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The Intersection of Family Acceptance and Religion on the Mental Health of LGBTQ Youth

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While family acceptance has been shown to be protective for LGBTQ youth, the role of family acceptance within religious contexts is less clearly described. This study explored the role of religious affiliation and family acceptance on mental health outcomes among LGBTQ youth using data from the LGBTQ National Teen Survey. Key variables included (1) religious affiliation, (2) family acceptance regarding LGBTQ identity or orientation, and (3) mean depression scores. Analysis of variance (ANOVA), Pearson's correlations, and multiple linear regression models were conducted, including an interaction term to test for differences in the primary association across religious groups. The analytic sample included 9,261 youth. Mean family acceptance was 2.43 on a scale of 0–4, with 4 indicating the highest level of family acceptance. Religious affiliation was strongly associated with degree of family acceptance ($p < .05$). Mean depression score was 13.30 on a scale of 0–30, with 30 indicating the highest level of depression; religious affiliation was strongly associated with mean depression score ($p < .05$). LGBTQ family acceptance was strongly inversely associated with depressive scores, even when adjusting for potential confounders (Beta = –2.37, $p < .001$). The interaction of family acceptance by religion was non-significant, indicating that this association was similar for youth in all religious groups. Findings were unchanged when adjusting for demographic covariates such as gender identity or race. Our research supports existing literature showing that family acceptance is a strong protective factor for LGBTQ youth, regardless of religion of origin.

Keywords: religion; family acceptance; adolescent health; transgender health; gay and lesbian health

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Statement of Public Health Significance: In this study, family acceptance was found to be strongly protective for all LGBTQ youth, regardless of religious affiliation. This has powerful implications on how providers can counsel and educate families and systems on strategies to best support LGBTQ youth, especially those with religious backgrounds.

INTRODUCTION

Childhood and adolescence are critical periods of development and socialization. Healthy patterns and developmental trajectories begin in childhood and adolescence, and these patterns often persist throughout an individual's life span.[1] It is critically important to promote resilience and positive youth development in children and adolescents. One group in particular, LGBTQ youth, may benefit from protective relationships to a greater extent than cisgender and heterosexual youth. Like all youth, LGBTQ youth experience development in multiple domains: socialization occurs at home, in school, in faith communities and places of worship, and through extracurricular activities. However, LGBTQ youth are more likely to experience discrimination, microaggression, and family rejection than their heterosexual and cisgender peers.[2,3] The daily experience of minority stress in part explains negative health outcomes among LGBTQ youth; these health disparities are well-documented.[4] LGBTQ youth experience much higher levels of physical and sexual abuse, substance use, homelessness, family rejection, depression, and suicidal ideation and attempts than their heterosexual peers.[5–8] Transgender youth in particular exhibit an increased risk of suicidal ideation[9] and poorer self-reported health.[10] Given these discouraging trends, expanding our understanding of protective and resilience-promoting factors for LGBTQ youth is a key priority.

It is well-established that supportive adults can promote youth resilience and provide a buffer from stressors, resulting in improved health outcomes.[11–13] The literature base supporting the critical importance of family acceptance for LGBTQ youth is robust and well-established.[14–18] The current literature points to a clear consensus that family acceptance provides marked benefits in mental and physical health. For example, while transgender youth have been found to have higher rates of depression and suicide, a study from 2016 found that transgender youth who were supported in their gender identity by their families had rates of depression similar to that of the general population.[16] Similarly, Ryan et al. found that higher levels of family acceptance correlate with improved self-esteem and overall health in lesbian, gay, and bisexual youth.[17] This has been further substantiated in longitudinal studies that support the correlation between family acceptance and positive mental health outcomes.[15] This large and growing body of literature suggests that family acceptance mitigates the health disparities facing LGBTQ youth.

While family acceptance is clearly a protective factor for LGBTQ youth, the role of religion is less clearly established. Among general samples of youth, spiritual coping and religion has been recognized as a protective factor, in particular against poor mental health outcomes and substance use.[19–24] However, the potential role of religion as a protective factor for LGBTQ youth is only beginning to be explored. Until recently, the majority of the research evaluating religion as a protective factor has focused on heterosexual youth. While religious entities vary in their acceptance of LGBTQ individuals and relationships, religion has historically been associated with stigma and ostracization for many LGBTQ communities.[25] Thus, some researchers

have sought to evaluate the role of religion specifically in the lives of LGBTQ youth, with early studies suggesting that the protective effects of religion may not extend to LGBTQ youth.[26,27] For example, a study by Rostosky et al. described a strong correlation between increased religiosity and lower rates of binge drinking, marijuana use, and cigarette smoking among a general sample of youth. However, when LGBTQ youth were analyzed separately, there were no significant correlations between religiosity and alcohol/drug use, leading the authors to conclude that the positive association with religion may not be applicable to LGBTQ youth.[27] Another study showed that while religiosity is protective against hazardous drinking among young heterosexual women, it is not protective among young sexual minority women.[26]

In addition to a lack of protective effects for LGBTQ youth, there is some data suggesting that there may be a correlation between religious affiliation and negative mental health outcomes. In a large study by Ream et al. involving over 1,000 youth and young adults aged 13–25, about two-thirds reported a conflict between their LGBTQ identity and their religious affiliation,[28] suggesting that religion has the potential to create duress for LGBTQ youth. A study by Lytle et al. described an increased risk of suicidal ideation among LGBTQ youth with high levels of religiosity compared to heterosexual youth with high levels of religiosity,[29] and Meanley et al. found that religiously affiliated gay and bisexual men were more likely to have poor psychological outcomes than gay and bisexual men without religious affiliation.[30] Hatzenbueler et al. quantified religious climate by measuring the degree of religiosity in counties in the state of Oregon, and found that LGBTQ youth in more religious communities had higher risk of problematic alcohol use, regardless of their own affiliation with religion.[31] A similar study evaluating religious climate in schools found increased risk of depression in LGBTQ youth at schools with high religiosity.[32] LGBTQ youth have also described harassment or discrimination in religious contexts.[33] Multiple studies have found that being a member of a religion with disapproving attitudes toward LGBTQ people increased internalized negative self-messages and homophobia.[28,34–36]

Conversely, growing up in a religious context did confer benefits in some of these studies: LGBTQ youth described developing a stronger sense of self, identifying the importance of acceptance of others, the incorporation of religious values into their lives, and social support from their religions.[37] Thus, it would seem that similar to all youth, LGBTQ youth benefit from social support and acceptance; some LGBTQ youth are able to find religious communities that accept their identity and serve as a source of support.[33]

While family acceptance has been reliably found to be a protective factor, it is unknown whether family acceptance remains protective for LGBTQ youth with different religious backgrounds, especially if the family's religion prohibits or discourages LGBTQ identities and behaviors. This study sought to describe the impact of religious affiliation on the well-known protective association between family acceptance and mental health for LGBTQ youth.

Informed by previous research,[17] we hypothesized that family acceptance would be inversely associated with depressive symptoms in this sample of LGBTQ youth. Building on previous literature by using a large dataset with many religious backgrounds represented, we hypothesized that youth with different religious backgrounds would have varying levels of depressive symptoms and family acceptance. We further hypothesized that the association between family acceptance and depressive symptoms would differ among youth with different religious backgrounds, with stronger associations among youth from religions that traditionally disapprove of LGBTQ identities and behaviors.

METHODS

Study Design and Sample

This study utilized an existing non-probability dataset (*LGBTQ National Teen Survey)*, an online survey regarding the experiences of LGBTQ teens in the United States. In partnership with the Human Rights Campaign (HRC), researchers at the University of Connecticut surveyed adolescents (aged 13–17) who identified as LGBTQ, could read English, and lived in the United States. The anonymous survey was hosted by Qualtrics.com. Recruitment was primarily through social media and through HRC's extensive network of community partners. Informed assent was obtained by all participants, and a waiver of parental consent was obtained from the University of Connecticut's Institutional Review Board. A waiver of parental consent was necessary due to the sensitive and confidential nature of questions asked. An exemption was obtained from the University of Minnesota Institutional Review Board for this secondary data analysis.

Four items on sexual/gender identity disclosure (i.e., whether or not a youth was "out" to their parents and siblings) were used to define the analytic sample. Approximately 30% (n = 5,182 of the 17,112 usable cases) were missing data on all four items, and an additional 22.4% (n = 2,669) responded that none of their parents and/or siblings knew about their sexual orientation and/or gender identity. These cases were excluded from analysis in order to ensure the relevance of the LGBTQ family acceptance items described below. The analytic sample therefore included 9,261 adolescents who were out to at least one parent or sibling. Participant demographics are described in Table 1. A total of 75% of participants were assigned female at birth, and the mean age was 15.6 years. Approximately two-thirds of the study participants identified as white.

TABLE 1. Participant Demographics (N = 9,261)

	N (%)
Assigned Sex	
Male	2,311 (25.0)
Female	6,950 (75.0)
Religion Born Into	
No religion	2,141 (30.4)
Buddhist/Hindu	70 (1.0)
Catholic	1,515 (21.5)
Jewish	214 (3.0)
Mormon	134 (1.9)
Muslim	39 (0.6)
Orthodox Christian	64 (0.9)
Protestant	2,870 (40.7)

(*Continued*)

TABLE 1. Participant Demographics (*N* = 9,261) (*Continued*)

	N (%)
Sexual Orientation	
Gay or Lesbian	3,637 (39.3)
Bisexual	2,860 (30.9)
Straight	144 (1.6)
Queer	451 (4.9)
Pansexual	1,381 (14.9)
Asexual	407 (4.4)
Questioning	171 (1.9)
Other	210 (2.3)
Gender Identity	
Cisgender Male	1,932 (20.9)
Cisgender Female	3,572 (38.6)
Transgender boy	989 (10.7)
Transgender girl	110 (1.2)
Assigned female at birth, non-binary	2,839 (25.8)
Assigned male at birth, non-binary	269 (2.9)
Race	
White	6,107 (66.0)
Black	407 (4.4)
Native American	42 (0.5)
Asian American	275 (3.0)
Hispanic/Latino	951 (10.3)
Multiple ethnoracial identities	1,308 (14.1)
Something else	163 (1.8)
Age in Years	
13	672 (7.3)
14	1,310 (14.2)
15	1,922 (20.8)
16	2,463 (26.6)
17	2,894 (31.3)
Mean age	15.6
Region	
Northeast	1,695 (18.3)
Midwest	2,223 (24.0)
South	3,294 (35.6)
West	2,049 (22.1)

(*Continued*)

TABLE 1. Participant Demographics (*N* = 9,261) (*Continued*)

	N (%)
Parent/Caregiver Highest Level of Education	
High school, GED, or less	3,037 (34.6)
College degree or post-graduate education	5,740 (65.3)

Note. GED = general education diploma.

Survey Methods

The survey, designed by researchers at the University of Connecticut, included safeguards against completion by ineligible responders and "*bots*" through a multi-step consent and sorting process. A response tree protocol prevented participation by contributors who were ineligible by age or country of residence. Post-hoc analysis was performed to identify misleading or extreme values on multiple questions. Researchers also analyzed open-ended questions and deleted suspicious entries not eliminated through the prior screening process. Duplicate surveys, in which a participant failed to complete a survey and then attempted a new survey, were deleted. A total of 188 cases were deleted through the aforementioned processes.

Key variables included family religion, family acceptance, and a depressive symptoms scale. For the purpose of statistical analysis, the survey response options were re-organized to create a total of eight groups for family religion. The four options of "atheist," "agnostic," "secular," and "nothing in particular" were combined to create a "No Religion" category. The categories "Something else" and "Multiple" were excluded from the statistical analysis. Due to small sample sizes in the Buddhist and Hindu religions, these religions were combined into a single category. Family acceptance was measured with an eight-item scale evaluating accepting attitudes toward LGBTQ individuals. The scale assessed four positive family behaviors and four negative family behaviors, as described in Table 2. These were adapted from an established scale published by Ryan et al.[17] Responses included: "doesn't apply to me," "never," "rarely," "sometimes," and "often." Negative items were reverse-scored, and the average was used to create a scale from 1 to 4, with higher scores reflecting higher levels of family acceptance (alpha [α] = .92).

The Kutcher Adolescent Depression Scale was used to evaluate depressive symptoms.[38] We modified the original 11-item measure by excluding an item regarding suicidality—the other ten items used in this study asks about frequency of depressive symptoms over the past week "on average" or "usually." For example, "Over the last week, how have you been 'on average' or 'usually' regarding the following items: Low mood, sadness, feeling blah or down, depressed, just can't be bothered." Participants could choose between four responses: "hardly ever, much of the time, most of the time, and all of the time." Responses were summed to range from 0 to 30, with higher scores indicating higher depressive symptoms (α = .90).

Family religion was asked with the question, "What religion were you born into?" Participants could choose from the following categories: "Protestant Christian," "Roman Catholic," "Mormon/Latter Day Saints," "Orthodox Christian," "Jewish," "Muslim," "Buddhist," "Hindu," Atheist, Agnostic, or Secular, "Nothing In Particular," "Something Else," or "Multiple."

TABLE 2. Family Acceptance Scale

How much do you feel that your family [members] . . .
1. Taunt or mock you because you are an LGBTQ person?[a]
2. Say negative comments about you being an LGBTQ person?[a]
3. Say bad things about LGBTQ people in general?[a]
4. Make you feel like you are bad because you are an LGBTQ person?[a]
5. Like you as you are in regards to being an LGBTQ person?
6. Say they were proud of you for being an LGBTQ person?
7. Get involved in the larger LGBTQ community?
8. Tell you that you are a role model as an LGBTQ person?

[a]Reverse coded items.

Analysis

All analyses were conducted using SAS 9.4. Bivariate analysis of variance (ANOVA) models were used to detect differences in depressive symptoms and family acceptance across the eight religion groups. Multi-variable ANOVA models tested the association between family acceptance and depressive symptoms in several stages. Model 1 was unadjusted. Model 2 adjusted for the categorical religion variable, and Model 3 further adjusted for demographic characteristics. An interaction term of family acceptance by religion was tested in Model 3 to explore whether the observed protective association was similar for youth in all eight religious groups. This term was not statistically significant so was removed from the model.

RESULTS

The largest groups by family religion were Protestant (40.7%), no religion (30.4%), and Catholic (21.5%). Mean depression score among the final sample was 13.30 (range = 0–30), and mean family acceptance was 2.43 (range = 1–4). Family religion was associated with depression mean ($F = 7.91$, $df = 7$, $p < .001$, see Table 3). Belonging to the Buddhist/Hindu, Mormon, Muslim, Orthodox Christian, or Protestant religion categories was associated with higher than average depression scores. Belonging to No Religion, Catholic, or Jewish religion categories was associated with lower than average depression scores; see post-hoc Tables A1 and A2 in the Appendix for details. Family acceptance was also associated with family religion, suggesting that family religion does play a role in the degree of family acceptance LGBTQ youth experience ($F = 80.78$, $df = 7$, $p < .001$, see Table 3); see post-hoc tables in the Appendix for details. Notably, family acceptance was higher than average in the No Religion and Jewish categories, and lower than average in all other religions.

There was a significant inverse association between family acceptance and depression scores overall ($F = 524.2$, $df = 1$, $p < .001$), with greater degrees of family acceptance corresponding with lower depression means (Table 4). Specifically, each unit of family acceptance was associated with almost three fewer points on the depressive symptoms scale ($B = -2.90$, $p < .001$; Model 1). This association was maintained even when adjusting for religious background (Model 2). Furthermore, Model 2 indicated that both Catholic and Jewish participants had significantly lower depressive symptom scores than Protestant youth, after accounting for family

TABLE 3. Family Acceptance and Depression Means by Religion (*n* = 7,047 with Religion Data and Out to Family)

	Depression Mean (Range = 0–30), Standard Deviation 7.5	Family Acceptance (Range = 1–4), Standard Deviation 0.8
No religion	12.94	2.66
Buddhist/Hindu	14.53	2.27
Catholic	12.70	2.36
Jewish	10.90	2.80
Mormon	14.61	2.27
Muslim	13.79	1.74
Orthodox Christian	14.48	2.08
Protestant	13.95	2.28
Total sample (*M*)	13.30 (SD = 7.5)	2.43 (SD = 0.8)

TABLE 4. Associations Between LGBTQ Family Acceptance, Religion, and Depression Scores

	Model 1	Model 2	Model 3
	Beta Estimate	Beta Estimate	Beta Estimate
LGBTQ family acceptance	−2.90***	−2.91***	−2.37***
Religion			
No religion		0.05	−0.47*
Buddhist/Hindu		0.54	0.66
Catholic		−1.06***	−0.69**
Jewish		−1.62**	−1.57**
Mormon		0.66	0.87
Muslim		−1.59	−2.09
Ortho Christian		−.09	−0.63
Protestant		ref	ref

*$p < .05$. **$p < .01$. ***$p < .001$.
Model 1: Unadjusted model
Model 2: includes LGBTQ family acceptance and religion born into
Model 3: includes LGBTQ family acceptance, religion born into, assigned sex, race, sexual orientation gender identity, primary caregiver's highest education, location.

acceptance. Associations were slightly attenuated but remained significant after further controlling for demographic covariates. The interaction of family acceptance by religion was nonsignificant ($p = .495$), indicating that the association of family acceptance and depression was similar for youth in all religious groups.

DISCUSSION

This study is the first of its kind to examine the role of religion and family acceptance in the lives of LGBTQ youth. Religious affiliation, while associated with both depressive symptoms and family acceptance, was not clearly identified as either a detrimental or protective quality for LGBTQ youth. Rather, we found that family acceptance, regardless of religious affiliation, continued to be a powerful protective factor for LGBTQ youth. These findings are consistent with previous research demonstrating the strong protective value of family acceptance for LGBTQ youth.[17,39] Importantly, this study identified that family acceptance is a protective factor for LGBTQ youth even within religions that have anti-LGBTQ beliefs and practices. This has important implications for parenting LGBTQ children in religious environments: parents need clear and consistent messages that supporting their child in their sexual orientation and gender identity is of absolute importance to promote their child's mental health. This was true for all religions regardless of gender identity, sexual orientation, race, and geographic location.

Interestingly, depression scores were lower than average for youth born into Jewish and Catholic families, as well as families who did not identify with a particular religion. Youth born into Protestant, Muslim, Buddhist/Hindu, Orthodox Christian, and Mormon families had higher average depression scores and lower average family acceptance scores. This may reflect attitudes toward LGBTQ youth within each religious context. While data evaluating each religion's degree of acceptance toward LGBTQ constituents is scarce, the HRC has described that Jewish denominations are generally affirming of LGBTQ people, while Catholic, Mormon, Orthodox Christian, and Muslim denominations trend toward less affirming.[40] The wide variation within denominations and sects of each religion makes this data difficult to interpret, particularly for the large percentage of Protestant youth in our sample. The finding that Catholic youth had higher levels of family acceptance and lower average depression scores was surprising given the formal faith position of the Catholic church; this may indicate that families consider themselves Catholic or that youth were born into a Catholic tradition, but may not fully endorse church teachings. Future studies should seek additional information about youths' perceptions of acceptance within their faith community in order to further describe the relationships between religious affiliation, depression, and family acceptance.

A key take home point from this research is the value of family acceptance for LGBTQ youth. Clinicians and other professionals who work with LGBTQ children and their families know that the vast majority of parents love and support their children, regardless of their family's religious affiliation. Many may also have seen that some of these same families—with loving parents who want the best for their children—still struggle to support and affirm their child's LGBTQ identity. This research suggests that it is possible for families to affirm and support an LGBTQ child even when that family is in a religious setting that may not provide similar support or affirmation. In order to do so, however, families need concrete strategies and tools to create a supportive and loving environment for LGBTQ children at risk of rejection and marginalization. Resources such as the Family Acceptance Project provide information for families on how to best support LGBTQ children[41]; their new educational materials specifically targeting Mormon families may be a particularly helpful example for working with young people from very conservative religious backgrounds.

This research has clinical implications for those working in child and adolescent health. First, all parents and caregivers of LGBTQ youth should be encouraged to support and accept their child just as they are, and to articulate their support to their child in clear, unequivocal language on a frequent basis. Parents and caregivers should also be counseled that their support

and acceptance of their LGBTQ child is beneficial for that child's health, even if this advice conflicts with religious teaching. Faith communities and religious leaders should be encouraged to clearly voice their support for LGBTQ children, adolescents, and their families. If faith communities and religious leaders are unable to clearly support LGBTQ constituents, family members and caregivers should be counseled that their family acceptance and support is still critically important, and may help mitigate negative effects of rejection and marginalization.

Future research could include qualitative methods to further explore the role of religion on the mental health of LGBTQ youth, especially regarding unanswered questions about the protective factors of participation in religious communities. For example, determining an adolescent's degree of participation in religious communities, the degree of their family's commitment to religious teachings, and specific questions about whether or not a religious community is supportive of LGBTQ youth would all provide valuable information that we are unable to obtain in our cross-sectional data.

This study does have additional limitations which need to be addressed. First, religion and spiritual practices are inherently difficult to measure, particularly using quantitative methods. This study utilized family's religious affiliation at time of the participant's birth as a proxy for religious affiliation, but this does not capture an individual's degree of participation in that religion, whether not an individual subscribes to a religion's doctrine, or whether a religious affiliation is affirming or non-affirming toward LGBTQ communities. Results may be different for youth whose family are either deeply involved in a religion, or whose religion teaches non-affirming practices; however, this information was not available in our secondary data analysis. Future studies should evaluate the effect of religion on LGBTQ mental health and family acceptance, but with a clearer understanding of participants' degree of involvement in their religion and the religion's beliefs regarding LGBTQ identities and relationships. Despite these limitations, religious affiliation and its relationship to mental health and family acceptance is an underexplored area, and this research lays the groundwork for future investigations on this topic.

Second, there are inherent limitations with web-based surveys. This study's recruitment method used the HRC's social media presence to advertise and recruit participants; as a result, participants by definition had at least some level of engagement with the LGBTQ community. We are likely missing the most vulnerable LGBTQ youth who do not have connections (either online or in real life) that would allow them to find and participate in this survey. The sample also includes a larger number of participants assigned female at birth; this imbalance is likely due to two factors. First, large population-based surveys have found that LGBTQ identities are more common among those assigned female than those assigned male.[42,43] Second, in non-probability samples, it is common for women to participate at higher rates than men.[44] We have adjusted for assigned sex in analysis (Table 4, Model 3) in order to reduce the possibility of bias due to this characteristic of the sample. There was no difference in the proportion of assigned sex among participants excluded from analysis due to not being out to family members (22.5% of assigned male, 22.3% of assigned female participants).

Third, because our study evaluated family acceptance as a key variable, we only include participants who were "out" to at least one family member. This is a necessary exclusion to measure family acceptance; however, this may underestimate the influence of familial factors on depression. Youth who have not come out to family members may anticipate family rejection and/or be more likely to belong to a family that does not affirm their LGBTQ identity.

The strengths of this study include its large sample size, strong measures of family acceptance and depressive symptoms, and the use of a national sample. This study also included a very diverse sample in terms of race, gender identity, and sexual orientation, which improves the

generalizability of our findings. Additionally, we had a large sample of transgender youth, while previous studies have focused on LGB populations.

CONCLUSIONS

Findings demonstrate that family acceptance is strongly protective for all LGBTQ youth regardless of religious affiliation. These results continue to demonstrate the importance of family acceptance in all contexts, even in the setting of religious beliefs that may not be supportive of a youth's LGBTQ identity. This has important implications for policy and advocacy. The medical and scientific community should work to provide information that address the importance of family acceptance and support of LGBTQ young people. Furthermore, teachers and school counselors, youth workers, mental health providers, and healthcare clinicians should advise parents that their support and acceptance of their LGBTQ child is beneficial for that child's health, even if this advice conflicts with religious teachings.

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APPENDIX: SUPPLEMENTARY MATERIALS

TABLE A1. Post-Hoc Analysis Comparing Depression Scores by Religion

	No Religion	Buddhist/ Hindu	Catholic	Jewish	Mormon	Muslim	Orthodox Christian	Protestant
No religion		0.1007	0.378	0.0005	0.0246	0.5266	0.1168	<0.001
Buddhist/Hindu	0.1007		0.0602	0.001	0.9493	0.649	0.9722	0.5459
Catholic	0.378	0.0602		0.0025	0.0109	0.4169	0.0713	<0.001
Jewish	0.0005	0.001	0.0025		<0.001	0.0446	0.0013	<0.001
Mormon	0.0246	0.9493	0.0109	<0.001		0.5873	0.9186	0.371
Muslim	0.5266	0.649	0.4169	0.0446	0.5873		0.6717	0.9043
Orthodox Christian	0.1168	0.9722	0.0713	0.0013	0.9186	0.6717		0.5848
Protestant	<0.001	0.5459	<0.001	<0.001	0.371	0.9043	0.5848	

Note. Highlighted cells indicate statistically significant *t*-tests comparing two groups.

TABLE A2. Post-Hoc Analysis Comparing Family Acceptance Scores by Religion

	No Religion	Buddhist/ Hindu	Catholic	Jewish	Mormon	Muslim	Orthodox Christian	Protestant
No religion		<0.001	<0.001	0.0163	<0.001	<0.001	<0.001	<0.001
Buddhist/Hindu	<0.001		0.1298	<0.001	0.9153	0.0005	0.4753	0.7797
Catholic	<0.001	0.1298		<0.001	0.0813	<0.001	0.0131	<0.001
Jewish	0.0163	<0.001	<0.001		<0.001	<0.001	<0.001	<0.001
Mormon	<0.001	0.9153	0.0813	<0.001		<0.001	0.3681	0.8526
Muslim	<0.001	0.0005	<0.001	<0.001	<0.001		0.0046	<0.001
Orthodox Christian	<0.001	0.4753	0.0131	<0.001	0.3681	0.0046		0.2047
Protestant	<0.001	0.7797	<0.001	<0.001	0.8536	<0.001	0.2047	

Note. Highlighted cells indicate statistically significant *t*-tests comparing two groups.