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GENDER IDENTITY, SEXUAL ORIENTATION, AND MOOD DISORDER SYMPTOMS: THE MODERATING ROLE OF PARENT-CHILD RELIGIOUS CONGRUENCE

by

JASMINE SWANN

(Under The Direction of C. Thresa Yancey)

ABSTRACT

This study sought to understand the factors related to increased symptoms of stress, anxiety, and depression among Sexual and Gender Minority (SGM) individuals. It is common for religious beliefs and Sexual and Gender minority ideals to clash. In the case of parent-child relationships, it is important to determine how the congruence of beliefs between parent and child may moderate mood disorder symptoms. A convenience sample of 271 individuals (46.5% identifying as a Gender and/or Sexual minority) completed an online survey. Participants provided information about their religious congruence with their closest parental or guardian figure and completed measures of current depression, anxiety, and stress symptoms (DASS-21, Lovibond & Lovibond, 1995). MANOVA analyses showed Sexual and Gender minority individuals reported higher levels of depression and stress compared to their cisgender, heterosexual peers. Additionally, parental attachment, parent-child religious congruence, and symptoms of depression, stress, and anxiety were correlated. Parent-child religious congruence did not significantly modify the relationship between sexual orientation/gender identity and symptoms of depression, anxiety, and stress.

INDEX WORDS: LGBT community, Religious congruence, Sexual and gender minorities, Religiosity, Value congruence, Parent-child relationships, Mood disorder symptoms

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JASMINE SWANN

B.S., Georgia Southern University, 2020

A Thesis Submitted to the Graduate Faculty of Georgia Southern University

in Partial Fulfillment of the Requirements for the Degree

MASTER OF SCIENCE

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DEDICATION

This thesis is dedicated to my family, who worked extremely hard to provide me with the opportunity to achieve a higher education. My mother, father, Olivia, my cousin Kim, my Aunt Cynthia, and my Uncle Michael. I appreciate everything you all have done for me.

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Secondly, I would like to give a huge thank you to my amazing group of friends, both in-person and online, that listened to me complain about my thesis for two years straight. Thank you all for listening to my vents, providing support, and being there for me every step of the way. You've helped me more than you'll ever know.

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CHAPTER 1

INTRODUCTION

Depression, Anxiety, and Stress

Psychological disorders related to depressive, anxious, and stress symptoms, such as major depressive disorder, generalized anxiety disorder, and adjustment disorders, are some of the most prevalent and impairing diseases in the general population (Costello et al., 2002). While these concerns are very common throughout the general population, they are even more prevalent among different minoritized groups, including those who identify as gender and sexual minorities (Skerrett et al., 2016).

Major depressive disorder and persistent depressive disorder affect about 7% and 0.5% of the United States population respectively, with women and girls diagnosed 1.5 to 3 times more than men and boys (APA, 2013). The World Health Organization (WHO) found that unipolar depression, including symptoms such as depressed mood, diminished interest or pleasure, insomnia, fatigue, and feelings of worthlessness, was the leading cause of disability in the world (Costello et al., 2002). Depressive symptoms can be debilitating, and the negative effects can be physical as well as mental. The 2014 Scientific Statement, published by the American Heart Organization (AHO), recommended depression be included as a risk factor for acute coronary syndrome (Cohen et al., 2015). The AHO explained that there are both biological and behavioral factors caused by depression that contribute to increased risk of cardiovascular disease (Cohen et al., 2015). Predictably, depression leads to the inability to complete risk-reduction tasks for cardiac disease, such as exercise and healthy eating (Cohen et al., 2015). Evidence also links diagnosed depression with inflammatory processes and autonomic nervous system dysfunction (Cohen et al., 2015).

Anxiety symptoms are characterized by disproportionate or irrational worry, fear, and panic. The lifetime prevalence rate of any anxiety disorder is over 25% in the United States (Cohen et al., 2015). It is not unusual to experience apprehension about certain events and

situations; however, when symptoms persist with no actual threat, or disproportionate to the actual threat, they can lead to increased risk of developing negative physiological effects. A mental health assessment of 49,321 men volunteering for prospective military service found that any anxiety disorder diagnosis had a strong association with coronary heart disease (Cohen et al., 2015). Unhealthy attempts to lessen or cope with anxiety symptoms, such as engaging in substance use, can also lead to increased risk for physical health problems (Cohen et al., 2015).

There is also mounting evidence suggesting exposure to daily stressors can increase the risk of developing medical problems such as cardiovascular disease (Cohen et al., 2015). Daily stressors can include, but are not limited to, tense or otherwise upsetting relationships with close loved ones, or anxiety due to an individual's general treatment in society due to their status as a marginalized identity. The Minority Stress Model (Meyer, 2003) describes how the stressors that come from being part of a marginalized group in society (such as discrimination, expectations of rejection, concealment out of fear, or internalized stigma) can contribute to the general poorer health of individuals in the marginalized community. This model is used frequently to explain health disparities between Sexual and Gender Minorities and their non-marginalized counterparts (Lick et al., 2013), in which SGM individuals consistently report higher scores of depression, anxiety, and suicidal ideation (Miller et al., 2020). Due to the risks associated with symptoms connected to depression, anxiety, and stress, it is important to learn how individual factors and family relationships may relate to the presence of these symptoms. In addition, it is important to look at the increased risk for these difficulties within the gender and sexual minority community.

Gender and Sexual Minorities

In recent decades, the LGBT community has expanded to include individuals with identities such as gay, lesbian, transgender, bisexual, and nonbinary, among many others. For the current study, the community will be referred to as Sexual and Gender Minorities (SGM). In recent decades, the public presence of the sexual and gender minority community has skyrocketed. Currently, over 11 million people (4.5%) in the United States identify as a gender or

sexual minority group member (Conron & Goldberg, 2020). As the SGM community becomes more open, there is a notable shift in public opinion regarding SGM individuals, with public support for marriage equality nearly doubling since the early 2000s (Flores, 2014). This change in public attitude was made most evident by the 2015 Obergefell v. Hodges Supreme Court case, which determined that barring marriage based on partner sex/gender was unconstitutional in the United States. Increased visibility is leading to individuals feeling able to be open about their sexual orientation and gender identity at younger ages (Human Rights Campaign, 2012), suggesting that societal acceptance is at an all-time high. However, there is also evidence that not every member of the SGM community is accepted equally. Lewis et al. (2017) found that public attitudes toward transgender individuals were notably more negative than attitudes toward lesbians and gay men. Lewis et al. (2017) discuss evidence suggesting that political factors, including religiosity, play a large part in shaping attitudes toward members of the Sexual and Gender Minority community.

It is important to discuss the challenges, specifically with mental health, that the SGM community faces due to societal treatment based on their identities. Members of the SGM community experience symptoms of depression, anxiety, and stress at a disproportionate rate compared with their cisgender, heterosexual counterparts (Goldbach & Gibbs, 2015). In turn, individuals who identify as a Sexual or Gender Minority also have significantly higher rates of suicidal ideation and suicide attempts than do those who identify as cisgender/heterosexual (Lewis, 2009). Evidence also suggests SGM individuals have a heightened vulnerability to non-fatal suicidal behaviors (Skerrett, Kolves, & De Leo, 2016). Further, SGM individuals are diagnosed with substance use disorders at a disproportionate rate (Skerrett, Kolves, & De Leo, 2016). Many of these adverse symptoms and experiences stem from how SGM individuals are treated in their respective societies. For example, members of the SGM community are at a much higher risk of being attacked or sexually assaulted than cisgender, heterosexual individuals

(Krautter, 2017). In addition, members of the SGM community are also frequently rejected by their families due to their sexual and/or gender identities (Miller et al., 2020).

Religious Beliefs

According to data retrieved from the 2020 US Census, around 77% of Americans identify with some form of religion (PRRI, 2020). An overwhelming majority (70%) identify as Christian, and the major non-Christian faiths add up to around 6% of the country. Judaism is the second most common faith in America, with around 1.9% of the population, and people identifying as Muslim make up around 1%. Religion serves as a source of comfort for many people, and studies indicated that religion or spirituality can have a positive influence on mental health, through promotion of coping, community, and positive beliefs and values (Weber & Pargament, 2014). On the opposite side, religious beliefs can also be detrimental to one's mental health, especially when the beliefs promoted by a religion do not align with one's personal values, ideals, or identities. Many people cite religious faith as the main source from which they draw their value systems, and in turn, faith can define their behaviors and attitudes toward the people in their community (Jagodzinski, 2009).

Religion and the SGM Community

The relationship between religiosity and the Sexual Gender Minority community is complex, and a broad subject of research interest. In social science fields, the major religion of a culture serves as an indicator of the culture's values and beliefs toward many subjects, including sexual orientation (Adamczyk, 2009). Therefore, to understand a culture's values, it is important to understand the religious system shaping those values. In the United States, religious variables relate to general societal attitudes regarding same-sex relationships (Olson, 2006). To further emphasize the influence religion has on a culture, Adamczyk and Felson (2006) found that individuals who did not personally identify as religious were still influenced by the overarching religious context of their society. There is also evidence that non-religious individuals who live in a more religious area of the country (e.g., the "Bible Belt" in the U.S.) hold more conservative

views related to gender and sexuality than those living in less conservative areas (Moore & Vanneman, 2003). Adamczyk and Pitt (2009) found that individual religious beliefs had a greater influence on attitudes regarding sexual orientation in countries with a strong self-expressive culture, such as the United States.

A large part of the strained relationship between religiosity and gender and sexual minorities is the association between sexual orientation and morality for many major religions (Olson et al., 2006). The discourse around moral values, particularly in the United States, has led to many large-scale debates and discussions surrounding identities, many of which are rooted in religious ideologies (Olson, Cadge, & Harrison, 2006). The 2003 Goodridge v. Department of Public Health case, which legalized same-sex marriage in Massachusetts, opened a nationwide debate on the morality of same-sex unions. The negative opinions that many religious followers have toward the SGM community present in diverse ways. These opinions influence important factors related to SGM rights, such as the right to marry and the right to adopt a child as a couple. These opinions can also influence how people interact with members of the Sexual and Gender Minority community.

It is also important to note the internal conflict that poses a threat to members of the SGM community who also identify with a religion that espouses negative/sinful teachings related to minority sexual orientations and gender identities. Religious identity conflict, holding religious beliefs that go against one's sexuality or gender identity, is strongly correlated with negative mental health outcomes, including mood disorders such as depression and anxiety in SGM young adults (Goldbach & Gibbs, 2015). Religious identity conflict can also lead to internalized homophobia, increasing the risk for suicidality among SGM young adults (Gibbs & Goldbach, 2015).

The presence of religion is not strictly negative. The role of religion in an SGM individual's life can be a source of stigma but can also be a source of resilience (Dahl & Galliher, 2010). Many SGM individuals also find comfort in a deity belief system and note that aspects of

religion help them accept and appreciate their sexuality or gender identity (Dahl & Galliher, 2010). Positive influences of religion in the lives of some SGM individuals include themes such as increased sense of self, acceptance of others, incorporation of religious values (into their own identity), and social support from their religious community (Dahl & Galliher, 2010).

Parent-Child Relationships

The psychological and physiological impact of the relationship between a child and parent cannot be overstated. Attachments begin forming between an infant and their caretakers within hours of the infant's birth, and the attachment style an infant develops can affect their interpersonal relationships well into adulthood (Landers & Sullivan, 2012). The development of attachment bonds helps children develop better understanding of their environments and establish a psychological sense of security, helping them adjust to and cope with stressful situations (Landers & Sullivan, 2012). Evidence suggests significant connections between the attachment bond between parent and child and the eventual mental health and personal adjustment of the child as they reach early to mid-adulthood (Raudino et al., 2013). A poor-quality parent-child relationship is a risk factor for developing mental health issues and substance use problems as an adult (Raudino et al., 2013).

According to developmentalist Bowlby (1969), a secure, early attachment evolves into complex and thoughtful social behaviors and relationships. When looking at possible trajectories for mood disorder symptoms, it is important to consider the type of relationship that someone had with their parents, even if they are well out of the adolescent or child ages.

Parent-Child Relationships and Belief Systems

As children begin to grow and form their own beliefs and identities, the communications between parents and child can shift depending on how closely the two parties' values align. Identity formation is an important part of adolescence and developing a value system (including a moral code) is a determining factor in children developing their own identities (Erikson, 1968). A child's first exposure to value systems, including religious beliefs, is usually through the system

their parents uphold, and as they begin to socialize with peers and non-family through their development, these values can change due to exposure from outside influences.

The nature of values, in relation to identity formation, is that these values serve as a guide providing criteria on which a person bases and justifies their actions. The transmission of values from parents to their children is often considered a success on the parents' behalf, or a sign that the child has been socialized in the "correct" way based on the value system that the parents hold (Barni et al., 2011). However, due to the unavoidable differences in generational values and ever-changing social norms, it is almost impossible for a parent and a child to have identical morals, values, or religious beliefs (Barni et al., 2011).

The conflict that comes from this divide in values/religious beliefs is one of the main focal points of this study. Incongruence in religious beliefs between a parent and their adult child can be a large cause of conflict, which can lead to a poor parent-child relationship (Raudino et al., 2013). Parent-child conflict, especially as the child develops into adolescence and adulthood, can have a large impact on the child's mental health and influence their methods of coping with this conflict (Gershoff et al., 2018).

Parent and Child Relationships among SGM Individuals

As stated previously, the relationship between a child and their parents or guardians significantly influences the child's mental health as they become an adult (Gershoff et al., 2018). This can be applied to children and adolescents who identify as part of the SGM community as well as those who identify as cisgender/heterosexual. It is important to consider how a family's faith can impact their relationship with their children when those children are members of the SGM community. The cognitive dissonance that forms when a religious parent has an SGM child can lead to a strained relationship on both ends. Miller, Watson, and Eisenberg (2020) found a strong correlation between religious affiliation and family acceptance in families with SGM children. Religious affiliations were categorized as Protestant, Jewish, Catholic, Muslim, Buddhist/Hindu, Orthodox Christian, and Mormon, as well as non-religious. While religious

affiliation itself was not significantly indicated to be either a protective factor nor a detriment to SGM youth's mental health, youth born into religious families (excluding Jewish and Catholic families) had on average lower family acceptance scores, and in turn higher depression scores (Miller et al., 2020).The nurturing role that family plays in a child's development cannot be overlooked. Family acceptance predicts greater self-esteem and protects against future mental health disorders such as depression (Ryan et al., 2010). Specifically, SGM youth who have accepting families are eight times less likely to attempt suicide than those youth whose families do not accept their gender identity or sexual orientation (McCormick & Baldridge, 2019). In a study where SGM teens were asked to identify the most important stressor in their lives, 26% of participants identified family acceptance over other choices such as school bullying or fear of being "out" or open about their sexuality or gender identity (Human Rights Campaign, 2012).

Furthermore, Resnik et al. (1997) found a sense of parent-child connectedness could protect against almost every health risk behavior in the child, including suicidality and substance use issues. The researchers also found that any disconnectedness between a parent and child was associated with high-risk behaviors, such as substance use, that lead to health and mood issues as the child develops (Resnik et al., 1997). The source of this disconnectedness could be attributed to many causes, including a feeling of incongruent religious beliefs between parents and their children, known as religious discord. Religious discord between parent and child is found to predict lower quality intergenerational relationships within the household (Stokes & Regnerus, 2008). Evidence also suggests that religious discord is one of the most common sources of intergenerational conflict, and an important factor in the relationship between parents and their adult children (Myers, 2004).

Current Study

Due to the ongoing moral argument surrounding religious attitudes and the Sexual and Gender Minority community, the relationship between the community and religion is often strained at best. Individuals who belong to the SGM community, compared to their cisgender,

heterosexual counterparts, are more likely to experience religious discord between themselves and their parents (Gibbs & Goldbach, 2015). Past literature shows correlations between family value congruence and relationship quality (Stokes & Regnerus, 2008). Family acceptance is the most predictive factor of SGM mental and physical health (McCormick & Baldridge, 2019). When an SGM individual has an accepting family, they are over eight times less likely to attempt suicide and six times less likely to meet criteria for depression compared to those whose families do not accept their identities (McCormick & Baldridge, 2019). The factors that influence family acceptance tend to vary across cultures, but many cite anti-SGM religious ideologies as one of the most prominent elements related to family acceptance (McCormick & Baldridge, 2019). Among SGM youth who have not yet come out to their families, 16% report religious beliefs as the reason they believe they would not be accepted by their family (Human Rights Campaign, 2012). Parental religious affiliation can also heavily influence the psychopathology of children raised in a non-accepting environment, most likely due to the stress of living in an environment where the individual feels threatened or isolated. Parental religious affiliation was found to be strongly correlated with more depressive symptoms in SGM youth (Miller, Watson, & Eisenberg, 2020). Research also demonstrates that perceived parental religiosity is a predictor for depressive symptoms and substance use in SGM individuals (MacBeth, 2021).

The purpose of the current study was to address the gap in research investigating parent-child religious congruence, mood disorders, and sexual orientation/gender identity. By measuring the perceived religiosity of the parents and the participant, I examined the association between familial religious congruence and current mood disorder symptoms in the Sexual and Gender Minority community compared to individuals who do not identify as SGM. The current study tested the following hypotheses/study aims:

- Hypothesis 1: Previous literature shows a consistent trend for Sexual and Gender Minority community members reporting more symptoms of depression, anxiety, and stress than individuals who do not belong to the Sexual and Gender Minority community

(Husain-Krautter, 2017; Skerrett et al., 2016). The current study aimed to further support these findings and predicted SGM individuals' self-reported symptoms of depression, anxiety, and stress would be significantly higher compared to those who do not identify as SGM.

- Hypothesis 2: Previous research also shows evidence of a relationship between parent-child religious congruence, parent-child relationship quality, and the psychosocial adjustment of the child. Stokes and Regnerus (2009) found a strong correlation between religious congruence and parent-child relationships, with religious discord leading to reports of poorer intergenerational relationships. Raudino et al. (2013) also found that poor parent-child relationships lead to poor psychosocial adjustment of individuals, who report higher levels of depression and anxiety. Based on the literature, it was expected that individuals who have less religious congruence with their parent or guardian would report more symptoms of depression, anxiety, and stress, as well as a poorer parent-child relationship quality.
- Study Aim 1: While specific directional information was not available from current literature, this study explored the relationship between identity (SGM vs. cisgender/heterosexual identities) and religious congruence with parents.
- Study Aim 2: To further investigate the interrelationships among parent/child religious congruence with parents, sexual orientation/gender identity and symptoms of depression, anxiety, and stress, the study examined the moderating effects of religious congruence with parents on the relationship between sexual orientation/gender identity and emotional indices.

CHAPTER 2

METHOD

Participants

Participants were recruited in multiple ways. Georgia Southern University students enrolled in psychology courses and over the age of 18 were recruited via SONA, the Psychology Department's online study management system. Sexual orientation and gender minority (SGM) students and community members over the age of 18 were recruited via flyers posted around campus and social media (e.g., Facebook, Twitter, and Instagram) posts. No other exclusion/inclusion criteria existed. The addition of recruitment via flyers and social media posts was to better recruit SGM individuals. Participants who were currently enrolled in psychology courses received course or extra credit for participation. Participants recruited through flyers and social media posts were given the option to email the researcher separately to be placed in a drawing to win one of five $10 electronic gift cards to Amazon.

The current study recruited a sample of 310 participants – 108 (34.8%) recruited via social media and campus flyers and 202 (65.1%) Georgia Southern University psychology students recruited via the SONA system. Examining the data led to 23 (7.4%) of the Non-SONA and four (1.2%) of the SONA participants being excluded from analysis due to discontinuing the survey or not answering any study questions. An additional two (0.6%) SONA participants were excluded due to age (reported age was 17). Subsequently, four (1.2%) Non-SONA and seven (2.26%) SONA participants did not complete demographic questions allowing for determining sexual orientation/gender identity category, and were also excluded from analyses. This resulted in a final sample of 269 participants with an age range of 18 to 60 (M = 21.15, SD = 4.49). Participants provided their gender and sexual orientation identities, with 126 participants (46.5%) identifying as members of the Sexual and Gender Minority community, and 143 participants (53.16%) identifying as cisgender/heterosexual. To provide further detail, 243 participants identified as cisgender (meaning their current gender orientation matches the gender they were

assigned at birth), and 26 identified as a different gender identity (e.g., nonbinary, transgender, agender). In addition, 126 participants (46.84%) identified as Gay, Lesbian, Bisexual, or another minority sexual orientation and 143 participants (53.16%) identified as having a heterosexual orientation. Most participants identified as White (156; 58.0%), with 55 (20.4%) identifying as African American, 30 (11.2%) identifying as Multiracial, 15 (5.6%) identifying as Latinx, 10 (3.7%) identifying as Asian American, and 3 (1.1%) identifying as Native American or another race not listed.

Measures

The following measures were presented in the following order via Qualtrics XM, an online survey and data collection software:

Current Mental Health of Participants

The Depression Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995). Participants completed the DASS, which measures current (past week) depression, anxiety, and stress symptoms. The DASS-21 is a 21-item self-report measure, where participants rate a series of statements by how much they apply to the participant over the past week, with 0 - "Did not apply to me at all," and 3 - "Applied to me very much, or most of the time." Questions from the DASS-21 include, "I couldn't seem to experience any positive feeling at all," "I found myself getting upset rather easily," and "I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)." The DASS-21 has high reliability (α = .82 - .97) in a diverse population (Lovibond & Lovibond, 1995). In the current study, good internal consistency was found for depression (Cronbach's α = .89), anxiety (Cronbach's α = .87), and stress (Cronbach's α = .81).

Religious Beliefs and Parent/Child Religious Congruence

The Belief into Action Scale-10 (BIAC-10; Koenig, Wang, Al Zaben, & Adi, 2015). The BIAC-10 is a 10-item self-report questionnaire measuring the amount of involvement an individual has in their chosen religion on a 10-point Likert scale ranging from "never" to "daily."

Questions include, “How often do you attend religious services?” and “To what extent have you decided to conform your life to the teachings of your religious faith?” The BIAC-10 has a high reliability in a diverse sample (α = .89; Koenig et al., 2015). In the current study, good internal consistency was found (Cronbach’s α = .89).

Self and Parent Religious Beliefs. Participants provided their current religious denomination, the religious denomination they were raised in, and their closest parental figure’s religious denomination.

Parent/Child Religious Congruence. Participants rated on a scale from 0-100% how closely their current religious beliefs aligned with the current religious beliefs of the parent with whom they have the closest relationship. (See Appendix.)

Parent/Child Relationship

The Experiences in Close Relationships-Relationship Structures Questionnaire (ECR-RS; Fraley et al., 2006; 2015). The ECR-RS is a 9-item scale designed to assess attachment patterns in close relationships. For this study, participants answered the questions in relation to the parent or guardian figure with whom they felt they had the closest relationship. The ECR-RS shows solid test-retest reliability in parent/child relationships (α = .80; Fraley et al., 2006). Participants rated a series of statements regarding their relationship with their attachment figure on a seven-point Likert scale ranging from “Strongly Disagree” to “Strongly Agree.” Statements include, “It helps to turn to this person in times of need,” “I find it easy to depend on this person,” and “I often worry that this person doesn’t really care for me.” The current study found excellent internal consistency for this measure (Cronbach’s α = .92).

The Child Rearing Values Scale (CRV; Feldman & Stenner, 1997). The CRV is a four-item scale examining which values a parent prefers to emphasize when raising their child. Participants selected the value for each item based on how they thought their closest parent or guardian would answer them. Participants were prompted to answer, for example, “Which quality from each pair would your closest parent say is more important for a child to have: (A) Respect

for Elders or (B) Independence." The current study found poor internal consistency for this measure (Cronbach's $\alpha = .59$).

Open-Ended Questions. Participants answered two open-ended questions regarding their relationship with the parent or guardian with whom they feel they have the closest relationship. Specifically, they answered, "Describe your relationship with your closest parent" and "What is religion's role in your relationship with this parent?" (See Appendix.)

Demographics

Demographics Questionnaire. Participants provided basic demographic information, including information on their sexual orientation and gender identity, which served as SGM/non-SGM variables. For the current study, participants who selected one of the majority genders (i.e., cis male/cis female) AND the majority sexual orientation (i.e., heterosexual) were included in the non-SGM group. All others were included in the SGM group for analyses. In addition, participants provided their age, race and ethnicity, and how they found the study.

CHAPTER 3

RESULTS

Preliminary Analyses

Prior to hypothesis testing, several preliminary analyses were conducted out of interest. A between-groups MANOVA was conducted, with sexual orientation/gender identity serving as the independent variable, and parental attachment (results from the ECR-RS) and general religiosity (from the BIAC-10) scores serving as the dependent variables. Results showed a significant relationship between sexual orientation/gender identity and both of the dependent variables, Wilk's Λ =.71, $F(2,259) = 53.44$, $p < .001$. Participants with minority sexual orientations/gender identities reported lower scores of parental attachment ($M = 44.94$, $SD = 12.12$) than participants who identified as cisgender and heterosexual ($M = 54.46$, $SD = 9.93$). Likewise, participants who identified as sexual or gender minorities reported less general religiosity ($M = 17.59$, $SD = 10.64$) than individuals who identified as cisgender and heterosexual ($M = 31.51$, $SD = 18.14$).

A bivariate correlation was also conducted to examine the relationship between parental attachment, religious congruence, and parental authoritarianism (from the CRV). A positive correlation was found between parental attachment and religious congruence, $r(245) = .36$, $p < .001$, indicating that higher scores of parental congruence are correlated with higher scores of parental attachment. A negative correlation was found between parental authoritarianism and parental attachment, $r(257) = -.18$, $p = .003$, indicating that higher scores of parental authoritarianism are correlated with lower scores of parental attachment.

Participants provided open-ended responses to questions about their relationship with their closest parental figure. Specifically, responses from the question, "What is religion's role in your relationship with this parent?" were examined for thematic similarities and differences. The responses from participants who reported high religious congruence with their parental figure (≥ 75%), and those who reported low religious congruence (≤ 25%) were

examined for themes. Out of the 269 participants who provided information about parent-child religious congruence, 69 (25.7%) reported a congruence score of lower than 25%. Within this group, 50 identified as a minority sexual orientation, 19 identified as heterosexual, 18 identified as non-cisgender, and 50 identified as cisgender. Several themes emerged among the low-congruence group, where religion either had a positive, negative, or nonexistent role in their relationship with their closest parent. Among participants who implied religion had a positive influence, quotes include: “There is no role, and the fact that she never forced me into religion is part of why I am close with her,” “We talk about religion often only because I often bring up my beliefs. He does not share all of the same beliefs as me, but he respects them and doesn’t force me to see it any different way,” and “Strong and guiding.”

For those in the ≤ 25% congruence group who implied religion had a negative impact, quotes included: “It’s one of the biggest roles within the relationship. It very much divides us,” “It divides me and her and I don’t tell her anything, because if it even slightly goes against it, she’ll yell at me and tell me […] that I’m going to hell,” and “I avoid the topic of religion or an argument will ensue.”

For those with low congruence who implied religion had a neutral, or nonexistent role in their parent-child relationship, quotes included: “Religion is very important to them but not to me,” “Used to be what grew us distant, since I was forced into religious events and I’ve never felt any sort of attachment to Christianity nor God. My relationship with my mom got better precisely because religion stopped being a part of it,” and “Religion does not play a role in my relationship with him. We celebrate some of his Christian holidays, he’s fine with […] my Pagan rituals, and we sometimes discuss the differences in our beliefs. That’s pretty much it.”

On the opposite end, 101 (37.5%) participants reported a parent-child religious congruence of 75% or more. Within this group, 99 identified as cisgender, and 2 as a minority gender identity. Subsequently, 74 identified as heterosexual, and 27 identified as a minority sexual orientation.

Of the high-congruence group, religion seemed to either have a minimal role, or a large/very important role in the parent-child relationship. For participants who mentioned religion having a minimal role, quotes included: “There is no religious role that plays a part in our relationship,” “We don’t discuss religion too much but our views on religion align a lot,” and “Plays little to no role aside from occasional discussions about spirituality as a whole.”

For participants with high congruence who implied religion had a large role in their relationship, quotes included: “God is at the center of our relationship,” and “We talk about it in almost every conversation. They are great role models in faith.”

Hypothesis 1 and Study Aim 1

Hypothesis 1 stated that members of the Sexual and Gender Minority community will experience higher symptoms of depression, anxiety, and stress compared to participants who did not identify as Sexual or Gender minorities. Further, the current study aimed to investigate whether a relationship exists between sexual orientation/gender identity and parent child religious congruence (Study Aim 1). To investigate these relationships, a between-groups MANOVA was conducted, with gender/sexual orientation serving as the independent variable, and Depression, Anxiety, and Stress scores (from the DASS – Hypothesis 1) and parent-child religious congruence scores (Study Aim 1) serving as the dependent variables. Overall, there is a significant relationship between sexual orientation/gender identity and the above variables, Wilk’s $\Lambda = .789$, $F(4, 228) = 15.22$, $p < .001$. Follow up ANOVAs indicate individuals with minority sexual orientation/gender identity experienced greater depressive symptoms than those who identified as cisgender/heterosexual, $F\ (1,233) = 15.16$, $p < .001$. Additionally, individuals with minority sexual orientation/gender identity experienced greater stress symptoms than those who identified as cisgender/heterosexual, $F\ (1,233) = 5.67$, $p = .018$. There were significant differences between SGM individuals and cisgender/heterosexual individuals on parent-child religious congruence ratings. Cisgender/heterosexual individuals reported significantly higher congruence in religious beliefs to their parents compared to those with a minority sexual

orientation/gender identity, F (1,233) = 48.75, $p < .001$. There was no significant difference between the groups on anxiety symptoms. See Table 1 for mean scores.

Table 1

Mean Scores on Depression, Anxiety, Stress, and Religious Congruence

Variables	Cisgender/Heterosexual *n* = 132		SGM *n* = 101	
	Mean	**SD**	**Mean**	**SD**
Depression**	12.43	5.31	15.37	6.17
Anxiety	12.04	4.59	13.05	4.63
Stress*	14.72	5.47	16.34	4.67
Religious Congruence**	69.19	28.46	40.48	34.20

Note: *mean differences are significant at the $p < .05$ level; **mean differences are significant at the $p < .001$ level.

Hypothesis 2

Hypothesis 2 stated that individuals who had less religious congruence with their parents would report higher signs of depression, anxiety, and stress, and have an overall lower parent-child relationship quality. Bivariate correlations were conducted to investigate the relationships among these variables. A negative correlation was found between depression and parent/child religious congruence, $r(240) = -.18$, $p < .001$, indicating that as parent child religious congruence decreases, symptoms of depression increase. Parental attachment was significantly negatively correlated with symptoms of depression ($r(256) = -.39$, $p < .001$), anxiety ($r(263) = -.31$, $p < .001$), and stress ($r(256) = -.29$, $p < .001$), indicating that lower scores of parental attachment are correlated with higher levels of depression, anxiety, and stress. Parental attachment was also positively correlated with religious congruence, $r(245) = .36$, $p < .001$, indicating that higher parent-child religious congruence leads to higher levels of parental attachment. See Table 2.

Table 2

Correlations among Depression, Anxiety, Stress, Parental Attachment, and Religious Congruence

	Depression	Anxiety	Stress	Parental Attachment
Parental Attachment	-.394**	-.313**	-.287**	-
Religious Congruence	-.184**	-.127*	-.131*	.364**

Note: * Correlation is significant at the .05 level (two-tailed); ** Correlation is significant at the .01 level (two-tailed).

Study Aim 2

Study Aim 2 was designed to explore any moderating effect of religious congruence on the relationship between sexual orientation/gender identity and symptoms of depression and stress. Since anxiety was not significantly affected by sexual orientation/gender identity, an analysis was not conducted for this variable. Two moderation models were conducted using model one in the PROCESS Macro for SPSS to examine if parent-child religious congruence moderated the relationship between sexual orientation/gender identity and symptoms of depression and stress. The analyses were 5000 bootstrapped samples. Neither of the moderation models were significant; depression (b = -.00, SE = .02, p = .73) and stress (b = -.03, SE = .02, p = .08) were not significantly affected by parent-child religious congruence.

CHAPTER 4

DISCUSSION

Historically, members of the sexual and gender minority (SGM) community consistently report higher levels of mood disorder symptoms including stress, depression, and anxiety (Goldbach & Gibbs, 2015). The challenges faced by those in this community, including discrimination and rejection, contribute to negative mental health and increased suicidal ideation or attempts (Skerrett, Kolves, & De Leo, 2016). Research also shows parental acceptance is a protective factor reducing the rates of depression, substance use, and suicidal ideation in SGM individuals (Ryan et al., 2010). Due to the strained relationship between religious faith and sexual or gender minorities, where religion is a potential source of stigma related to sexuality and gender identity (Schmitz & Woodell, 2018), the current study aimed to examine the relationship among parent-child religious congruence, sexual orientation/gender identity, and mood disorder symptoms.

Hypothesis 1 - Sexual and Gender Minorities and Mood Disorder Symptoms. A significant relationship was found between sexual orientation/gender identity and symptoms of depression and stress. Results indicate individuals who identified as a sexual or gender minority experienced higher rates of depression and stress symptoms compared to individuals who identified as cisgender and heterosexual. This aligns with previous literature, stating that sexual and gender minorities are more likely to experience symptoms of depression, including suicidal ideation (Goldbach & Gibbs, 2015; Skerrett et al., 2016). The current study did not, however, find a significant relationship between sexual orientation/gender identity and anxiety. It was expected, given previous literature (Goldbach & Gibbs, 2015), that sexual and gender minorities would also experience higher rates of anxiety compared to non-sexual and gender minorities. A few factors that may account for the results include the types of questions asked – the questions designed to measure anxiety on the DASS-21 include statements such as: “I experienced breathing difficulty,” “I had a feeling of shakiness,” and “I perspired noticeably (e.g., hands sweaty) in the

absence of high temperatures or physical exertion." These questions measure the physical aspects of general anxiety – it might have been more helpful to find or design a measure examining specific situational anxiety related to gender identity or religiously related experiences that were non-affirming of gender or sexual orientation identities (e.g., religious gatherings, conversations with parents) for the current study.

Hypothesis 2 - Parent-Child Relationships, Religious Congruence, and Mood Disorder Symptoms. Results of the current study show a strong positive correlation between parent-child religious congruence and parent-child relationships. Specifically, as parent-child religious congruence increased, parental attachment increased. This is consistent with previous findings, with Stokes and Regnerus (2009) also finding a strong correlation between religious congruence and parent-child relationships. Results also showed a significant negative correlation between depression and parent-child religious congruence. This indicates that as parent-child religious congruence scores went down, symptoms of depression increased. This is consistent with previous literature, showing a negative correlation between parent-child relationships and psychosocial adjustment in individuals (Raudino et al., 2013). Altogether, these findings may indicate that parent-child relationship quality is related to religious congruence, and in turn may affect mood disorder symptoms such as depression.

Study Aim 1 - Sexual and Gender Minorities and Religious Congruence. The current study showed a significant relationship between sexual orientation/gender identity and parent-child religious congruence. Individuals who identified as cisgender and heterosexual reported significantly higher religious congruence with their parents compared to individuals who identified as a sexual or gender minority. While no hypothesis was made for this study aim, results are consistent with literature in related areas. Schmitz and Woodell (2018) found that members of the sexual and gender minority community often view religion as both a familial and institutional source of stigma and discrimination related to their sexuality or gender identity.

These findings can be used to further explore effective affirming care and support for sexual and gender minority individuals experiencing difficulties in their relationships with their families.

Study Aim 2 - Parent-Child Religious Congruence as a Moderator. The current study found that parent-child religious congruence did not significantly moderate the relationship between sexual orientation/gender identity and symptoms of depression and stress. There was no prior known literature examining this relationship; however, previous conclusions in this study show correlations between parent-child religious congruence and symptoms of depression, as well as linking gender identity/sexual orientation with symptoms of both depression and stress. Further, there is prior research showing a complicated relationship between sexual orientation/gender identity and religious beliefs (Schmitz & Woodell, 2018), as well as the current study finding that sexual and gender minorities are less likely to experience religious congruence with their parents. It is possible that religious congruence is not a driving force for the differences observed between SGM individuals and their cisgender/heterosexual counterparts or that the one item manner that religious congruence was assessed in the current study was not robust enough to detect a relationship. Future studies should continue to explore possible factors that impact the relationship between gender identity/sexual orientation and symptoms of depression and stress, including using different ways to explore parent/child religious differences and potential impacts.

Strengths

A relatively diverse sample, with 43% of participants identifying as a non-White race and 46.5% identifying as a sexual or gender minority was utilized in the current study. Participants were recruited from a variety of different backgrounds and ages due to the use of the Internet and social media platforms such as Facebook, Instagram, Snapchat, and Twitter. Additionally, this is the first known study examining parent/child religious congruence and its relationship to sexual orientation, gender identity, and symptoms of depression and stress. Exploring factors related to

the increased incidence of depression, anxiety, and stress among SGM individuals is important due to the increased incidence of these symptoms for the SGM community.

Limitations

There were several factors that, due to the method of research, were unable to be controlled for in this study. The current study could not control for factors such as age, race or ethnicity, or the individual's own relationship with religion. The study also had an average sample size – the study originally included 310 participants; however, after cleaning data and excluding participants who did not complete the survey, there were 271 participants, some of whom still did not answer every question. The sample also largely consisted of collegiate undergraduate students who were completing the survey for course credit and therefore the results may not generalize to other groups/populations. Though efforts were made to recruit a large sexual or gender minority population, the current study was unable to recruit participants in ways other than described. There is no available literature to suggest whether using an online social media format for participant recruitment is the best way to recruit this population. It is also very possible that individuals' personal relationship with religion is not easily quantifiable or summed up in Likert-scale questionnaires, and therefore may not be accurately represented in the current data. In addition, a medium sample size (as available here) may influence power.

Implications

The results of the current study have several implications on areas of interest in research, including religion and sexual and gender minorities. Results from Hypothesis 1 and Study Aim 1 contribute to previous literature surrounding the specific circumstances impacting the mental health of sexual and gender minorities. Sexual and gender minorities had more symptoms of depression and stress, and less parent-child religious congruence compared to their cisgender/heterosexual counterparts. These findings may lead to the development of more affirming therapy methods focusing on the roles that religiosity and parent-child relationships play in the presentation of mood disorder symptoms in sexual and gender minorities. In addition,

the findings point to a strong relationship between parent/child religious congruence and attachment and depression and stress symptoms. Regardless of gender identity or sexual orientation, those with less religious congruence and poorer attachment with their parents are more likely to show symptoms of depression and stress. These findings can support assessment and interventions for depression and stress and the parent/child relationship.

Directions for Future Research

To expand on this study, future research can focus on narrowing down specific factors influencing why parent-child religious congruence relates to symptoms of depression and stress, such as religious ceremony attendance, nature of upbringing, and how religion may influence parenting styles. Future research can also examine the relationships between religion and the SGM community, and the factors influencing the drastically different relationships that sexual and gender minorities may have with religion depending on the environment in which they were raised. Clinical research could focus on the effectiveness of faith-based therapies and potential effectiveness for sexual and gender minorities; specifically, the implications that a healthier relationship with religion can have on mood disorder symptoms. More moderating analyses would also be a possible route for future research, potentially exploring any moderating effects that specific religions (Christianity, Judaism, Islam, etc.) have on the relationship between sexual and gender minorities and symptoms of depression, stress, and anxiety.

Previous research shows strong indicators that sexual orientation/gender identity predicts the development of suicidal behaviors and substance use issues (Lewis, 2009; Skerrett et al., 2016). Symptoms of depression and stress are consistent predictors for certain physical health detriments, such an increased risk for cardiovascular disease (Cohen et al., 2015). Future research on the physical health of sexual and gender minorities, compared to non-sexual and gender minorities, based on depressive and stress symptoms, would be an interesting area of research. Also, parental attachment may be more important than religious congruence in explaining some

of the differences found in the current study. Attachment may be an important variable to explore as a potential moderator.

Conclusion

Sexual and gender minorities are consistently at an increased risk of developing mental health issues such as suicidal ideation, substance use issues, and mood disorder symptoms. To provide affirming care to the SGM community, it is important to understand possible factors influencing the development of these symptoms. The current study found that sexual and gender minorities reported higher rates of depression and stress symptoms compared to non-sexual and gender minority participants. Additionally, individuals who identified as a sexual or gender minority reported lower rates of parent-child religious congruence compared to individuals who did not identify as a sexual or gender minority. Strong correlations were also found between parent-child religious congruence, parent-child relationships, and symptoms of depression. Specifically, as parent-child religious congruence decreased, parent-child relationship quality also decreased, and symptoms of depression increased. The results of this study can be used to further clinical research on treatment of sexual and gender minority individuals.

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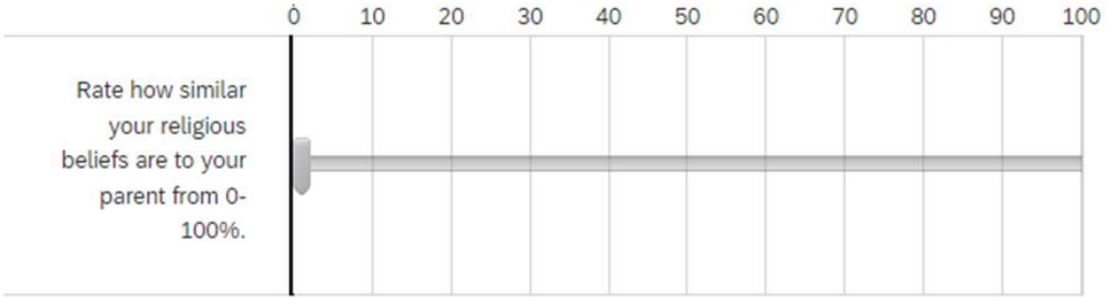
APPENDIX

MEASURES CREATED FOR USE IN THE CURREN STUDY

Religious Congruence:

Thinking again of the parent with whom you have the closest emotional relationship, how closely do your religious beliefs align with that parent?



Parent-Child Relationships

1. Describe your relationship with your closest parent.

2. What is religion's role in your relationship with this parent?

Religious Demographics

What is your current religious affiliation, if any?

- ○ Agnostic
- ○ Asian Folk Religion
- ○ Atheist
- ○ Baha'i
- ○ Buddhist
- ○ Christian [click for more options]
- ○ Hindu
- ○ Jewish
- ○ Muslim
- ○ Sikh
- ○ Unitarian Universalist
- ○ Wicca
- ○ Nothing in Particular
- ○ Other: _____

[If Christian is selected, the following options appear.]

Which Christian denomination do you affiliate with?

- ○ Adventist
- ○ African Methodist
- ○ Anabaptist
- ○ Assemblies of God
- ○ Baptist
- ○ Bible Church
- ○ Brethren
- ○ Catholic/Roman Catholic
- ○ Christian & Missionary Alliance
- ○ Christian Reformed
- ○ Christian Science
- ○ Church of Christ
- ○ Church of God
- ○ Church of the Nazarene
- ○ Congregational
- ○ Disciples of Christ
- ○ Episcopal/Anglican
- ○ Holiness
- ○ Jehovah's Witness
- ○ Latter-Day Saints
- ○ Lutheran
- ○ Mennonite
- ○ Methodist
- ○ Non-denominational
- ○ Orthodox (Eastern, Greek, Nigerian, Russian)
- ○ Pentecostal
- ○ Presbyterian
- ○ Quaker/Friends
- ○ Reformed Church in American/Dutch Reformed
- ○ Salvation Army
- ○ Seventh-Day Adventist
- ○ Unitarian Universalist
- ○ United Church of Christ
- ○ Other: _____

Do you consider yourself evangelical?

- ○ No
- ○ Yes

What religion were you raised in, if any?

- ○ Agnostic
- ○ Asian Folk Religion
- ○ Atheist
- ○ Baha'i
- ○ Buddhist
- ○ Christian [click for more options]
- ○ Hindu
- ○ Jewish
- ○ Muslim
- ○ Sikh
- ○ Unitarian Universalist
- ○ Wicca
- ○ Nothing in Particular
- ○ Other: _____

[If Christian is selected, the following options appear.]

Which Christian denomination were you raised?

- ○ Adventist
- ○ African Methodist
- ○ Anabaptist
- ○ Assemblies of God
- ○ Baptist
- ○ Bible Church
- ○ Brethren
- ○ Catholic/Roman Catholic
- ○ Christian & Missionary Alliance
- ○ Christian Reformed
- ○ Christian Science
- ○ Church of Christ
- ○ Church of God
- ○ Church of the Nazarene
- ○ Congregational
- ○ Holiness
- ○ Jehovah's Witness
- ○ Latter-Day Saints
- ○ Lutheran
- ○ Mennonite
- ○ Methodist
- ○ Non-denominational
- ○ Orthodox (Eastern, Greek, Nigerian, Russian)
- ○ Pentecostal
- ○ Presbyterian
- ○ Quaker/Friends
- ○ Reformed Church in American/Dutch Reformed
- ○ Salvation Army
- ○ Seventh-Day Adventist
- ○ Unitarian Universalist

- ○ Disciples of Christ
- ○ Episcopal/Anglican
- ○ United Church of Christ
- ○ Other: _____

Were you raised evangelical?

- ○ No
- ○ Yes

Thinking again of the parent with whom you have the closest emotional relationship, **what is their current religious affiliation, if any?**

- ○ Agnostic
- ○ Asian Folk Religion
- ○ Atheist
- ○ Baha'i
- ○ Buddhist
- ○ Christian [click for more options]
- ○ Hindu
- ○ Jewish
- ○ Muslim
- ○ Sikh
- ○ Unitarian Universalist
- ○ Wicca
- ○ Nothing in Particular
- ○ Other: _____

[If Christian is selected, the following options appear.]

Which Christian denomination does your parent affiliate with?

- ○ Adventist
- ○ African Methodist
- ○ Anabaptist
- ○ Assemblies of God
- ○ Baptist
- ○ Bible Church
- ○ Brethren
- ○ Catholic/Roman Catholic
- ○ Christian & Missionary Alliance
- ○ Christian Reformed
- ○ Christian Science
- ○ Church of Christ
- ○ Church of God
- ○ Church of the Nazarene
- ○ Congregational
- ○ Disciples of Christ
- ○ Episcopal/Anglican
- ○ Holiness
- ○ Jehovah's Witness
- ○ Latter-Day Saints
- ○ Lutheran
- ○ Mennonite
- ○ Methodist
- ○ Non-denominational
- ○ Orthodox (Eastern, Greek, Nigerian, Russian)
- ○ Pentecostal
- ○ Presbyterian
- ○ Quaker/Friends
- ○ Reformed Church in American/Dutch Reformed
- ○ Salvation Army
- ○ Seventh-Day Adventist
- ○ Unitarian Universalist
- ○ United Church of Christ
- ○ Other: _____

Does your parent consider themself evangelical?

- ○ No
- ○ Yes