MALADAPTIVE COPING, HETEROSEXIST HARASSMENT, REJECTION AND DISCRIMINATION, AND STATE ANGER; CORRELATES OF DEPRESSION IN THE LGBT COMMUNITY

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This study was designed to:

- Inventory medical conditions and health behaviors that impact the Lesbian, Gay, Bisexual and Transgendered (LGBT) communities of the Dallas Metroplex area

- Assess psychosocial factors, such as social support, anger, depression, stress, and coping to gain a better understanding of the diverse LGBT communities

- Build onto the existing LGBT literature by examining health-related behaviors (e.g., obesity and smoking)

- Examine discrimination in healthcare settings for LGBT peoples

- Identify basic healthcare needs for the different LGBT communities and potential barriers that may be deterring the different communities from obtaining optimal care
• Compared to heterosexuals, gay and bisexual individuals are at an increased risk for depression and suicide (Berg, Mimiaga, & Safren, 2008).

• Members of the LGBT community face unique stressors such as harassment, rejection and discrimination (Friedman, Marshal, Stall, Cheong, & Wright, 2007).

• Among marginalized populations, a relationship exists between perceived discrimination and anger (Zukoski & Thorburn, 2009) and between perceived discrimination and negative mental health outcomes, such as suicide ideation and depression (Hwang & Goto, 2009).

• Maladaptive coping strategies (e.g., self-blame, substance use, and denial) have been previously associated with depression (e.g., Radat et al., 2008).

• Using Lazarus and Cohen’s (1977) transactional model of stress and coping as a framework, we predict that when faced with HHRD as a stressor, LGBT individuals who react with maladaptive coping techniques and state anger will have higher levels of depression.
THEORETICAL MODEL

Stressor

HHRD

Secondary Appraisal

State Anger

Maladaptive Coping

Outcome

Depression

Lazarus & Cohen, 1977
1. State anger will be significantly positively correlated with depression.

2. High levels of maladaptive coping will be significantly positively correlated with depression.

3. Heterosexist harassment, rejection, and discrimination will be significantly positively correlated with depression.

4. State anger, utilization of maladaptive coping techniques, and heterosexist harassment, rejection, and discrimination will account for a significant amount of variance in levels of depression.
Depression

**Center for Epidemiologic Studies Depression Scale (CES-D; Radlof, 1977)**

- 20 items on a 4 point likert-type scale ($\alpha=.63-.93$) used to assess levels of depression. A score of 16 or greater indicates a high chance of depressive symptoms.

- 1=rarely/none of the time, 4=most of the time

- “I thought my life had been a failure”

- Concurrent validity was established by Drebbing et al. (1994).
Heterosexist Harassment, Rejection, and Discrimination Scale (HHRDS; Szymanski 2006)

• 14 items on a 6 point likert-type scale ($\alpha = .9$) used to measure perceived heterosexist harassment, rejection, and discrimination experienced by a member of the LGBT sample.

• 1 = this event has never happened to you, 6 = this event happened almost all the time

• “In the past year, how many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are a Lesbian/Gay/Bisexual person?”

• Concurrent validity was established by Szymanski (2009).
State Anger

State-Trait Anger Expression Inventory (STAXI; Spielberger, 1999)

- 57 items on a 4 point likert-type scale used to measure intensity of anger as an emotional state and the disposition to experience angry feelings as personality trait.

- 1=not at all, 4=very much so

- Concurrent validity was established by Spielberger (1994).

- **State Anger**: 15 item subscale used to measure anger at a particular moment as an emotional state (α=.9) “I feel like yelling.”
Maladaptive Coping

Brief COPE (Carver, 1997)
• 28 items on a 4 point likert-type scale (α=.9) used to assess usage of adaptive and maladaptive coping strategies.

• 1=I haven’t been doing this at all, 4=I’ve been doing this a lot

• “I’ve given up the attempt to cope.”

• In this study we looked specifically at substance use, self blame, and denial as maladaptive coping mechanisms. Each measure contained 2 items for a total of 6 items.
Data Collection

• Questionnaire Development System (QDS) survey

• Self report

• Dallas based community organization recruitment

• Psychosocial aspects (i.e. depression, HHRD, state anger, and maladaptive coping)

• Participants received research incentives of 25 dollars for their time
## DEMOGRAPHICS (N=187)

### AGE
Mean = 34.6  
SD = 14.1  
Range = 18-76

### SEX
<table>
<thead>
<tr>
<th>Sex</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>98</td>
<td>52.4%</td>
</tr>
<tr>
<td>Female</td>
<td>89</td>
<td>47.6%</td>
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### ETHNICITY
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<tr>
<th>Ethnicity</th>
<th>Frequency</th>
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<td>European-American</td>
<td>125</td>
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<tr>
<td>African-American</td>
<td>22</td>
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<tr>
<td>Latino/a</td>
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<td>Asian-American</td>
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<td>Other</td>
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### SEXUAL ORIENTATION
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<td>26.7%</td>
</tr>
<tr>
<td>Lesbian</td>
<td>49</td>
<td>26.2%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>51</td>
<td>27.3%</td>
</tr>
<tr>
<td>Transgendered</td>
<td>37</td>
<td>19.8%</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>(SD)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------</td>
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<tr>
<td>State-Anger</td>
<td>17.28</td>
<td>(4.91)</td>
</tr>
<tr>
<td>Maladaptive Coping</td>
<td>10.60</td>
<td>(3.53)</td>
</tr>
<tr>
<td>HHRD</td>
<td>23.05</td>
<td>(10.10)</td>
</tr>
<tr>
<td>Depression</td>
<td>33.56</td>
<td>(10.15)</td>
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### Bivariate Analysis

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<tbody>
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<td>1.Age</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>2.Sex</td>
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<td></td>
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<tr>
<td>3.European-American</td>
<td>.19**</td>
<td>-.03</td>
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<td>4.State-Anger</td>
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<td>.02</td>
<td>-.18*</td>
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<tr>
<td>5.Maladaptive Coping</td>
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<td>.11</td>
<td>-.07</td>
<td>.26**</td>
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<tr>
<td>6.HHRD</td>
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<td>.15*</td>
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<td>.20**</td>
<td></td>
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<tr>
<td>7.Depression</td>
<td>-.17*</td>
<td>.05</td>
<td>-.13</td>
<td>.38**</td>
<td>.56**</td>
<td>.18*</td>
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*p < .05, **p < .01
### MULTIVARIATE ANALYSIS

**CRITERION:** Depression

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<th>VIF</th>
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<td>-.13</td>
<td>.77</td>
<td>1.31</td>
</tr>
<tr>
<td>Sex</td>
<td>-.42</td>
<td>-.33</td>
<td>.86</td>
<td>1.16</td>
</tr>
<tr>
<td>European-American</td>
<td>-1.36</td>
<td>-1.03</td>
<td>.91</td>
<td>1.10</td>
</tr>
<tr>
<td>State Anger</td>
<td>.49</td>
<td>3.82</td>
<td>.90</td>
<td>1.11</td>
</tr>
<tr>
<td>Maladaptive Coping</td>
<td>1.37</td>
<td>7.48</td>
<td>.86</td>
<td>1.17</td>
</tr>
<tr>
<td>HHRD</td>
<td>.08</td>
<td>1.30</td>
<td>.90</td>
<td>1.11</td>
</tr>
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</table>

adj. $R^2 = .36$, $F(6, 180) = 18.16$, $p < .001$
• Hypothesis 1 supported

• Hypothesis 2 supported

• Hypothesis 3 was partially supported

• Hypothesis 4 was supported

1. State anger was significantly positively correlated with depression.

2. High levels of maladaptive coping was significantly positively correlated with depression.

3. Although heterosexist harassment, rejection, and discrimination were not significant predictors of depression, they did contribute to the overall variance.

4. State anger, utilization of maladaptive coping techniques, and heterosexist harassment, rejection, and discrimination accounted for a significant amount of variance in levels of depression.
• Minimizing maladaptive coping techniques and state anger may help reduce depression in LGBT individuals.

• Although we did not find a significant relationship between HHRD and depression, it did contribute to the overall variance. Given the pervasiveness of these variables in LGBT communities, these factors should be considered when examining LGBT samples.

• Future research should examine if a relationship between HHRD on anger or HHRD and maladaptive coping exists, as well as other predictors of depression within the LGBT community.
Knowing the predictors of depression specific to this community could prove invaluable in guiding therapists to more accurately assess risks to mental health among LGBT individuals and potentially lead to developing interventions that target healthier coping alternatives.
LIMITATIONS

• Data collected were self-report

• Ceiling effects in all measures

• Because we used a cross-sectional, correlational design, causality can not be inferred from our results.
ACKNOWLEDGEMENTS

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• Dallas Resource Center
REFERENCES


