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Personality, coping and mental health among lesbian, gay, and bisexual community members

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ABSTRACT

The present study makes one of the first attempts to integrate personality, coping and mental health in lesbian, gay, and bisexual (LGB) community members. Specifically, active (i.e., seeking social support, stopping unpleasant emotions, problem-focused coping/solving, and education/advocacy) and passive (i.e., internalization, substance use, and detachment) coping styles were hypothesized to mediate the association of personality traits and mental health symptoms (i.e., depressive, anxiety and general distress symptoms). Participants consisted of 336 LGB outpatients from an urban community health clinic in the southwestern United States. Results demonstrated that: (1) passive coping mediated the relationship between Neuroticism and mental health symptoms, (2) both active and passive coping mediated the extraversion-mental health symptoms association, and (3) significant mediation emerged via active coping for the association of conscientiousness and mental health symptoms. Implications are discussed for clinical practice with LGB persons, and the integration of personality, coping and mental health theory and research.

A pressing reality is that lesbian, gay and bisexual (LGB) identity is an identified risk factor for many psychological symptoms (distress, depression, anxiety, substance abuse; e.g., Cochran, Sullivan, & Mays, 2003; Cramer, McNiel, Holley, Shumway, & Boccellari, 2012). Despite clear elevated risk among LGB persons, evaluation of mental health with coping and other individual difference risk factors in an integrative way is still lacking. The present study synthesizes understanding of the interplay between character traits, coping styles, and mental health among LGB persons.

1. Personality and mental health: associations and application in LGB individuals

The five-factor model (FFM; McCrae & Costa, 1992; McCrae & Costa, 2003) includes five broad domains: neuroticism, extraversion, openness to experience, agreeableness and conscientiousness. FFM theory (FFT; McCrae & Costa, 2003) postulates that individuals have both *basic tendencies* (i.e., inherent genetically-influenced patterns of thoughts, feelings, and behaviors) and *characteristic adaptations*, suggesting the interplay between personality and the surrounding environment yield selection of unique behaviors. Importantly, FFT posits (McCrae & Costa, 2003), and some empirical literature supports (e.g., Cramer, Stroud, Fraser, & Graham, 2014), the notion that it is necessary to assess all five personality domains simultaneously to fully capture the collective role of personality.

The FFM has provided valuable information in understanding mental health sequelae, with the weight of the evidence suggesting high neuroticism, low extraversion and low conscientiousness are linked to a greater prevalence of internalizing problems such as depression, stress, and anxiety (e.g., Carver & Connor-Smith, 2010; Jokela & Keltikangas-Jarvinen, 2011; Lockenhoff, Ironson, O'Cleirigh, & Costa, 2009). Indeed, recent meta-analytic evidence across ten cohort studies affirms the roles of neuroticism, extraversion and conscientiousness in prospectively predicting the formation of depressive symptoms (Hakulinen et al., 2015). This is not to say that openness and agreeableness are uncorrelated with internalizing mental health symptoms; however, their roles appear more population or situation specific. For instance, agreeableness has been shown to be associated with depressive symptoms among low social support for chronic medical patients (e.g., Hoth, Christensen, Ehlers, Raichle, & Lawton, 2007). Notably, examination of personality and mental health among LGB persons is sorely lacking. One recent study by Wang et al. (2014) reported findings that

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gay men had elevated risk for depression, controlling for personality. However, authors failed to examine nuanced effects of personality on mental health among LGB persons.

2. Coping: models and associations with personality and mental health

2.1. Styles of coping

Much of the empirical coping literature describes two styles: active (positive) and passive (avoidant) coping (e.g., Bowleg, Craig, & Burkholder, 2004; Lock & Steiner, 1999). Active coping strategies include, but are not limited to, emotion-focused, problem/solution-oriented, social support, and cognitive appraisal of situations (e.g., Bowleg et al., 2004; Slater et al., 2013). Incorporated as part of active coping is a model proposed by Chesney, Neilands, Chambers, Taylor, and Folkman (2006) that identified three factors of coping in the formation of one's *Coping Self-Efficacy*: use of problem-focused coping (similar to perceived efficacy of dealing with the problem at hand), stopping unpleasant emotions and thoughts (efficacy related to emotion-focused coping), and obtaining support from friends and family (highlighting beliefs about one's ability to seek social support to cope with difficulties). Chesney and colleagues' model asserts that an individual's coping self-efficacy, or belief in their ability to deal with a stressful situation, impacts the relationship of coping behaviors with mental health and well-being outcomes (e.g., anxiety, stress).

Passive coping is the tendency to avoid or move away from the stressor (Connor-Smith & Flachsbart, 2007). Passive coping can be described as efforts to direct attention away from the problem at hand, such as denial, self-distraction, substance use, and detachment (e.g., David & Knight, 2008; Kuyper & Fokkema, 2011), and is common among LGB persons, especially in response to heterosexism (e.g., Lehavot & Simoni, 2011; Lock & Steiner, 1999). Passive coping can also encapsulate internalizing or detaching from negative experiences in general (e.g., Wei, Alvarez, Ku, Russell, & Bonett, 2010) and LGB (Herek, Gillis, & Cogan, 2009) persons.

2.2. Personality and coping

Traits outlined in the FFM are indeed associated with the utilization of various coping strategies (Beauchamp, Lecomte, Lecomte, Leclerc, & Corbiere, 2011). Generally, active coping is positively related to higher levels on extraversion, openness, agreeableness, and conscientiousness, and active coping is negatively associated with neuroticism (e.g., Fickova, 2009; Hambrick & McCord, 2010). Active strategies of problem-solving and social support are particularly positively linked to extraversion and negatively to neuroticism (e.g., Carver & Connor-Smith, 2010; Connor-Smith & Flachsbart, 2007). Additionally, neuroticism is negatively associated with cognitive restructuring and acceptance (Connor-Smith & Flachsbart, 2007; Fickova, 2009; Hambrick & McCord, 2010).

Passive coping is positively linked to neuroticism and negatively related to agreeableness and conscientiousness (e.g., Beauchamp et al., 2011; Carver & Connor-Smith, 2010; Geisler, Wiedig-Allison, & Weber, 2009). For instance, neuroticism is positively associated with the passive coping strategies of denial, withdrawal, substance use, distraction, and wishful thinking (Connor-Smith & Flachsbart, 2007; Fickova, 2009). Openness is positively associated with wishful thinking, and agreeableness and conscientiousness are negatively related to denial and the use of substances to cope (Connor-Smith & Flachsbart, 2007; Fickova, 2009). Overall, this body of literature suggests the following set of pathways for the present study: (1) neuroticism is positively linked with active and negatively linked with passive coping, (2) extraversion is positively linked with active and negatively linked with passive coping, (3) openness is positively associated with active and passive coping, (4) agreeableness is positively correlated with active and negatively linked with passive coping, and (5) conscientiousness is positively correlated with active coping and negatively associated with passive coping.

2.3. Coping and mental health

Generally, active coping styles are associated with better mental health outcomes than passive coping styles among LGB individuals (e.g., David & Knight, 2008; Szymanski & Owes, 2008). Moreover, a dense literature demonstrates positive impacts of active coping, as well as negative influences of avoidant coping, on mental health outcomes specifically for LGB adolescents, adults, and couples (e.g., Doty, Willoughby, Lindahl, & Malik, 2010; Lopez, Antoni, Fekete, & Penedo, 2012). Active coping in the form of social support (i.e., a strong connection and identification with the LGB community) appears to ameliorate the negative effects of sexual stigma and marginalization (e.g., Balsam & Mohr, 2007; Fingerhut, Peplau, & Ghavami, 2005). This literature suggests the following pathways in the present study: (1) a negative pathway from passive coping to mental health, and (2) a positive pathway from active coping to mental health.

3. The present study: integrating personality, coping and mental health among LGB persons

Consistent with a sexual minority-based coping models of general health (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009), it is plausible that the *type* of coping may explain, or mediate, the relation between individual differences and mental health. It should be noted that the most robust evidence consistently implicates neuroticism, extraversion and conscientiousness in coping and mental health. In light of pathways suggested in the literature review, the following hypotheses were expected:

H1. We would observe indirect pathways from neuroticism to mental health, via both active and passive coping.

H2. We would observe indirect pathways from extraversion to mental health, via both active and passive coping.

H3. We would observe indirect pathways from conscientiousness to mental health, via both active and passive coping.

In light of the inconsistent associations of agreeableness and openness with mental health symptoms, we investigate these trait-driven pathways as potential population-specific coping pathways.

4. Method

4.1. Participants

Participants were 336 self-identified lesbian, gay, and bisexual patients at Legacy Community Health Services in Houston, Texas. Screening data for participants included: a) self-identification as LGB, b) a minimum of 18 years of age, and c) possessing an English 10th grade reading level to ensure comprehension of materials.

5. Materials

All participants completed the following questionnaires among the larger study. Internal consistency values from the present data are reported in the results.

5.1. Demographics

Participants (n = 336) completed a standard demographics questionnaire reporting age (mean age = 42.26, *SD* = 11.14), gender (male = 71.7%; female = 23.2%; male-to-female = 2.4%; female-to-

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