sex partnership	109	60	101	50.3

Note. Overall sample sizes (Sample 1: $N = 403$, $M_{age} = 34.4$, $SD = 12.2$; Sample 2: $N = 545$, $M_{age} = 32.8$, $SD = 12.4$).
[a] (e.g., mostly straight, fluid). [b] (e.g., demi-girl, transmasculine). [c] (e.g., eclectic pagan/witch, Buddhist).

Table 2
Affirming and Nonaffirming LDS Beliefs Items

Items used in Sample 1	Items used in Sample 2
"I personally believe … ":	"I personally believe … ":
1. My Heavenly Father and Mother love me (A)	1. My Heavenly Father and Mother love me (A)
2. God disapproves of gender transitioning and same-sex sexual behaviors (N)	2. God disapproves of same-sex sexual behaviors (N)
3. I must have done something wrong in the preearth life to be LGBTQ in this life (N)	3. I must have done something wrong in the preearth life to be LGBQ/SSA in this life (N)
4. It is a part of my Heavenly Father's plan for me to be LGBTQ (A)	4. It is a part of my Heavenly Father's plan for me to be LGBQ/SSA (A)
5. All people will be resurrected as heterosexual and cisgender (N)	5. All people will be resurrected as heterosexual (N)
6. Having a same-sex relationship or expressing my gender differently than expected based on the sex assigned to me at birth will likely lead to me being separated from my parents and/or siblings in the Celestial Kingdom (N)	6. Having a same-sex relationship will likely lead to me being separated from my parents and/or siblings in the Celestial Kingdom (N)
7. Because of the Atonement, Jesus Christ knows what it is like to be LGBTQ (A)	7. Because of the atonement, Jesus Christ knows what it is like to be LGBQ/SSA (A)
8. Having a same-sex relationship or expressing my gender differently than expected based on the sex assigned to me at birth will likely exclude me from having a spouse and children of my own in the Celestial kingdom (N)	8. Having a same-sex relationship will likely exclude me from having a spouse and children of my own in the Celestial Kingdom (N)
9. Jesus Christ can help me through the challenges related to being LGBTQ (A)	9. Jesus Christ can help me through the challenges related to being LGBQ/SSA (A)
10. I must enter into a heterosexual marriage in the temple in order to be exalted (N)	10. I must enter into a heterosexual marriage in the temple in order to be exalted (N)
11. If I do not enter into a heterosexual marriage, then lifelong celibacy is required for me to enter the Celestial kingdom (N)	11. If I do not enter into a heterosexual marriage, then lifelong celibacy is required for me to enter the Celestial Kingdom (N)
12. Jesus Christ is merciful to me because I am LGBTQ (A)	12. Jesus Christ is merciful to me because I am LGBQ/SSA (A)
13. Like addiction, my sexual orientation or gender identity may be best viewed as a temptation (N)	13. Like addiction, my sexual attractions may be best viewed as a temptation (N)
14. I am spiritually weaker than others because I experience same-sex attraction or gender dysphoria (N)	14. I am spiritually weaker than others because I experience same-sex attractions (N)

Note. LDS = Latter-day Saint; LGBTQ = lesbian, gay, bisexual, transgender, and/or queer/questioning; LGBQ/SSA = lesbian, gay, bisexual, queer/questioning, or same-sex attracted. For details on the factor loadings, please see Supplemental Materials. (A) indicates affirming beliefs, while (N) indicates nonaffirming beliefs.

internalized stigma were used because data were collected independently by two separate research teams.

Criterion Variables

Depression. In Sample 1, depression was measured using the Patient Health Questionnaire–9 (Kroenke et al., 2001). Participants were asked to indicate the frequency with which they experience various symptoms within the past 2 weeks, including "feeling tired or having little energy." Each item was scored using the standard format. Internal consistency was good (a = .88). In Sample 2, depression was measured at Times 2 and 3 using the 10-item Center for Epidemiologic Studies Depression-Revised-10 (CESD-R-10) using the standard format (Bjorgvinsson et al., 2013). Across waves, internal consistency of the CESD-R-10 was good to excellent (α = 0.87–.90). The different measures used for depression symptoms were used because data were collected independently by two separate research teams.

Suicide Risk. In both samples, suicide risk was assessed using the Suicide Behaviors Questionnaire–Revised (SBQ-R), a four-item self-report (Osman et al., 2001) assessing lifetime thoughts or suicide attempts, past year suicidal ideation, current suicide plan, and estimated likelihood of future attempts. The authors of the scale reported good internal consistency for the scale across various demographics (Osman et al., 2001). In Sample 1, the scale evidenced acceptable internal consistency (a = .73). In Sample 2, suicide risk was assessed at Times 2 and 3, and evidenced acceptable internal consistency across waves (a = .71–.78).

Control Variables

Former LDS Status. Former LDS status was coded as "0" being current LDS and "1" being formerly LDS.

Cisgender Female Status. Identifying as cisgender female was coded as "0," while being cisgender male was coded as "1."

Attrition and Missing Data

Regarding item nonresponse and attrition in the Sample 2 (i.e., longitudinal data set), 402 participants answered questions regarding suicide risk at Time 1, 179 at Time 2 (55.4% attrition from T1), and 143 at Time 3 (64.4% attrition from T1). Additionally, 397 participants answered questions regarding depression at Time 1, 178 at Time 2 (55.2% attrition from T1), and 141 at Time 3 (64.5% attrition from T1). To examine missingness, we correlated observed values of demographics and all relevant study variables (e.g., depression, r/s struggles, internalized stigma, LDS beliefs) at their respective time points with whether suicide risk and depression and was observed T3. Among this sample, none of the observed values were significantly associated with missingness on for suicide risk or depression. The overall pattern of these findings suggests that the

data are likely missing at random (MAR), or only conditional on observed variables.

Missing data were handled using full information maximum likelihood (FIML), which uses all available data in order to estimate model parameters (Baraldi & Enders, 2010; Enders & Bandalos, 2001). FIML is suitable for data that are missing completely at random or MAR; in other words, when missingness is unsystematic or only conditional on observed variables. In addition, FIML reduces bias and increases power and efficiency when data are missing not at random relative to other methods such as listwise deletion (Baraldi & Enders, 2010).

Analysis Plan

To test our cross-sectional hypotheses for Sample 1, we used STATA (Version 16.1) to first explore correlations among the study variables in order to determine if direct relationships exist as expected. Based off of the correlations, we then conducted a hierarchical linear regression examining the influence of control variables, LDS beliefs, and internalized stigma and doubt struggles on depression and suicide risk, respectively. Then, to test our hypotheses in Sample 2, we conducted a path analysis model in a structural equation modeling framework in Mplus (Version 8.3; Muthén & Muthén, 1998–2017). As suggested by Cole and Maxwell (2003), we tested the proposed mediation pathways with the predictor variables at Wave 1, mediators measured at Wave 2, and criterion measured at Wave 3, while considering the mediators and criterion variables at their previous time points ($t - 1$). Furthermore, we estimated a covariance between the two predictors (affirming beliefs and nonaffirming beliefs), the two mediators (internalized stigma and religious/spiritual struggles), the two criterion variables (depression and suicide risk), as well as regression paths from both independent variables to each of the mediators, and from each mediator to the outcome.

For the longitudinal model, standard model fit indices are reported, including χ^2, root-mean-square error of approximation (RMSEA), comparative fit index (CFI), Tucker–Lewis index (TLI), and standardized root-mean-square residual (SRMR). We used standard cutoffs to evaluate model fit (RMSEA < .06, CFI < .95, TLI < .95, SRMR < .08; Hu & Bentler, 1999). To assess direct and indirect effects, we report the component paths of interest in the model as well as bootstrapped confidence intervals for the effects using 5,000 samples. Direct and indirect effects with p values of less than .05 for the a and b paths and a 95% bootstrapped confidence interval not including 0 were considered significant. Data and analyses syntax are available from the corresponding author, upon request.

Results

Descriptive Statistics

Sample 1

In Sample 1, the average score for suicide risk as measured by the SBQ-R was 7.89 ($SD = 3.53$), and the mean level of depression on the Patient Health Questionnaire-9 was 7.94 ($SD = 5.77$), which signifies that Sample 1 is generally mildly depressed and at greater risk for suicide than the general population (Kroenke et al., 2001; Osman et al., 2001). Mean level for doubt struggles was 2.1 ($SD = 1.16$), which suggests that experienced doubts about their religious/spiritual beliefs "a little bit" over the last month period (see Table 3).

Furthermore, pairwise correlations demonstrated that greater affirming beliefs were related to internalized stigma ($r = .14$, $p < .01$) and religious/spiritual struggles ($r = .26$, $p < .001$), but were unrelated to suicide risk and depression ($ps > .24$), while greater nonaffirming beliefs were related to greater internalized stigma ($r = .63$, $p < .001$), religious/spiritual struggles ($r = .30$, $p < .001$), and depression ($r = .19$, $p < .001$), but not suicide risk ($p = .72$). Former LDS status was unrelated to suicide risk and depression ($ps > .59$),

Table 3
Cross-Sectional Correlation Matrix and Descriptives of Study Variables in Samples 1 and 2

Variable	*n*	*M*	*SD*	1	2	3	4	5	6	7	8
				Sample 1							
1. Suicide risk	403	7.6	3.14	—							
2. Depression	403	7.9	5.8	.45***	—						
3. Internalized stigma	402	2.1	1.3	.15**	.25***	—					
4. Religious/spiritual struggles (doubt)	403	2.1	1.4	.16**	.34***	.31***	—				
5. Affirming beliefs	403	16.2	6.0	−.05	−.01	.14**	.25***	—			
6. Nonaffirming beliefs	403	18.0	9.0	.03	.19**	.63***	.30***	.25***	—		
7. Cisgender female	322	—	—	.14**	.18**	−.16**	−.02	−.12*	−.15**	—	
8. Former LDS	403	—	—	.03	.01	−.22***	−.23***	−.50***	−32***	.07	—
				Sample 2							
1. Suicide risk (T1)	402	8.58	3.7	—							
2. Depression (T1)	397	13.4	6.6	.47***	—						
3. Internalized stigma (T1)	407	18.7	9.0	.13**	.20***	—					
4. Religious/spiritual struggles (T1)	497	2.3	0.8	.41***	.47***	.44***	—				
5. Affirming beliefs (T1)	411	18.4	5.3	−.16***	−.16**	.09	−.15***	—			
6. Nonaffirming beliefs (T1)	411	19.9	8.8	−.01	.06	.68***	.21***	.20***	—		
7. Cisgender female (T1)	450	—	—	.16**	.07	−.07*	−.03	−.10	−.11*	—	
8. Former LDS (T1)	503	—	—	.14**	.02	−.36***	−.22***	−.44***	−.45***	.07	—

Note. LDS = Latter-day Saint. Variables from Sample 2 are each from Time 1 (T1).
* $p < .05$. ** $p < .01$. *** $p < .001$.

while cisgender female status was weakly correlated to both ($r = .15$ and .18, respectively, $ps < .01$; see Table 3).

Sample 2

In Sample 2, the average score for suicide risk at Time 3 was 8.24 ($SD = 3.72$), and above a cut score of 8 on the SBQ-R is commonly used to signify clinical samples (Osman et al., 2001). Furthermore, the mean level of depression on the CESD-R-10 was 13.2 ($SD = 7.33$) and above the cut score of 10 commonly considered to indicate a person is depressed (Björgvinsson et al., 2013). These findings suggest Sample 2 was more depressed and at risk for suicide than the general population (see Table 3). The mean level of religious/spiritual struggles was 2.1, suggesting the sample experienced religious/spiritual struggles about their sexual orientation/attractions "a little bit" over the last month.

Regression Analyses

Based off of the pairwise correlations, we used Sample 1 to conduct a hierarchical linear regression model for depression, starting with nonaffirming beliefs and cisgender female identity and then adding internalized stigma and religious/spiritual struggles. In Model 1, nonaffirming LDS beliefs ($B = .27$, $SE = .004$; $p < .001$) and cisgender female identity ($B = .23$, $SE = .07$; $p < .001$) were each related to greater depression scores. When internalized stigma and religious/spiritual struggles were entered into Model 2, nonaffirming beliefs became nonsignificant ($p = .536$), while cisgender female identity remained statistically significant ($B = .23$, $SE = .07$; $p < .001$). Both internalized stigma ($B = .21$, $SE = .03$; $p < .001$) and religious/spiritual struggles ($B = .31$, $SE = .03$; $p < .001$) were also statistically significantly related to more depression scores (see Table 4).

Longitudinal Mediation Analysis

Using Sample 2, we then conducted a longitudinal mediation model examining the direct and indirect effects of both affirming/nonaffirming beliefs onto suicide risk and depression, through internalized stigma and religious/spiritual struggles, with cisgender female identity and former LDS status as controls. The longitudinal model appeared to fit the data reasonably well, although the TLI was slightly below the cutoff, $\chi^2(23) = 61.14$, $p < .001$, RMSEA = .06, CFI = .95, TLI = .92, SRMR = .05. Results are depicted in Figure 1. In this model, greater nonaffirming beliefs at Time 1 predicted higher levels of internalized stigma at Time 2 ($\beta = 0.17$, $p < .01$), even when controlling for previous levels of internalized stigma. Furthermore, higher levels of internalized stigma at Time 2, predicted higher levels of depression at Time 3 ($\beta = 0.23$, $p < .01$), even after controlling for previous levels of depression, cisgender female status, and former LDS status. Further, former LDS status at baseline predicted greater depression at Time 3 ($\beta = 0.20$, $p < .05$). No other pathways were statistically significant, with the exception of the mediators/outcomes at their previous time points (see Figure 1). Additionally, there was a small statistically significant specific indirect effect of nonaffirming beliefs to internalized stigma to depression ($\beta = 0.04$, 95% confidence interval [0.003, 0.091]). However, there were no other statistically significant total, indirect, or specific indirect effects. Additionally, affirming and nonaffirming beliefs at Time 1 were neither directly nor indirectly related to suicide risk at Time 3.

Table 4
Cross-Sectional Hierarchical Regression of Nonaffirming Beliefs, R/S Struggles, Internalized Stigma With Depression Using Sample 1

	Depression			
	Model 1		Model 2	
Variable	*b* (*SE*)	β	*b* (*SE*)	β
Cis female	**.29*** (0.07)**	**0.22**	**.30*** (0.07)**	**0.23**
Nonaffirming LDS beliefs	**0.02*** (.04)**	**0.27**	0.003 (.04)	.04
Internalized stigma			**0.10*** (0.03)**	**0.21**
Doubt (religious/spiritual struggles)			**.17*** (0.03)**	**0.31**
Model fit statistics				
F	18.53*		26.56*	
R^2	0.10		.23	
R^2_{change}			0.13	

Note. *SE* = standard error; LDS = Latter-day Saint. Sample 1. $N = 322$. Bold text represents statistical signficance.
* $p < .01$.

Discussion

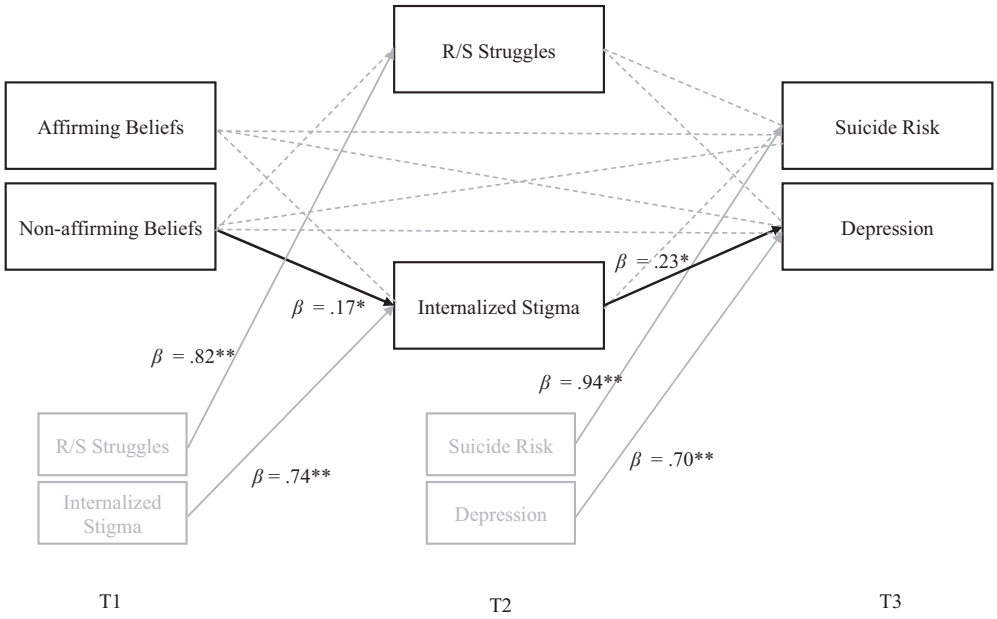
To our knowledge, this is the first study to explicitly test if holding affirming or nonaffirming LDS beliefs are related to or predict future depression and suicide risk for current/former LDS SM. Our results showed cross-sectionally and longitudinally that nonaffirming LDS beliefs are related to and predict depression, particularly through internalized stigma. However, we also found that nonaffirming beliefs were unrelated to suicide risk, a surprising finding considering previous cross-sectional and qualitative research on LDS SMs. Additionally, we found mixed support for affirming beliefs being protective against depression and suicide risk. Affirming beliefs at Time 1 were negatively correlated with depression at Times 1 and 3, and with suicide risk at Time 1, but were not correlated with either in Sample 1. Furthermore, there was no significant direct or indirect effects of affirming beliefs on either outcome in the cross-sectional regression or longitudinal path analyses.

As noted in our review of the literature, current and former LDS SM are commonly exposed to nonaffirming beliefs by lay ecclesiastical leaders, family members, and peers (Beckstead & Morrow, 2004; Jacobsen & Wright, 2014; Mattingly et al., 2016; McGraw et al., 2021; Simmons, 2017). Such exposure may explain why this population frequently reports experiencing minority stressors and adverse mental health outcomes (Dehlin et al., 2014; McGraw et al., 2021; Simmons, 2017). However, understanding how holding such nonaffirming beliefs might affect the mental health of current and former LDS SM has not been well understood. The results of the present study provide compelling evidence that internalized stigma may be one mechanism whereby nonaffirming religious beliefs about one's sexual orientation or attractions lead to symptoms of depression.

Nonaffirming religious beliefs about one's sexuality may be particularly prone to inducing proximal minority stressors like internalized stigma, because they frequently center on a person's meaning making system (Dahl & Galliher, 2012; Moscardini et al., 2018; Rosenkrantz et al., 2016). For example, religious beliefs commonly frame a person's understanding of themselves, their relationships with others, their purpose in life, and what may

Figure 1

Estimated Predication of Affirming/Nonaffiriming LDS Beliefs to Suicide Risk and Depression Sample 2



Note. LDS = Latter-day Saint. Significant pathways are indicated with bold lines. Estimate is given as standardized path coefficients. Sample 2. $N = 444$. Bootstrapped 5,000.
* $p < .05$. ** $p < .01$, covariances are included in the model but not shown.

come after death. Thus, when SM hold nonaffirming religious beliefs about same-sex sexuality, such as believing their sexual orientation is evidence of spiritual deficiency or that their same-sex sexual behaviors may result in them being separated from their family in the afterlife, then they will likely begin to feel like their entire self is deeply flawed or has little value. Thus, the religious meaning that they make of their sexual orientation becomes associated with sin, moral failings, and stigma, which then in turn leads them to feel increasingly depressed.

Recent qualitative work by Gibbs and Goldbach (2021) demonstrates this process among non-LDS SM adolescents. Many of the SM adolescents in their sample detailed that receiving antigay messages from religious leaders and parents led them to hold nonaffirming religious beliefs (e.g., "I grew up thinking that gays were bad and an abomination," p. 14), which led them to further internalize these stigmatizing messages (e.g., "I always grew up thinking that so I would always bash myself," p. 14). As a result, many struggled with feelings of poor self-esteem, hopelessness, and other depressive symptoms (Gibbs & Goldbach, 2021). The current findings suggest this process is very similar among current and former LDS SM and that longitudinal models can detect these processes.

However, our findings also bring into question previous research that has suggested a link between nonaffirming LDS beliefs and risk for suicide. Quantitative studies of non-LDS SMs have found a connection between some global measures of religious processes (e.g., service attendance and religious belief salience) and suicidal thoughts (Dyer, 2022; Park & Hsieh, 2022). Furthermore, samples of LDS SM have found a connection between more specific religious/spiritual processes (e.g., religious/spiritual struggles or religious coping) and suicidal thoughts (Lefevor, McGraw, & Skidmore, 2022); something qualitative interviews of LDS SM have confirmed (Anderton, 2010; Benson, 2001; Beckstead & Morrow, 2004; Bradshaw et al., 2015). However, the results from the present study suggests that nonaffirming LDS beliefs may not lead to such experiences directly or indirectly through internalized stigma and religious/spiritual struggles.

There are a number of reasons that might explain why nonaffirming LDS beliefs were statistically unrelated to suicide risk in our study. First, suicide risk is a complex and largely heterogeneous phenomenon that is difficult to predict even when using well established risk factors (e.g., hopelessness, self-harm, thwarted belongingness). For example, recent meta-analytic findings have suggested that many constructs that have been previously identified as strongly related to suicide risk are frequently unable to predict future suicidal thoughts or attempts beyond chance (Franklin et al., 2017). Such difficulty in predicting suicidal thoughts and behaviors has led some suicidologists to recommend forgoing the practice or at least to examine it more ideographically (Bryan, 2021; Kaurin et al., 2022). Thus, if nonaffirming LDS beliefs are directly or indirectly related to suicidal thoughts and behaviors, it is likely that more intensive longitudinal methods (e.g., ecological momentary assessment) are needed to understand these relationships. Such methods may be theoretically more consistent, as some qualitative studies have shown nonaffirming LDS beliefs were implicated in moments of suicidal crises, rather than prolonged suicide risk (Benson, 2001; Brzezinski, 2000). Such a shift in methods would also be consistent with broader trends in suicide research.

Second, it may be that nonaffirming LDS beliefs are indirectly related to suicide risk through alternative pathways, other than internalized stigma and religious/spiritual struggles. For example,

it may be that nonaffirming LDS beliefs lead to thoughts and feelings of hopelessness, or to interpersonal challenges such as perceiving oneself as a burden. Examining the relationship between nonaffirming LDS beliefs and constructs such as hopelessness or perceived burdensomeness might also be one way to test how and if such religious/spiritual processes integrate into modern day suicide theories such as the Three-Step Theory of Suicide (Klonsky & May, 2015) or the Interpersonal-Psychological Theory of Suicide (Joiner, 2005). Third, it may be that nonaffirming LDS beliefs, while leading to internalized stigma and depression, simply are not severe enough of a phenomenon to lead to suicide risk. Thus, the current findings may represent genuine population level dynamics, where nonaffirming LDS beliefs are related to depression, but not suicide.

Given the mixed findings regarding affirming LDS beliefs, it is unclear how or if such affirming religious beliefs might be at play in the above-mentioned process. Previous research has found that generally affirming Christian beliefs may be protective against suicidal thoughts (Lefevor, McGraw, & Skidmore, 2022). Religiousness is generally found to be related to better mental health and well-being, even among SMs (Lefevor et al., 2021), possibly because it can provide a sense of purpose/meaning, interpersonal connectedness, and behavioral prohibitions, which may make it a protective factor against thoughts of suicide (Koenig, 2012). It may be that negative correlations observed between affirming LDS beliefs and suicide risk or depression reflect these processes.

At the same time, it is noteworthy that affirming LDS beliefs did not emerge as a significant predictor of any outcomes once other variables were taken into account. Consequently, it may be best understood that the presence of nonaffirming beliefs—at least in an LDS context—may negate potential health-promoting aspects of affirming beliefs. More research is needed to better understand how these two different types of beliefs interact to affect health outcomes.

Implications for Prevention and Intervention of Psychopathology

Discussing religious beliefs with patients can be intimidating, and some therapists have been hesitant to address such topics (Carlson et al., 2002). However, given our findings it may be important for clinicians to approach nonaffirming beliefs and subsequent internalized stigma in therapy, in order to adequately treat any underlying psychopathology. Of course, it would be unethical for clinicians to outright attempt to change their patients' religious/spiritual beliefs. However, clinicians may benefit from giving space for their patients to explore what their religious/spiritual beliefs are and how they may be relevant to the presenting problem. To this end, we provide some illustrations for how clinicians might sensitively broach the topic of nonaffirming religious beliefs with their LDS SM patients, using cognitive-behavioral therapy (CBT) and acceptance and commitment therapy (ACT) techniques as examples.

One approach that is common in many therapies, including CBT, is determining the *trustworthiness* of certain cognitions and challenging thoughts that are identified as untrustworthy, untrue, or distorted. Here, clinicians can potentially leverage a common LDS worldview in order to help SM patients determine if their religious/spiritual beliefs are distorted or untrustworthy. For example, several of the nonaffirming beliefs that these samples endorsed may not be considered authoritative teachings of the Church of Jesus Christ of Latter-day Saints (e.g., "I must have done something wrong in the preearth life to be lesbian, gay, bisexual, transgender, and/or queer/questioning in this life"). Within LDS communities, holding beliefs that are considered "official" is an important part of their LDS worldview (Hatch, 2021). While there is considerable debate about what constitutes actual doctrine of the Church, it is commonly understood that official positions must come from specific leadership bodies of the Church, such as the First Presidency and the Quorum of the Twelve Apostles (Church of Jesus Christ of Latter-day Saints, 2016). Thus, single statements from past or present leaders of the Church may not constitute official teachings (although they may still be very influential in how members think about issues), but must be regularly endorsed by the collective leadership bodies (Church of Jesus Christ of Latter-day Saints, 2016). Thus, while some of the nonaffirming beliefs our sample endorsed are officially taught by the Church (e.g., "God disapproves of same-sex sexual behaviors"), clinicians may be able to help their patients identify what nonaffirming beliefs are not considered "official, " which can then allow patients to challenge and/or diffuse them without fear of abandoning beliefs they may feel are sanctioned by the Church. However, clinicians should be cautious not to work outside their competency in this regard and suggest that they themselves can indicate what is official doctrine or not.

Alternatively, within an ACT framework, clinicians and patients do not challenge or attempt to get rid of cognitions, but rather attempt to reframe and relate to them in different ways, while emphasizing living a value-driven life (see Harris, 2008). This approach may be particularly helpful for patients and clinicians who may not feel comfortable challenging cognitions that are so closely related to religious/spiritual beliefs. For example, clinicians may help patients explore what is most important to them by helping them identify their values, which can help bring into dialog their religious/spiritual beliefs and behaviors. Through diffusion work, the clinician can help the patient *notice* their nonaffirming beliefs and internalized stigma cognitions and treat them as "ongoing cognitive events" that do not have to be treated as truths which must be believed or challenged (Yadavaia & Hayes, 2012, p. 550). Instead, clinicians can help patients avoid challenging, negotiating, or fusing with those beliefs and internalized stigma, and can instead encourage them to examine the ways in which those cognitions do and do not contribute to them taking value-driven actions. There is growing evidence that ACT can be used to target internalized stigma among SM patients; thus, it may be an important treatment to consider when working with LDS SM (Yadavaia & Hayes, 2012).

Similarly, within a multicultural or intersectionality-informed lesbian, gay, bisexual, transgender, and/or queer/questioning-affirming framework (Freeman-Coppadge et al., 2021), therapists may work with LDS SM clients to understand the intersectional discrimination they experience (Crenshaw, 1989). By validating that the discrimination clients experience is attributable to larger, oppressive societal structures, therapists may help clients to both correctly attribute the source of their distress (i.e., to societal structures rather than their own shortcomings) and ultimately empower them to challenge those structures.

Limitations and Future Directions

There are a number of important limitations to this article. First, because of the convenience methods used to recruit our community samples, we cannot generalize our findings to the broader current/former LDS SM population. While community samples are

important in exploring complex phenomenon among difficult to recruit populations (such as LDS SMs), they may also limit our ability to generalize the findings beyond our samples. Comparisons of community and probability samples of SMs more broadly suggest that while important similarities exist between samples (e.g., the signs or directions of relationships), some community samples may overestimate the strength of effects or prevalence of certain phenomenon (e.g., Krueger et al., 2020; Salway et al., 2019). It is possible that the statistically significant relationships we found do not replicate or are weaker among other LDS SM samples or among randomized and representative samples.

Furthermore, the large majority of participants in both Samples 1 and 2 were White/Caucasian. Although the large majority of LDSs in the United States are White/Caucasian (Pew Research Center, 2014), relatively little is known about the specific experiences of Black, Indigenous, or other people of color (BIPOC) that are LDS SM. Thus, our findings might not generalize to the experiences of LDS BIPOC SM. Future research would be well served in quantitatively and qualitatively exploring these specific experiences. Given these limitations related to sample generalizability, future research would benefit both from collecting data using random or representative samples, as well as from more racially/ethnically diverse groups of LDS SM. Such efforts would increase the confidence in these findings.

Second, concerning Sample 2, because the longitudinal data we collected were over a relatively short amount of time (i.e., 3 months), with 1 month between each wave, it is possible that we were unable to detect any changes to suicide risk because such little time and variance occurred. As such, future research should attempt to collect data over longer time periods and/or using measures that are much more sensitive to change. Additionally, as noted previously, future research might also benefit from using more intensive longitudinal methods such as ecological momentary assessment. Such efforts would be more consistent with current thinking in suicide research, as well as determine if nonaffirming LDS beliefs are better conceptualized as important during suicidal crises, than prolonged suicide risk. Furthermore, sample dropout/attrition may have also impacted these results. Future research should seek funding in order to offer incentives to each participant, which has been shown to decrease dropout rates. Third, it is likely that there are different pathways that lead to depression and suicide risk that we were unable to test due to the constraints of our samples. As such, future studies that are adequately large, may be able to test for alternative paths, perhaps using cross-lagged panel models.

Additionally, because data collection spanned different times of the COVID-19 pandemic, it may be that stresses and differences related to restrictions, isolation, physical illness, or being around nonaffirming family members, may have impacted participants in unique ways. Given the uncertain/unpredictable ongoing course of the COVID-19 pandemic, future research should consider controlling for these influences. Further, the data collected in our samples mostly focused on if participants were current or formerly LDS. Thus, we were not able to address the degree to which former LDS SM may have joined other faith traditions that also held heterosexist views in ways that may act as confounding variables for the current results. Future studies may benefit from considering the impact of religious switching or leaving religion altogether might have on these processes.

Last, some of our variables may have been affected by a "floor effect" where participants did not experience high base rates of the phenomenon (e.g., with doubt struggles). Thus, our results may not accurately depict the potential affects that more prevalent issues of religious/spiritual struggles might have on negative outcomes, like depression or suicide risk.

Future researchers could expand on our findings in multiple important ways. First, it may be helpful to explore the prevalence and effects of nonaffirming religious beliefs on SMs more broadly, rather than just on LDS SM. A sizeable portion of SM are religious or come from religious backgrounds (Scheitle & Wolf, 2017). Thus, understanding how other specific or broad nonaffirming beliefs might impact the health and well-being of SMs more broadly may be an important next step. Second, it may be important to consider how specific religious beliefs impact other minority stressors and symptoms of psychopathology. Other minority stressors, such as concealment and rejection sensitivity may be importantly related to a person's nonaffirming religious beliefs. Likewise, depression has been best conceptualized as one cluster of internalizing symptoms. Thus, it may be important to explore if nonaffirming religious beliefs are related to other internalizing symptoms (e.g., anxiety) and externalizing behaviors (e.g., substance use). Such effort to expand the current findings could showcase the importance of nonaffirming beliefs as a risk factor for other SMs, minority stressors, and symptoms of psychopathology.

Conclusion

Using data from two independent samples, we found cross-sectional and longitudinal evidence that holding nonaffirming LDS beliefs may be related to and predict future depression, through internalized stigma among current and former LDS SM. Furthermore, we found nonaffirming and affirming LDS beliefs were unrelated to suicide risk. These findings suggest the need for clinicians and scholars to consider the ways in which religious/spiritual beliefs may influence psychopathology for SM.

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