



Article

# Influence of the COVID-19 Pandemic on Italian LGBT+ Young Adults' Mental Health: The Role of Neuroticism and Family Climate

Marina Miscioscia <sup>1,2,\*</sup> , Mikael Poli <sup>1</sup>, Alessio Gubello <sup>3</sup> , Alessandra Simonelli <sup>1</sup>, Michela Gatta <sup>2</sup>, Jorge Gato <sup>4</sup> and Paola Rigo <sup>1</sup>

<sup>1</sup> Department of Developmental Psychology and Socialization, University of Padua, 35131 Padua, Italy

<sup>2</sup> Department of Women's and Children's Health, University of Padua, 35128 Padua, Italy

<sup>3</sup> Faculty of Psychology and Education Sciences, Université Libre de Bruxelles, 1050 Brussels, Belgium

<sup>4</sup> Faculty of Psychology and Education Sciences and Center for Psychology, University of Porto, Rua Alfredo Allen, 4200-135 Porto, Portugal

\* Correspondence: marina.miscioscia@unipd.it; Tel.: +39-049-827-6548

**Abstract:** Vulnerable populations have been among the most affected by the social consequences of the COVID-19 pandemic; among those, young people and sexual and gender minorities have seen their situation exacerbated by new specific regulations. The aim of the present study was twofold: first, to assess the role of family climate, concerning participants' LGBT+ status during lockdown restrictions, in mediating the impact of the COVID-19 pandemic on personal quality of life and mental health (stress, depression, and anxiety); second, to assess how individual stable traits can moderate the relationship between the individual impact of COVID-19 on mental health outcomes. A total of 407 young adults aged 18 to 35 (M age = 25.03 years; SD = 4.68) who self-identified as being part of a sexual or gender minority took part in this study. Results highlight the association between negative family climate and internalizing symptoms of psychological distress, and its role as a partial mediator of the relationship between the impact of the COVID-19 pandemic at the individual level and mental health outcomes. Additionally, low personality trait levels of neuroticism significantly decreased the strength of the relationship between LGBT+ status during blocking restrictions and internalizing symptoms.

**Keywords:** COVID-19; LGBT+ mental health; psychological well-being; young adults



**Citation:** Miscioscia, M.; Poli, M.; Gubello, A.; Simonelli, A.; Gatta, M.; Gato, J.; Rigo, P. Influence of the COVID-19 Pandemic on Italian LGBT+ Young Adults' Mental Health: The Role of Neuroticism and Family Climate. *Int. J. Environ. Res. Public Health* **2022**, *19*, 15795. <https://doi.org/10.3390/ijerph192315795>

Academic Editors: Liliana Dell'Osso and Paul B. Tchounwou

Received: 30 September 2022

Accepted: 24 November 2022

Published: 27 November 2022

**Publisher's Note:** MDPI stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.



**Copyright:** © 2022 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

## 1. Theoretical Background

Around two years have passed since the COVID-19 pandemic started to spread around the world, and studies, spanning from social and educational science to physical and mental health research, have accumulated evidence of the consequences of the restrictive measures put in place to stop or slow down the transmission of the SARS-CoV-2 virus [1]. Among the most impactful restrictive measures, numerous nations—including the Italian government—ordered the total or partial closure of work, educational and public places, and a state of quarantine for all citizens.

In Italy, containment measures in the form of full lockdown restrictions for the whole population were mandated via a Legislative Decree [2] from 9 March to 4 May 2020 (also known as “Phase 1”), and included stay-at-home restrictions (with bans on leaving one's own house and on traveling outside one's own municipality unless strictly necessary, e.g., essential work or health emergencies), closure of schools and universities, sports facilities, and all non-primary-necessity businesses, and the introduction of evening curfew regulations. Such measures were progressively lifted until December 2020 [3], when they were reintroduced following a spike in COVID-19 cases, to then be eased again in different

regions at different times starting from 22 April 2021, on the basis of the incidence of cases at the regional level [4].

In the context of actions aimed at containing the spread of epidemics, quarantine-based social isolation represented an important and significant environmental challenge that carried many adverse effects on the population's psychological wellbeing [5–10]. The impact of the COVID-19 pandemic radically prevented interpersonal contact in almost all individuals' contexts. Distance learning and teleworking and the impossibility of meeting in person with friends, partners, and potential romantic interests constituted critical challenges to individual psychosocial adjustment and wellbeing [11–14].

### 1.1. Prior Knowledge: Societal Stressors for LGBT+ People Living in Italy

Several international sources estimating LGBT+ acceptance within society indicate a generally unfavorable climate for sexual and gender minorities in Italy. In their Rainbow Europe 2022 map [15], the European region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) reports that Italy is lagging behind in terms of achieving full equality for LGBT+ people. It occupies the 33rd place out of the 49 countries that were included in this statistic, scoring 24.76% on a scale from "Gross violations of human rights, discrimination" (0%) to "Respect of human rights, full equality" (100%) with respect to different aspects of legal and policy human rights management: equality and non-discrimination, family, hate crime and hate speech, legal gender recognition and bodily integrity, civil society space, and asylum. Furthermore, Italy's latest available Global Acceptance Index (GAI, developed by the Williams Institute (UCLA) for the LGBTI Global Development Partnership) [16] is 6.94 on a scale from 0 to 10, indicating that overall, societal attitudes towards LGBT+ people, while not completely negative, can still improve. More recently, LGBT+ rights have been in the spotlight in Italy with debate surrounding the approval (still pending as of August 2021) of the anti-homotransphobia bill presented by Italian Chamber of Deputies member Alessandro Zan [17], arousing both positive and negative attention to sexual and gender minority people during a time of substantial challenges for the whole population.

Despite tentative steps forward in terms of legislation and policy, societal attitudes towards non-heterosexual people still represent a key element for the psychosocial well-being of SGM (Sexual and Gender Minority) groups that can produce detrimental outcomes for quality of life. The Organization for Economic Co-operation and Development (OECD) [18] highlights that Italy scored a 3.3 on a survey exploring acceptance of homosexuality on a scale from 1 ("Homosexuality is never justifiable") to 10 ("Homosexuality is always justifiable") in their latest "Society at a Glance" report, with the average for the 38 OECD member countries being 5.1. According to the latest European Union data report 2019 [19], only 68% of Italians agreed with the statement "Gay, lesbian and bisexual people should have the same rights as heterosexual people", and 59% agreed with the statement "There is nothing wrong in a sexual relationship between two persons of the same sex". Importantly, one-third (33%) would be completely uncomfortable if their child were involved in a romantic relationship with a person of the same sex. Overall, 69% felt that discrimination on the basis of sexual orientation was widespread in their country: in fact, Italy ranked 4th (out of 28 member states) for rate of perceived widespread discrimination against sexual minorities among the general population, with higher ranks indicating higher perceived diffuse inequality of treatment [19].

Regarding gender minority individuals, it was only in 2017 that the Italian Constitutional Court declared that sex reassignment surgery (SRS) was not mandatory to access legal gender identity recognition [20]. For those gender minority individuals who seek gender affirmation treatments, this process can be taxing in terms of availability of resources and time. Gender-affirmation clinics are scarce, particularly in the south, and are not present in all Regions [21]. Often, it takes several years between the initial request to undertake medical treatment and obtaining legal recognition of one's gender identity (i.e., for local courts to allow name and gender marker rectification on identity documents) (see, for

instance [22]). With regard to intersex people, the Italian legislation does not contemplate protection from non-consensual surgical interventions in childhood, a common practice that is still implemented today in most countries around the world despite its reported harmfulness [23–25], effectively hampering the possibility for self-determination and the right to bodily integrity and autonomy [26].

### *1.2. COVID-19 and Psychological Adjustment for LGBT+ People*

The historically vulnerable segments of the population have been the most affected by the COVID-19 pandemic [9]. For example, disparities in both medical and psychosocial outcomes have been documented for Black, Asian, and other ethnic minority populations in the U.S. and Europe [27–31], as well as for sexual and gender minorities [32,33]. The pandemic has amplified the disparities between the LGBT+ community and the rest of the population, since the former suffer not only from financial and social complications, but also from consequences of the stigma associated with their LGBT+ identity [34,35]. Challenges brought about by the pandemic for LGBT+ people have included hampered access to clinical care, including HIV testing and treatment [36] and psychological support, and maltreatment and abuse within the household, as well as the impossibility of pursuing legal recognition of their gender identity [33,37,38]. In general, younger people appear to be more likely to experience higher levels of anxiety, depression, stress, and post-traumatic stress than older adults [9,10] and several studies have shown that the COVID-19 pandemic represented an additional stress factor for the psychosocial adjustment of LGBT+ young adults [39–43].

Regarding the Italian situation, Mattei et al. [44] observed that the economic recession amplified by the public health crisis may have further aggravated the burden on mental health for LGBT+ groups through heightened discrimination. The situation seems to have been aggravated in the case of transgender and GQNB (genderqueer/nonbinary) Italian people, due to higher stress levels due to living with non-accepting family members, perceived lack of support from LGBT+ circles, and difficulties in accessing health facilities and undertaking hormone replacement therapy [45].

### *1.3. Factors Associated with Psychological Adjustment during Pandemic Time*

Diener [46] identified three macro areas of elements influencing subjective well-being (SWB): temperament and personality, values and goals, and cultural and societal factors. This last group of factors, in particular, can influence SWB through a variety of mechanisms related to a country's ability to fulfill basic needs (food, clean water, and health) and to the community's coping patterns, degree of regulation of individual desires, and social support, the latter particularly within families [46]. Well-being has been associated with how individuals negotiate and adapt to the developmental transitions of adult life throughout the life cycle [47,48], as well as with personality traits (neuroticism in particular) [49,50], parental support and family dynamics [51–53], and achievement of early career goals and paid workload [54,55].

Individual factors, such as aspects of the personality as conceptualized according to the Big Five model [56], play an important role in determining an adjustment to stressful situations; indeed, resilience was positively associated with trait extraversion and conscientiousness and negatively correlated with neuroticism, which entails low emotional stability [57,58]. Although the mechanisms through which neuroticism may affect psychological well-being are still debated [59], one possible explanation is that it may act through the cognitive appraisal of environmental demands. In this regard, Schneider [60] found both neuroticism and threat appraisals to be associated with negative emotional experiences and poor task performance, with the first predicting the second. High neuroticism levels may indeed predispose to worse psychophysical stress responses [61,62], especially when environmental demands are interpreted to be threatening and to exceed one's own coping resources. So far, the literature has highlighted connections between neuroticism and various cognitive aspects of individuals' experiences, such as rumination

and worrying [63], time perspective [64], and cognitive emotion regulation strategies such as self-blame and catastrophizing [65,66], as well as environmental factors. Considering the latter, evidence suggests that values of a given culture could influence the level of neuroticism contributing to dysfunctional adjustment to life challenges [67,68].

The personal environment, especially the family and home context, represents a key factor influencing resilience and psychosocial adjustment throughout the lifespan [69–71]. Resilience has been described as a dynamic process that encompasses the ability to maintain psychophysical well-being when faced with adversities [72,73], favoring positive psychological functioning over time [74]. Connor and Davidson [75] conceptualize it as a measure of an individual's stress coping ability; indeed, high levels of resilience are linked to better psychophysical outcomes, while lower levels are associated with negative mental health indicators such as depression and anxiety [76]. Importantly, resilience and adaptation can be influenced by psychosocial factors, such as personality traits, optimism, family functioning, and natural disasters (for a comprehensive account, see [70]), and while most are considered to be relevant at all ages, Noble and McGrath [71] report that some aspects of the environment, such as a positive family context and peer relationships, represent an important element for young people's adjustment and psychosocial well-being. Indeed, although higher levels of psychosocial maladjustment have been reported by the global community at large following the outbreak of the pandemic, younger people appear to be more likely to experience higher symptoms of anxiety, depression, stress, and post-traumatic stress disorder than older adults [10].

In minority groups at risk of discrimination, not only within the socio-cultural context but also within the domestic environment [77], a deepening understanding of how low levels of affective resilience—a dimension of personality traits that reflects stable strategies to recover the homeostasis from dysregulated states of Self—can contribute as an additional threatening risk factor for individual mental health [78]. In an extremely complex context such as that in the wake of state-mandated social isolation and home confinement measures, particular attention should be paid to the influence that COVID-19 pandemic restrictions could have had on family interactions in LGBT+ young people's experience, as family constitutes one of the most immediate sources of direct impact on an individual's healthy development [79,80], as well as representing a key element that health professionals can focus on to promote psychological wellbeing in the population [81,82].

Among the LGBT+ community, young individuals were more likely to report higher symptoms of depression and anxiety during the COVID-19 pandemic and complained of being either uncomfortable at home, isolated from their heterosexual and cisgender friends, or not working [40–43,83,84]. Additionally, not attending higher education, experiencing the daily impact of the COVID-19 pandemic, and having a negative family climate were significantly associated with higher levels of internalizing symptoms [40]. However, research has shown that personality and personal environment can both exert an influence on an individual's experience in different ways across different age ranges [85], favoring or hampering positive mental health outcomes in young adults' adjustment to adverse situations [86].

Following on from the aforementioned, the present work aimed to assess the psychosocial correlates of the COVID-19 pandemic on Italian LGBT+ young adults to identify potential predictors of adverse mental health conditions. The first aim was to assess the role of family climate in relation to participants' LGBT+ status during lockdown restrictions in mediating the impact of the COVID-19 pandemic on personal quality of life and mental health (stress, depression, anxiety). We expect to observe family climate to be a partial mediator between the impact of COVID-19 in terms of personal impact and depression, anxiety and stress [84]. In line with research on resilience in psychosocial adaptation to stressful events [58], the second aim was to assess how individual stable traits can moderate the relationship between the individual impact of COVID-19 on mental health outcomes. The literature confirms that low levels of neuroticism are associated with better wellbeing

and low levels of mental health. We expect to observe a stable individual factor, i.e., trait neuroticism, to be a moderator.

## 2. Materials and Methods

### 2.1. Participants

Our sample included 407 participants (Mage = 25.03 years; SD = 4.68). Inclusion criteria were being 18–35 years of age, residing in Italy, identifying as being part of a sexual or gender minority, having disclosed one's sexual or gender minority status to one's family, having been in contact with one's family during the lockdown and at the time of completion of the questionnaire, and having completed the questionnaire in its entirety. We collected data from 1294 participants; after applying inclusion criteria, 887 responses were excluded from our analyses. Participants who chose to freely describe their sexual orientation as they saw fit (using the dedicated space comprised in the questionnaire) included: biromantic asexual, homoromantic asexual, panromantic demisexual, demisexual, fluid, polyamorous pansexual, mostly heterosexual, queer, and questioning. Similarly, participants who indicated their gender identity as "other" described themselves as genderfluid, genderqueer, questioning, not defining, queer, and transgender non-binary. A total of 32.18% of participants reported previous health (physical or psychological) problems. Table 1 summarizes our sample's main sociodemographic characteristics.

**Table 1.** Sociodemographic characteristics of participants.

Variable	n	%	Variable	n	%
<b>Sex assigned at birth</b>			<b>Area of residence</b>		
Female	228	56.02	Rural	110	27.03
Male	171	42.01	Urban	297	72.97
Intersex	3	0.74	<b>Relationship status</b>		
Prefer not to say	5	1.23	Not in a relationship	190	46.68
<b>Gender identity</b>			In a relationship	217	53.32
Cisgender women	170	41.77	<b>Living with family</b>		
Cisgender men	150	36.86	Yes	277	68.06
Transgender persons	16	3.93	No	130	31.94
Non-binary persons	51	12.53	<b>Educational level</b>		
Other	21	5.16	Lower secondary	25	6.14
<b>Sexual orientation</b>			Upper secondary	211	51.84
Gay/lesbian	230	56.51	Bachelor's	89	21.87
Bisexual	104	25.55	Postgraduate	82	20.15
Pansexual	40	9.83	<b>Work status</b>		
Asexual	9	2.21	Student	172	42.26
Heterosexual	5	1.23	Student-worker	47	11.55
Other	19	4.67	Full-time worker	92	22.60
<b>Nationality</b>			Part-time worker	32	7.86
Italian	397	97.54	Unemployed	49	12.04
Other	10	2.46	Payroll subsidies	1	0.25
<b>Region of residence</b>			Other	14	3.44
North	261	64.13	<b>Work changes due to COVID-19</b>		
Centre	69	16.95	Yes	161	39.56
South	52	12.78	No	246	60.44
Islands	25	6.14			

### 2.2. Procedure

The present study is a part of the "Project Global Queerantime", where data from seven European and Latin American countries have been collected with the aim of researching the social support networks and psychological health of LGBTQ+ individuals during the COVID-19 pandemic [40]. The research project was approved by the Ethics Committee of the University of Padova, Italy (Psychological Research Areas of the University of Padova n. 3591/2020); this research involving human participants was performed following the Declaration of Helsinki. The research protocol consisted of a 71-item questionnaire created and hosted on the online platform Qualtrics, which could be accessed through a web link. Participants were recruited via non-probabilistic convenience and chain sampling (through Facebook, Instagram, local and national LGBTQ+ associations, and word-of-mouth). Local and national LGBTQ+ associations were invited, with a letter from the Principal Investigator, to support and publicize the study by inviting their associates to participate (sending them

an email with an endorsement to the research and the Qualtrics link). The associates were informed that the study was anonymous and not compulsory; they were also informed that, at the conclusion of data collection and analysis, the association was going to organize dissemination seminars with the research team.

The first page of the questionnaire displayed an informed consent form describing the research project and main objective which the participants were asked to agree to; consent was expressed by clicking on the “next page” arrow in the bottom right corner of the page, which redirected to the first section of the questionnaire (sociodemographic variables), and could be withdrawn at any point during the study. Contact information for the Principal Investigator was provided should the participants need further clarifications during completion and, more generally, should they have any concerns or questions regarding the research project.

All participants were informed of the anonymity of their answers unless they agreed to be contacted again for future studies by providing a personal email address: in this case, confidentiality was guaranteed, and participants were informed that all contact information would be available to the research team exclusively. In all cases, participants were informed that data would be analyzed on an aggregate and anonymous basis.

Data were collected in two waves from 30 May 2020 to 21 April 2021. Wave one lasted from May 2020 to July 2020; wave two took place from December 2020 to April 2021.

### 2.3. Measures

#### 2.3.1. Psychosocial Effects of the COVID-19 Pandemic (Ad Hoc Questionnaire)

We administered 11 items relating to the psychosocial effects that the COVID-19 pandemic may have entailed specifically for LGBT+ young adults who were in contact with their family during the period of state-mandated restrictions (Table 1). All the items were originally devised in an ad hoc manner by Gato et al. [4] on the basis of a review of the literature and translated and adapted to the Italian context by our team by means of a back translation. To uncover the underlying structure of the Psychosocial Effects of the COVID-19 Pandemic section of the questionnaire, we replicated the procedure employed by the Portuguese research group [40,84]. Before proceeding, we reverse scored item 8 to align all numerical rating scales. We conducted a Kaiser–Meyer–Olkin (KMO) test, obtaining an overall KMO value of 0.778 for the remaining sample ( $n = 337$ ), indicating moderate reciprocal correlation between the 11 items, which were therefore suitable for the EFA. The analysis yielded a 3-factor structure, explaining 48.1% of the total variance. The null hypothesis that three factors were sufficient in explaining the covariance among the variables was accepted ( $\chi^2(25) = 30.14, p = 0.219$ ). Items 4, 5, and 11 were removed from further analysis because of low correlation with the rest of the items: the communality values were 0.16, 0.04, and 0.13, respectively, and their highest rotated factor loadings were 0.37 (item 4), 0.18 (item 5), and 0.33 (item 11) (cut-off for inclusion  $\geq 0.40$ ). We then conducted a second EFA with the remaining 8 variables. A KMO value of 0.753 confirmed our data’s suitability for further analysis, and our EFA further substantiated the previous 3-factor structure, explaining 61.9% of the total variance. The model’s goodness of fit was tested, and the null hypothesis that three factors were sufficient in explaining the covariance among the variables was accepted,  $\chi^2(7) = 13.06, p = 0.07$ . EFA results are reported in Table 2. We averaged the scores belonging to each factor in order to obtain three composite summary scores: for individual impact (factor 1) and social isolation (factor 2), higher values (range: 0–10) indicate a worse subjective experience [43]. For family climate (factor 3), after the second EFA we returned to the original raw scores for item 8, and reversed the scores for items 6 and 7, so that higher values of the composite score (range: 0–10) indicate a better subjective experience.

**Table 2.** Results of the Second EFA for Psychosocial Effects of the COVID-19 Pandemic items.

	Factor Loading			Communality	Uniqueness
	1	2	3		
Item 1	0.71	0.20		0.55	0.45
Item 2	0.73	0.17		0.58	0.42
Item 3	0.76	0.16	0.18	0.64	0.36
Item 6	0.35	0.20	0.53	0.44	0.56
Item 9	0.31	0.68	0.11	0.57	0.43
Item 10	0.18	0.97	0.12	0.99	0.01
Item 7	0.17	0.11	0.79	0.67	0.33
Item 8			0.72	0.51	0.49
% Explained variance	0.24	0.20	0.19		
Eigenvalue	1.90	1.56	1.49		
Coefficient alpha	0.81	0.73	0.84		

Note. n = 407. ‘Maximum likelihood’ extraction method was used in combination with a ‘varimax’ rotation. Item 8 was reverse scored before the analysis.

*Factor 1 (Individual Impact)* gathered all questions pertaining to the impact that the COVID-19 pandemic may have implied for participants at the individual level. The items included in this measure were:

- “To what extent has the COVID-19 pandemic affected your life?”
- “To what extent do you currently feel limited in carrying out your usual activities due to the COVID-19 pandemic?”
- “To what extent has the COVID-19 pandemic affected you emotionally (has made you feel angry, scared, upset or depressed)?”

*Factor 2 (Social Isolation)* gathered all questions relating to the degree of perceived isolation from peers due to state-mandated restrictions. The items included in this measure were:

- “To what extent has the COVID-19 pandemic made you feel isolated from your heterosexual or cisgender friends?”
- “To what extent has the COVID-19 pandemic made you feel isolated from your LGBT+ friends?”

*Factor 3 (Family Climate)* gathered all questions related to the participants’ subjective wellbeing as LGBT+ young adults in a family system while COVID-19 restrictions were in place. The items included in this measure were:

- “To what extent do you feel uncomfortable in your family in this specific moment of the COVID-19 pandemic?”
- “To what extent did you feel “suffocated” because you could not express your LGBT+ identity with your family when restrictions were in place?”
- “If the people you currently live with are aware of your LGBT+ identity. how do they respond to this?”

### 2.3.2. NEO Five-Factor Inventory-3 (NEO-FFI-3)

The NEO-FFI-3 [87,88] provides a self-report measure of personality traits according to the Big Five theory of personality [56,89]. For the purposes of this study, we used a neuroticism scale with 12 items, each rated by the participant on a 5-point Likert scale ranging from 1 to 5, where 1 = “Strongly disagree” and 5 = “Strongly agree”, according to their pre-COVID-19 pandemic experience. Neuroticism scores were calculated by reverse scoring the appropriate items, summing all values to obtain raw scores (range: 12–60), computing z-scores, and finally calculating T-scores (M = 50, SD = 10) through a standardization process. Standardized coefficient alpha for Neuroticism was 0.87 (the Italian validation of the instrument reports  $\alpha = 0.75$  [88]). Because biological sex affects NEO-FFI-3 Neuroticism results but not much is known about the influence of gender identity, particularly in the case of gender variance, in calculating z-scores we applied the average and SD for the female population for our cisgender female participants, the average and SD for the male population for our cisgender male participants, and the total population average and SD for our non-cisgender participants.

### 2.3.3. Enacted Stigma Scale of the Minority Stress Scale (MSS)

The Enacted Stigma dimension contained in the MSS [90], which we employed for control purposes, assesses the frequency of experienced stigma in the form of physical and verbal aggression, discrimination, and subjective feelings of societal exclusion (e.g., “Because of my sexual orientation I have been the target of verbal aggressions”). Originally validated for use with Italian gay and bisexual men and based on minority stress theory [35], we adapted it to include gender minorities as well (for example, the item above was rephrased as “Because of my sexual orientation or gender identity I have been the target of verbal aggressions”). The Enacted Stigma scale is composed of four items to which answers are given on a 5-point Likert scale ranging from 1 (“Never”) to 5 (“Always”). Enacted stigma scores were calculated by averaging the values of the 4 items composing the scale (range: 1–5).

### 2.3.4. Depression, Anxiety and Stress Scale (DASS-21; for Mental Health Measures)

This self-report questionnaire [91,92] is designed to measure the level/intensity of internalizing problems over the previous week. The instrument is divided into 3 subscales (Depression, Anxiety, Stress) containing 7 items each. Participants were asked to indicate the extent to which each item reflected their experience using a 4-point Likert scale where 0 = “Did not apply to me at all”, 1 = “Applied to me to some degree, or some of the time”, 2 = “Applied to me to a considerable degree or a good part of time”, and 3 = “Applied to me very much or most of the time”. Items include statements such as “I was unable to become enthusiastic about anything”, “I felt I was close to panic”, and “I was intolerant of anything that kept me from getting on with what I was doing”. The standardized coefficient alpha for each 7-item scale was 0.92, 0.89, and 0.89, for Depression, Anxiety, and Stress, respectively. For their Italian community sample, Bottesi et al. [92] reported coefficient alpha values of 0.82, 0.75, and 0.85, respectively. DASS-21 scores were calculated by summing the values of the 7 items for each separate scale (range for all scales: 0–21).

## 2.4. Data Analysis

Data were analyzed using the statistical software R 3.6.3 [93], the integrated development environment RStudio 1.2.5003-1 [94] and jamovi 1.8 [95]. Figures were created using R 3.6.3 [93] and RStudio 1.2.5003-1 [94].

### 2.4.1. Preliminary Analysis

To better describe the sample, we preliminary assessed the influence of *sex assigned at birth* (four levels: female, male, intersex, other), *gender identity* (four levels: cisgender, transgender, non-binary, other), and *sexual orientation* (four levels: homosexual, bisexual, pansexual, other) on depression, anxiety, stress and individual impact through three separate nonparametric Kruskal–Wallis one-way analyses of variance (ANOVA), and post hoc Dwass–Steel–Critchlow–Fligner (DSCF) pairwise comparisons. As control analysis for the influence of time (on measures of psychosocial well-being, we checked for differences in dependent variables between wave 1 and wave 2 participants through a nonparametric independent samples Mann–Whitney U test.

### 2.4.2. Multiple Regressions: Predictors of Adverse Mental Health Conditions

To identify potential psychosocial correlates of the COVID-19 pandemic as predictors of psychological distress measures (DASS), we ran three linear regression models with (M1) depression, (M2) anxiety and (M3) stress as our dependent variable (DV). All the models (M1, M2, and M3) included the same predictors and differentiated for the dependent variable. For each DV, we tested and compared fit for two multiple linear regression models through the adjusted R<sup>2</sup> coefficient of determination. Model 1 included variables age, gender identity, sexual orientation, living situation, educational level, employment situation, relationship status, other medical and/or psychological conditions, enacted stigma, and wave (two levels: 1 = May–July 2020; 2 = December 2020–April 2021). Model 2

included all Model 1 variables with the addition of neuroticism and COVID-19-related variables, i.e., individual impact, family climate, and social isolation.

### 2.4.3. Conditional (Moderated) Mediation Analysis: Mechanisms Underlying Psychological Distress during the COVID-19 Pandemic

To gain a deeper understanding of the psychosocial mechanisms underlying mental health in our sample, we computed three separate conditional (moderated) mediation models with four variables in jAMM; for three distinct DVs (depression, anxiety, stress), each model included individual impact as a covariate, family climate as a mediator and neuroticism as a moderator.

## 3. Results

### 3.1. Descriptive and Preliminary Analysis

We computed descriptive statistics (Table 3) for our sample to explore the characteristics of participants.

**Table 3.** Descriptive Statistics for the Psychosocial Effects of the COVID-19 scale, DASS-21, NEO-FFI-3 Neuroticism and MSS Enacted stigma for the entire group of participants.

Variable	Mean	SD	Median	MAD	Min	Max	Skew	Kurtosis	SE
Individual Impact	7.24	2.06	7.67	1.98	0	10	−0.88	0.32	0.10
Social Isolation	5.93	3.07	6.50	3.71	0	10	−0.54	−0.74	0.15
Family Climate	6.55	2.67	7.00	2.97	0	10	−0.57	−0.61	0.13
DASS_Depression	10.81	6.39	11	8.90	0	21	0.06	−1.21	0.32
DASS_Anxiety	7.51	6.11	6	5.93	0	21	0.60	−0.85	0.30
DASS_Stress	12.91	5.35	13	5.93	0	21	−0.23	−0.94	0.27
NEO-FFI3_Neuroticism	72.88	14.89	74.32	15.44	25.34	102.59	−0.26	−0.52	0.74
MSS_Enacted stigma	2.11	0.76	2	0.74	1	5	0.60	0.05	0.04

Overall, according to the recommended cut-off scores for conventional severity labels, 33 participants reported moderate levels of depression, and moderate to severe anxiety and stress on average. Mean NEO-FFI-3 Neuroticism scores were over 2 SD above the mean for T-scores ( $M = 50$ ,  $SD = 10$ ), indicating high levels of trait neuroticism. MSS Enacted stigma scores indicate that, globally, participants reported experiencing sporadic episodes of aggression on the basis of their sexual orientation and/or gender identity.

We reported below the significant results of preliminary analyses assessing for differences between participants based on sex assigned at birth, gender identity, sexual orientation, and time of data collection.

*Sex assigned at birth:* Kruskal–Wallis ANOVA results indicated a statistically significant influence of sex assigned at birth on all DASS-21 scores ( $\chi^2$  depression (3) = 18.11,  $p < 0.001$ ,  $\epsilon^2 = 0.05$ ;  $\chi^2$  anxiety (3) = 16.92,  $p < 0.001$ ,  $\epsilon^2 = 0.04$ ;  $\chi^2$  stress (3) = 23.96,  $p < 0.001$ ,  $\epsilon^2 = 0.06$ ),  $\epsilon^2 = 0.03$ ). Epsilon-squared coefficients suggest a weak effect on anxiety and neuroticism, and a moderate effect on depression and stress. Post hoc DSCF pairwise comparisons indicated statistically significant differences between AMAB (assigned male at birth) and AFAB (assigned female at birth) participants in depression ( $W = -5.416$ ,  $p < 0.001$ ), anxiety ( $W = -5.207$ ,  $p < 0.001$ ), stress ( $W = -6.865$ ,  $p < 0.001$ ), and individual impact ( $W = -3.867$ ,  $p = 0.032$ ), all of which were higher for the AFAB group.

*Gender identity:* Kruskal–Wallis ANOVA results indicated a statistically significant although weak influence of gender identity on depression ( $\chi^2(3) = 8.32$ ,  $p = 0.040$ ,  $\epsilon^2 = 0.02$ ). DSCF pairwise comparisons indicated statistically significant differences between cisgender and non-binary participants for depression ( $W = 3.926$ ,  $p = 0.028$ ), with the non-binary group obtaining higher depression.

*Sexual orientation:* Kruskal–Wallis ANOVA results also indicated a statistically significant influence of sexual orientation on measures of depression ( $\chi^2(3) = 18.12$ ,  $p < 0.001$ ,  $\epsilon^2 = 0.05$ ), anxiety ( $\chi^2(3) = 11.12$ ,  $p = 0.011$ ,  $\epsilon^2 = 0.03$ ), stress ( $\chi^2(3) = 14.22$ ,  $p = 0.003$ ,  $\epsilon^2 = 0.04$ ). The measure of effect size suggests a weak influence of sexual orientation on anxiety and stress, and a moderate influence on depression. Post hoc DSFC pairwise com-

parisons highlighted a statistically significant difference between bisexual and homosexual participants for depression ( $W = -4.497, p = 0.008$ ), stress ( $W = -3.660, p = 0.047$ ), and between homosexual and pansexual participants for depression ( $W = 4.623, p = 0.006$ ), anxiety ( $W = 4.562, p = 0.007$ ), stress ( $W = 4.420, p = 0.010$ ).

*Time (wave 1 vs. wave 2):* Finally, to examine the influence of time on measures of psychosocial well-being (wave 1 vs. wave 2) Mann–Whitney U test indicated a small statistically significant influence of time of completion of the questionnaire on depression ( $U = 14564, p = 0.003, rrb = 0.18$ ) anxiety ( $U = 14062, p < 0.001, rrb = 0.21$ ), stress ( $U = 14351, p = 0.001, rrb = 0.20$ ) and a moderate influence on individual impact ( $U = 9451, p < 0.001, rrb = 0.47$ ). The wave 2 group reported higher scores in all variables.

### 3.2. Multiple Regressions: Predictors of Adverse Mental Health Conditions

Model 1 (M1 Depression; M2 Anxiety; M3 Stress) indicated that other medical and/or psychological conditions ( $F$  depression (2, 391) = 19.45,  $p < 0.001$ ;  $F$  anxiety (2, 391) = 22.52,  $p < 0.001$ ;  $F$  stress (2, 391) = 12.01,  $p < 0.001$ ); enacted stigma ( $F$  depression (1, 391) = 15.40,  $p < 0.001$ ;  $F$  anxiety (1, 391) = 20.58,  $p < 0.001$ ;  $F$  stress (1, 391) = 10.45,  $p = 0.001$ ); and time of completion of the questionnaire ( $F$  depression (1, 391) = 4.91,  $p = 0.027$ ;  $F$  anxiety (1, 391) = 6.77,  $p = 0.010$ ;  $F$  stress (1, 391) = 5.83,  $p = 0.016$ ) significantly predicted all DASS-21 scores. Furthermore, the employment situation significantly predicted depression ( $F$  (1, 391) = 7.63;  $p = 0.006$ ), while age significantly predicted anxiety ( $F$  (1, 391) = 9.77,  $p = 0.002$ ) and stress ( $F$  (1, 391) = 4.97,  $p = 0.026$ ) (Table 4). However, with the exception of other medical and/or psychological conditions and age, all predictors lost their statistical significance once the three COVID-19 scales and neuroticism were added to the model (Model 2: M1 Depression; M2 Anxiety; M3 Stress). More specifically, in Model 2, individual impact ( $F$  depression (1, 387) = 10.81,  $p = 0.001$ ;  $F$  anxiety (1, 387) = 9.40,  $p = 0.002$ ;  $F$  stress (1, 387) = 22.00,  $p < 0.001$ ) and neuroticism ( $F$  depression (1, 387) = 143.83,  $p < 0.001$ ;  $F$  anxiety (1, 387) = 49.97,  $p < 0.001$ ;  $F$  stress (1, 387) = 65.24,  $p < 0.001$ ) predicted all DASS-21 scores, while family climate ( $F$  depression (1, 387) = 7.92,  $p = 0.005$ ;  $F$  anxiety (1, 387) = 11.32,  $p < 0.001$ ) and other medical and/or psychological conditions ( $F$  depression (2, 387) = 4.22,  $p = 0.004$ ;  $F$  anxiety (2, 387) = 8.92,  $p < 0.001$ ) predicted depression and anxiety scores. Age was also reconfirmed as a predictor of anxiety ( $F$  (1, 387) = 7.65,  $p = 0.006$ ).

Model 2 showed higher goodness-of-fit and prediction power than Model 1 for all the DASS-21 scales, explaining between 38 and 52% of the variance for all the DV scores, as indicated by adjusted  $R^2$  values.

### 3.3. Condition (Mediated) Moderation in jAMM: Mechanisms Underlying Psychological Distress during the COVID-19 Pandemic

*Depression.* Neuroticism did not moderate the path in a substantial way from individual impact to family climate ( $IE = -0.003, CI = [-0.010, 0.004], beta = -0.036, z = -0.781, p = 0.435$ ) and family climate and depression ( $IE = 0.007, CI = [-0.005, 0.018], beta = 0.110, z = 1.174, p = 0.240$ ) (Table 5; Figure 1a). However, neuroticism moderated the path from individual impact to depression, because the interaction between individual impact and depression is different from zero ( $IE = 0.017, CI = [0.004, 0.031], beta = 0.093, z = 2.538, p = 0.011$ ).

**Table 4.** Multiple Regressions for Depression, Anxiety and Stress as dependent variables.

Predictor (model 1)	M1 De- pression				M2 Anxiety							M3 Stress									
	Estimate	SE	t	p	95% C.I.			Estimate	SE	t	p	95% C.I.			Estimate	SE	t	p	95% C.I.		
					Stand. Estimate	Lower	Upper					Stand. Estimate	Lower	Upper					Stand. Estimate	Lower	Upper
Intercept <sup>a</sup>	6.534	2.183	2.993	0.003				5.064	2.093	2.420	0.016				9.746	1.921	5.073	<0.001			
Age	-0.131	0.078	-1.670	0.096	-0.096	-0.209	0.017	-0.235	0.075	-3.126	0.002	-0.180	-0.293	-0.067	-0.154	0.069	-2.228	0.026	-0.134	-0.253	-0.016
Gender Identity																					
other-cis	0.509	1.306	0.390	0.697	0.080	-0.322	0.481	-0.937	1.252	-0.749	0.455	-0.153	-0.556	0.249	1.680	1.149	1.462	0.145	0.314	-0.108	0.736
nb-cis	0.496	0.908	0.546	0.585	0.078	-0.202	0.357	-0.524	0.870	-0.603	0.547	-0.086	-0.366	0.194	0.416	0.799	0.521	0.602	0.078	-0.216	0.371
tg-cis	-1.346	1.543	-0.872	0.384	-0.211	-0.685	0.264	-1.249	1.479	-0.844	0.399	-0.204	-0.680	0.272	-1.325	1.358	-0.976	0.330	-0.248	-0.747	0.251
Sexual Orientation:																					
other-homo	0.374	1.132	0.330	0.742	0.058	-0.290	0.407	0.202	1.085	0.186	0.852	0.033	-0.316	0.382	-0.106	0.996	-0.106	0.915	-0.020	-0.386	0.346
bisex-homo	1.677	0.710	2.364	0.019	0.263	0.044	0.481	0.487	0.680	0.716	0.474	0.080	-0.139	0.299	1.172	0.625	1.876	0.061	0.219	-0.011	0.448
pan-homo	1.893	1.038	1.823	0.069	0.296	-0.023	0.616	1.685	0.995	1.692	0.091	0.276	-0.045	0.596	1.407	0.914	1.540	0.124	0.263	-0.073	0.599
Living in Family	0.753	0.661	1.140	0.255	0.055	-0.040	0.150	0.315	0.634	0.497	0.619	0.024	-0.071	0.119	-0.153	0.582	-0.264	0.792	-0.013	-0.113	0.086
Education	0.035	0.637	0.055	0.957	0.003	-0.094	0.100	-0.065	0.611	-0.106	0.915	-0.005	-0.102	0.092	0.335	0.561	0.598	0.551	0.031	-0.071	0.133
Employment Situation	-1.810	0.655	-2.763	0.006	-0.141	-0.242	-0.041	0.147	0.628	0.234	0.815	0.012	-0.089	0.113	-0.018	0.577	-0.031	0.976	-0.002	-0.107	0.104
In a Romantic Relationship	-0.348	0.595	-0.584	0.559	-0.027	-0.119	0.064	-0.119	0.571	-0.208	0.835	-0.010	-0.101	0.082	0.544	0.524	1.039	0.299	0.051	-0.045	0.147
other problems:																					
pnr-no	3.281	0.930	3.528	<0.001	0.513	0.227	0.800	3.153	0.891	3.537	<0.001	0.516	0.229	0.803	2.677	0.818	3.271	0.001	0.500	0.200	0.801
yes-no	3.901	0.656	5.943	<0.001	0.610	0.409	0.813	4.079	0.629	6.482	<0.001	0.668	0.465	0.870	2.564	0.578	4.438	<0.001	0.479	0.267	0.691
Enacted Stigma	1.528	0.389	3.924	<0.001	0.183	0.091	0.274	1.693	0.373	4.536	<0.001	0.212	0.120	0.304	1.108	0.343	3.233	0.001	0.158	0.062	0.255
Time	1.399	0.631	2.216	0.027	0.102	0.012	0.192	1.574	0.605	2.601	0.010	0.120	0.029	0.210	1.341	0.556	2.414	0.016	0.116	0.022	0.211
Predictor (model 2)					95% C.I.							95% C.I.							95% C.I.		
Estimate	SE	t	p	Stand. Estimate	Lower	Upper	Estimate	SE	t	p	Stand. Estimate	Lower	Upper	Estimate	SE	t	p	Stand. Estimate	Lower	Upper	
Intercept <sup>a</sup>	-7.898	2.324	-3.399	<0.001			-3.255	2.442	-1.333	0.183				-0.444	2.192	-0.202	0.840				
Age	-0.020	0.063	-0.315	0.753	-0.014	-0.105	0.076	-0.183	0.066	-2.765	0.006	-0.140	-0.239	-0.040	-0.099	0.059	-1.663	0.097	-0.086	-0.188	0.016
Gender Identity																					
other-cis	0.123	1.033	0.119	0.905	0.019	-0.299	0.337	-1.507	1.085	-1.389	0.166	-0.247	-0.596	0.103	1.208	0.974	1.240	0.216	0.226	-0.132	0.584
nb-cis	-0.369	0.719	-0.513	0.608	-0.058	-0.279	0.164	-1.263	0.755	-1.672	0.095	-0.207	-0.450	0.036	-0.201	0.678	-0.297	0.767	-0.038	-0.287	0.212
tg-cis	-1.740	1.219	-1.427	0.154	-0.272	-0.647	0.103	-1.446	1.281	-1.129	0.260	-0.237	-0.649	0.176	-1.406	1.150	-1.222	0.222	-0.263	-0.685	0.160
Sexual Orientation:																					
other-homo	0.715	0.899	0.795	0.427	0.112	-0.165	0.389	0.681	0.945	0.720	0.472	0.111	-0.193	0.415	0.473	0.848	0.558	0.578	0.088	-0.223	0.400
bisex-homo	0.541	0.564	0.959	0.338	0.085	-0.089	0.258	-0.329	0.593	-0.556	0.579	-0.054	-0.245	0.137	0.355	0.532	0.667	0.505	0.066	-0.129	0.262
pan-homo	0.786	0.822	0.956	0.340	0.123	-0.130	0.376	0.870	0.864	1.007	0.315	0.142	-0.136	0.420	0.682	0.776	0.879	0.380	0.127	-0.158	0.412

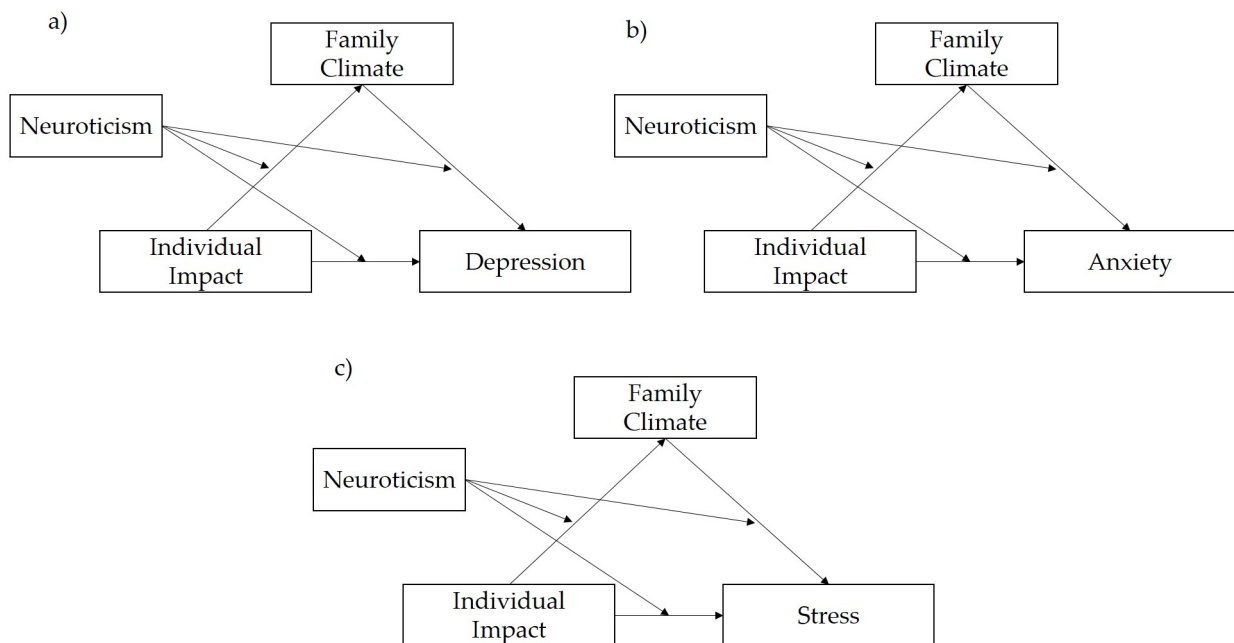
Table 4. Cont.

Predictor (model 1)	M1 De- pression				M2 Anxiety				M3 Stress												
	Estimate	SE	t	p	Stand. Estimate	95% C.I.		Estimate	SE	t	p	Stand. Estimate	95% C.I.		Estimate	SE	t	p	Stand. Estimate	95% C.I.	
						Lower	Upper						Lower	Upper						Lower	Upper
Living in Family	0.977	0.537	1.820	0.070	0.071	−0.006	0.149	0.563	0.564	0.997	0.319	0.043	−0.042	0.128	−0.162	0.507	−0.320	0.749	−0.014	−0.101	0.073
Education	−0.170	0.502	−0.338	0.736	−0.013	−0.090	0.063	−0.245	0.528	−0.463	0.643	−0.020	−0.104	0.064	0.166	0.474	0.349	0.727	0.015	−0.071	0.101
Employment Situation	−0.886	0.522	−1.695	0.091	−0.069	−0.149	0.011	0.895	0.549	1.630	0.104	0.073	−0.015	0.161	0.717	0.493	1.455	0.146	0.067	−0.024	0.157
In a Romantic Relationship	−0.144	0.479	−0.301	0.763	−0.011	−0.085	0.062	0.265	0.503	0.526	0.599	0.022	−0.059	0.102	0.719	0.451	1.593	0.112	0.067	−0.016	0.150
other problems:																					
pnr–no	1.008	0.748	1.346	0.179	0.158	−0.073	0.388	1.504	0.786	1.912	0.057	0.246	−0.007	0.499	1.092	0.706	1.547	0.123	0.204	−0.055	0.463
yes–no	1.562	0.545	2.868	0.004	0.244	0.077	0.412	2.389	0.572	4.175	<0.001	0.391	0.207	0.575	0.834	0.514	1.624	0.105	0.156	−0.033	0.345
Enacted Stigma	0.013	0.329	0.038	0.969	0.002	−0.076	0.079	0.302	0.346	0.873	0.383	0.038	−0.047	0.123	−0.154	0.311	−0.497	0.620	−0.022	−0.109	0.065
Time	0.186	0.532	0.350	0.727	0.014	−0.063	0.090	0.340	0.559	0.607	0.544	0.026	−0.058	0.110	−0.012	0.502	−0.023	0.982	$-9.95 \times 10^{-4}$	−0.087	0.085
Individual Impact	0.460	0.140	3.288	0.001	0.148	0.060	0.237	0.451	0.147	3.065	0.002	0.152	0.054	0.249	0.619	0.132	4.691	<0.001	0.238	0.138	0.338
Family Climate	−0.286	0.102	−2.815	0.005	−0.120	−0.203	−0.036	−0.360	0.107	−3.365	<0.001	−0.157	−0.249	−0.065	−0.167	0.096	−1.742	0.082	−0.083	−0.178	0.011
Social Isolation	−0.094	0.085	−1.101	0.272	−0.045	−0.126	0.035	0.133	0.090	1.486	0.138	0.067	−0.022	0.155	0.066	0.080	0.818	0.414	0.038	−0.053	0.128
Neuroticism	0.228	0.019	11.993	<0.001	0.530	0.443	0.617	0.141	0.020	7.069	<0.001	0.344	0.248	0.439	0.145	0.018	8.077	<0.001	0.402	0.304	0.500

<sup>a</sup> Represents reference level.

**Table 5.** Multiple Linear Regression Models’ Goodness-of-fit Measures and Comparison in Predicting DASS-21 Depression, Anxiety, Stress, and General Distress Scores.

Overall Model Test							
Model	R	R <sup>2</sup>	adj. R <sup>2</sup>	F	df1	df2	p
<b>Depression</b>							
Model fit measures							
1	0.495	0.245	0.216	8.45	15	391	<0.001
2	0.732	0.537	0.514	23.58	19	387	<0.001
Comparison							
	Model		ΔR <sup>2</sup>	F	df1	df2	p
	1	2	0.292	60.9	4	387	<0.001
<b>Anxiety</b>							
Model fit measures							
1	0.491	0.241	0.212	8.29	15	391	<0.001
2	0.664	0.441	0.413	16.04	19	387	<0.001
Comparison							
	1	2	0.199	34.5	4	387	<0.001
<b>Stress</b>							
Model fit measures							
1	0.408	0.166	0.134	5.2	15	391	<0.001
2	0.642	0.412	0.383	14.27	19	387	<0.001
Comparison							
	1	2	0.246	40.5	4	387	<0.001



**Figure 1.** Moderated Mediation Models: (a) Depression; (b) Anxiety and (c) Stress.

We can see the mediation effect looking at the mean level of the moderator (Table 6). At the average mediated effect across levels of the neuroticism (mean level), family climate partially mediated the effect of individual impact on depression (IE= 0.066, CI = [0.010, 0.121], beta= 0.021, z= 2.31, p = 0.021). Moreover, the single components of the indirect path, the direct and total mediation were significant.

**Table 6.** Moderation Estimates with Neuroticism as a moderator (Depression = dependent variable). The tables show the moderation effects (interactions) and the conditional mediation. Confidence intervals were computed with method standard (Delta method).

Moderator	Interaction	Estimate	SE	Lower	Upper	$\beta$	z	p	
neuroticism	neuroticism:individual_impact $\Rightarrow$ family_climate	-0.003	0.004	-0.010	0.004	-0.036	-0.781	0.435	
	neuroticism:individual_impact $\Rightarrow$ depression	0.018	0.007	0.004	0.031	0.093	2.538	0.011	
	neuroticism:family_climate $\Rightarrow$ depression	0.007	0.006	-0.005	0.018	0.110	1.174	0.240	
Moderator levels		95% C.I. (a)							
neuroticism	Type	Effect	Estimate	SE	Lower	Upper	$\beta$	z	p
Mean-1-SD	Indirect	individual_impact $\Rightarrow$ family_climate $\Rightarrow$ depression	0.075	0.033	0.010	0.140	0.024	2.250	0.025
Mean-1-SD	Component	individual_impact $\Rightarrow$ family_climate	-0.201	0.075	-0.347	-0.055	-0.155	-2.700	0.007
Mean-1-SD		family_climate $\Rightarrow$ depression	-0.372	0.092	-0.552	-0.193	-0.155	-4.070	<0.001
Mean-1-SD	Direct	individual_impact $\Rightarrow$ depression	0.253	0.139	-0.020	0.525	0.081	1.820	0.069
Mean-1-SD	Total	individual_impact $\Rightarrow$ depression	0.341	0.139	0.068	0.614	0.110	2.450	0.014
Mean	Indirect	individual_impact $\Rightarrow$ family_climate $\Rightarrow$ depression	0.066	0.028	0.010	0.121	0.021	2.310	0.021
Mean	Component	individual_impact $\Rightarrow$ family_climate	-0.244	0.065	-0.371	-0.116	-0.188	-3.740	<0.001
Mean		family_climate $\Rightarrow$ depression	-0.270	0.092	-0.449	-0.090	-0.113	-2.950	0.003
Mean	Direct	individual_impact $\Rightarrow$ depression	0.516	0.123	0.276	0.756	0.166	4.210	<0.001
Mean	Total	individual_impact $\Rightarrow$ depression	0.587	0.122	0.348	0.826	0.189	4.820	<0.001
Mean+1-SD	Indirect	individual_impact $\Rightarrow$ family_climate $\Rightarrow$ depression	0.048	0.031	-0.012	0.108	0.015	1.560	0.118
Mean+1-SD	Component	individual_impact $\Rightarrow$ family_climate	-0.286	0.094	-0.471	-0.101	-0.220	-3.030	0.002
Mean+1-SD		family_climate $\Rightarrow$ depression	-0.167	0.092	-0.347	0.012	-0.070	-1.830	0.068
Mean+1-SD	Direct	individual_impact $\Rightarrow$ depression	0.780	0.176	0.434	1.125	0.251	4.420	<0.001
Mean+1-SD	Total	individual_impact $\Rightarrow$ depression	0.833	0.176	0.488	1.179	0.268	4.720	<0.001

For high levels of neuroticism (mean + SD), the mediated effect of family climate to predict depression became smaller and did not reach the level of significance (IE = 0.048, CI = [-0.012, 0.108], beta = 0.015, z = 1.56, p = 0.118). Instead, the direct mediation of individual impact to depression showed a larger effect (IE = 0.516, CI = [0.276, 0.756], beta = 0.166, z = 4.21, p < 0.001).

For low levels of neuroticism (mean-SD), the mediated effect of family climate to predict depression maintained the level of significance (IE = 0.075, CI = [-0.010, 0.140], beta = 0.024, z = 2.25, p = 0.025). Instead, the direct mediation of individual impact to depression showed a smaller effect that did not reach the significance (IE = 0.253, CI = [-0.019, 0.525], beta = 0.081, z = 1.821, p = 0.069).

*Anxiety.* Neuroticism moderated the path from Individual Impact to Anxiety (IE = 0.025, CI = [0.010, 0.039], beta = 0.138, z = 3.389, p < 0.001). As in the previous model (depression), neuroticism did not moderate the path in a substantial way from individual impact to family climate (IE = -0.003, CI = [-0.010, 0.004], beta = -0.036, z = -0.781, p = 0.435) and family climate and anxiety (IE = 0.007, CI = [-0.020, 0.005], beta = 0.124, z = -1.195, p = 0.232 (Table 7; Figure 1b).

At the average mediated effects across levels (mean level) of neuroticism (Table 7), family climate partially mediated the effect of individual impact on anxiety (IE = 0.081, CI = [0.018, 0.144], beta = 0.027, z = 2.52, p = 0.012). Moreover, the single components of the indirect path, the direct and total mediation were significant.

For high levels of neuroticism (mean + SD), the mediated effect of family climate to predict anxiety was significant, but without showing either a larger or smaller moderator impact compared to the mean level of neuroticism (IE = 0.127, CI = [0.028, 0.225], beta = -0.042, z = 2.53, p = 0.012). Instead, the direct mediation of Individual Impact to Anxiety showed a larger effect (IE = 1.052, CI = [0.686, 1.418], beta = 0.352, z = 5.63, p < 0.001).

**Table 7.** Moderation Estimates with Neuroticism as a moderator (Anxiety = dependent variable). The tables show the moderation effects (interactions) and the conditional mediation. Confidence intervals were computed with method standard (Delta method).

Moderator	Interaction	Estimate	SE	Lower	Upper	$\beta$	z	p	
neuroticism	neuroticism:individual_impact $\Rightarrow$ family_climate	-0.003	0.004	-0.010	0.004	-0.036	-0.781	0.435	
	neuroticism:individual_impact $\Rightarrow$ anxiety	0.025	0.007	0.011	0.039	0.138	3.389	<0.001	
	neuroticism:family_climate $\Rightarrow$ anxiety	-0.007	0.006	-0.020	0.005	-0.124	-1.195	0.232	
Moderator levels		95% C.I. (a)							
neuroticism	Type	Effect	Estimate	SE	Lower	Upper	$\beta$	z	p
Mean-1·SD	Indirect	individual_impact $\Rightarrow$ family_climate $\Rightarrow$ anxiety	0.044	0.026	-0.006	0.094	0.015	1.740	0.082
Mean-1·SD	Component	individual_impact $\Rightarrow$ family_climate	-0.201	0.075	-0.347	-0.055	-0.155	-2.700	0.007
Mean-1·SD		family_climate $\Rightarrow$ anxiety	-0.221	0.097	-0.411	-0.031	-0.097	-2.280	0.023
Mean-1·SD	Direct	individual_impact $\Rightarrow$ anxiety	0.307	0.147	0.019	0.596	0.104	2.090	0.037
Mean-1·SD	Total	individual_impact $\Rightarrow$ anxiety	0.338	0.149	0.046	0.629	0.114	2.270	0.023
Mean	Indirect	individual_impact $\Rightarrow$ family_climate $\Rightarrow$ anxiety	0.081	0.032	0.018	0.144	0.027	2.520	0.012
Mean	Component	individual_impact $\Rightarrow$ family_climate	-0.244	0.065	-0.371	-0.116	-0.188	-3.740	<0.001
Mean		family_climate $\Rightarrow$ anxiety	-0.332	0.097	-0.522	-0.142	-0.145	-3.420	<0.001
Mean	Direct	individual_impact $\Rightarrow$ anxiety	0.680	0.130	0.425	0.934	0.229	5.240	<0.001
Mean	Total	individual_impact $\Rightarrow$ anxiety	0.755	0.130	0.500	1.010	0.254	5.810	<0.001
Mean+1·SD	Indirect	individual_impact $\Rightarrow$ family_climate $\Rightarrow$ anxiety	0.127	0.050	0.028	0.225	0.042	2.530	0.012
Mean+1·SD	Component	individual_impact $\Rightarrow$ family_climate	-0.286	0.094	-0.471	-0.101	-0.220	-3.030	0.002
Mean+1·SD		family_climate $\Rightarrow$ anxiety	-0.442	0.097	-0.632	-0.252	-0.192	-4.560	<0.001
Mean+1·SD	Direct	individual_impact $\Rightarrow$ anxiety	1.052	0.187	0.686	1.418	0.352	5.630	<0.001
Mean+1·SD	Total	individual_impact $\Rightarrow$ anxiety	1.172	0.188	0.803	1.541	0.394	6.230	<0.001

For low levels of neuroticism (mean-SD), the mediated effect of family climate to predict depression did not maintain the significance (IE = 0.044, CI = [-0.006, 0.094], beta = 0.015, z = 1.74, p = 0.082). Instead, the direct mediation of individual impact to depression showed a smaller effect compared to the mean and high levels of neuroticism (IE = 0.307, CI = [0.019, 0.560], beta = 0.104, z = 2.09, p = 0.037).

*Stress.* Neuroticism did not moderate the direct and indirect paths in a substantial way, including with respect to the single components of the indirect path (Table 8; Figure 1c).

At the average mediated effects across levels (mean level) of neuroticism, family climate did not mediate the effect of individual impact on stress, and individual impact totally predicted stress (IE = 0.710, CI = [0.485, 0.935], beta = 0.273, z = 6.185, p < 0.001). Moreover, the single component of the indirect path from individual impact to family climate and the total mediation were significant (Table 8).

For high levels of neuroticism (mean + SD), the partially mediated effect of family climate to predict stress was significant (IE = 0.072, CI = [0.005, 0.139], beta = 0.027, z = 2.104, p = 0.035). Instead, the direct mediation of individual impact to anxiety showed a slightly larger moderation effect (IE = 0.843, CI = [0.519, 1.167], beta = 0.323, z = 5.105, p < 0.001). Moreover, the single components of the indirect path and total mediation were significant.

For low levels of neuroticism (mean-SD), the mediated effect of family climate to predict depression did not maintain the significance. instead, the direct mediation of individual impact to depression showed a smaller moderation effect compared to the mean and high levels of neuroticism (IE = 0.577, CI = [0.322, 0.832], beta = 0.222, z = 6.185, p < 0.001).

**Table 8.** Moderation Estimates with Neuroticism as a moderator (Stress = dependent variable). The tables show the moderation effects (interactions) and the conditional mediation. Confidence intervals were computed with method standard (Delta method).

Moderator	Interaction	Estimate	SE	Lower	Upper	β	z	p	
neuroticism	neuroticism:individual_impact ⇒ family_climate	−0.003	0.004	−0.010	0.004	−0.036	−0.781	0.435	
	neuroticism:individual_impact ⇒ stress	0.009	0.007	−0.004	0.022	0.056	1.369	0.171	
	neuroticism:family_climate ⇒ stress	−0.008	0.006	−0.019	0.003	−0.149	−1.422	0.155	
Moderator levels		95% C.I. (a)							
neuroticism	Type	Effect	Estimate	SE	Lower	Upper	B	z	p
Mean-1·SD	Indirect	individual_impact ⇒ family_climate ⇒ stress	0.004	0.017	−0.030	0.038	0.001	0.207	0.836
Mean-1·SD	Component	individual_impact ⇒ family_climate	−0.201	0.075	−0.347	−0.055	−0.155	−2.698	0.007
		family_climate ⇒ stress	−0.018	0.086	−0.186	0.150	−0.009	−0.208	0.835
Mean-1·SD	Direct	individual_impact ⇒ stress	0.577	0.130	0.322	0.832	0.222	4.430	<0.001
Mean-1·SD	Total	individual_impact ⇒ stress	0.566	0.130	0.311	0.820	0.217	4.354	<0.001
Mean	Indirect	individual_impact ⇒ family_climate ⇒ stress	0.033	0.023	−0.012	0.077	0.013	1.443	0.149
Mean	Component	individual_impact ⇒ family_climate	−0.244	0.065	−0.371	−0.116	−0.188	−3.736	<0.001
		family_climate ⇒ stress	−0.134	0.086	−0.302	0.034	−0.067	−1.565	0.118
Mean	Direct	individual_impact ⇒ stress	0.710	0.115	0.485	0.935	0.273	6.185	<0.001
Mean	Total	individual_impact ⇒ stress	0.737	0.114	0.514	0.960	0.283	6.481	<0.001
Mean+1·SD	Indirect	individual_impact ⇒ family_climate ⇒ stress	0.072	0.034	0.005	0.139	0.027	2.104	0.035
Mean+1·SD	Component	individual_impact ⇒ family_climate	−0.286	0.094	−0.471	−0.101	−0.220	−3.032	0.002
		family_climate ⇒ stress	−0.251	0.086	−0.419	−0.083	−0.124	−2.922	0.003
Mean+1·SD	Direct	individual_impact ⇒ stress	0.843	0.165	0.520	1.167	0.323	5.105	<0.001
Mean+1·SD	Total	individual_impact ⇒ stress	0.908	0.165	0.586	1.231	0.349	5.518	<0.001

#### 4. Discussion

The overall goal of this study was to evaluate the psychosocial correlates of the COVID-19 pandemic on Italian LGBT+ young adults to identify potential individual and contextual factors as predictors of less adverse mental health conditions. Preliminarily, we assessed the psychosocial outcomes of the COVID-19 pandemic on Italian LGBT+ young adults, exploring correlations between psychological symptoms (depression, anxiety, stress), individual impact of the COVID-19 pandemic (family climate, perceived degree of social isolation), the individual personality tendency toward negative feelings (e.g., neuroticism), and enacted stigma. We found a significant association between negative attitudes towards young adults’ LGBT+ identity within the family context and internalizing symptoms of distress. These findings are in line with literature published before [96,97] and during the COVID-19 pandemic [40–45,84], further highlighting even more the fundamental role of the family environment during pandemic restrictions as a potential risk factor for young people of sexual and gender minorities [76–79]. Despite no statistically significant differences in distress having been reported between participants living with their own family and in different configurations (e.g., living alone or with roommates), the latter reported overall more feelings of freedom in expressing their LGBT+ identity. Finally, we also found an association between minority stress and adverse mental health outcomes, further corroborating the existing literature on the topic [34,35,98–101].

As our first aim, the factors that consistently and meaningfully predicted all DASS-21 scores were the individual impact of the COVID-19 pandemic and family climate. The individual impact of the COVID-19 pandemic as a predictor was expected, as the COVID-19 health emergency taxed the general population, decreasing the psychophysical well-being of people worldwide [6–8]. The results indicate that family climate (related to participants’ LGBT+ status during lockdown restrictions) partially mediated the relationship between the impact of the COVID-19 pandemic on an individual level and mental health conditions in the form of depression and anxiety.

Regarding the second aim, we also found that the personality trait of neuroticism significantly moderated the strength of the relationship between LGBT+ status during lockdown restrictions and internalizing symptoms. Over the years, psychological research has extensively documented that the individual disposition of traits to experience negative and adverse effects may be more associated with lower psychological well-being [49,50,102].

Our results also suggest that, in the presence of lower and medium neuroticism, the family climate mediates the relationship between individual impact and depression. In the presence of higher neuroticism, the family climate loses its mediating effect, and the role of personality traits emerges as being decisive. Regarding the relationship between individual impact and anxiety, the family climate mediating their relationship emerges as being decisive.

Our findings contribute to furthering our understanding of the role of neuroticism in the impact on the psychological well-being of LGBT+ young people and, presumably, the general population, during a global health emergency represented by the COVID-19 pandemic. In fact, although research so far has focused on the cisgender and heterosexual population, there is no reason to conclude that the explanatory power of trait disposition to experience negative emotions in terms of mental health outcomes would be different for sexual and gender minorities, particularly those belonging to Western cultural groups, where Big Five Personality Theory has been most studied.

#### *Limitations and Further Studies*

Our study is not exempt from limitations. First, non-probability convenience sampling limits the generalizability of our findings to the population at large. Indeed, our participants were on average highly educated, and resided predominantly in urban areas of Northern Italy. Furthermore, the length of the questionnaire (around 20 min) and its exclusively online administration may have led to self-selection bias. Additionally, although we chose a nonparametric approach, the unequal sample size for the intersex, transgender, non-binary, and pansexual and “other” sexual and gender minority groups poses concerns regarding the robustness of the statistical analyses, particularly with respect to those carried out in order to explore differences among participants based on sex assigned at birth, gender identity, and sexual orientation. Future research should include a larger number of intersex, transgender, gender variant, and alternative sexual minority people, and evaluate the psychosocial effects of the COVID-19 pandemic related to the specific needs of various marginalized groups. In this regard, as in previous studies [40,41,83,84] our research study applied an approach that did not consider internal differences in the LGBT+ group. This aspect represents a limitation that requires further investigation using a multi-method approach (e.g., qualitative investigations; observational methods) in order bring out the specific challenges and needs of specific groups.

Nevertheless, our work also presents various strengths. First, the overall sample size was moderately large, also thanks to the numerous local and national LGBT+ associations that contributed to recruitment; as a consequence, a wide variety of sexual and gender minority identities were represented. Furthermore, to the best of our knowledge, this is the first study exploring the role of neuroticism in moderating psychological distress symptoms in sexual and gender minorities.

#### **5. Conclusions**

In conclusion, the present findings support the need for large scale interventions aimed at reducing negative family attitudes towards sexual and gender minority identities and promoting understanding and acceptance, as perceived family support in relation to LGBT+ status may play a role in putting young adults at increased risk for worse mental health conditions following the impact of the COVID-19 pandemic at the individual level. The implications in clinical terms have been discussed; a brief mention of some social considerations is equally important. The context of aggregation and exchange with other LGBT+ people is a crucial protective factor [103], even more so in specific moments of

individual development. The pandemic, and the social restrictions associated with it, restricted exploration of identity in confrontation with others, limiting this aspect to a solitary context within stigmatizing contexts as well. The social–political context must recognize this important role for LGBT+ associations. Conversely, associations must recognize their importance by promoting projects aimed at the most fragile segment of LGBT+ population by using online devices not only as dissemination tools but also by finding new spaces of aggregation.

**Author Contributions:** Conceptualization, M.M., J.G. and P.R.; methodology, M.M., M.P., J.G. and P.R.; validation, M.M. and P.R.; formal analysis, M.P. and P.R.; investigation, M.M., M.P., A.G., A.S. and M.G.; resources, M.M.; data curation, M.P. and A.G.; writing—original draft preparation, M.M., M.P. and P.R.; writing—review and editing, M.M., J.G. and P.R.; visualization and supervision, M.M. and P.R.; project administration, M.M. and J.G.; funding acquisition, M.M. All authors have read and agreed to the published version of the manuscript.

**Funding:** The present research study was carried out with the supporting grant 2019 (Budget Integrato Ricerca Dipartimenti—BIRD195080) of the Department of Women’s and Children’s Health University of Padua.

**Institutional Review Board Statement:** The research project was approved by the Ethics Committee of the University of Padova (n. 3591/2020) in date 8 May 2020.

**Informed Consent Statement:** Informed consent was obtained from all the subjects involved in the study.

**Data Availability Statement:** Restrictions apply to the availability of these data. Data are available from the Principal Investigators (MM and PR) upon reasonable request.

**Acknowledgments:** The authors are grateful to all the participants, LGBT+ activists and associations for their support in this research project.

**Conflicts of Interest:** The authors declare no conflict of interest.

## References

1. Cénat, J.M.; Farahi, S.M.M.M.; Dalexis, R.D.; Darius, W.P.; Bekarkhanechi, F.M.; Poisson, H.; Labelle, P.R. The global evolution of mental health problems during the COVID-19 pandemic: A systematic review and meta-analysis of longitudinal studies. *J. Affect. Disord.* **2022**, *315*, 70–95. [[CrossRef](#)] [[PubMed](#)]
2. Dpcm 8 March 2020 n. 59, Official Journal of the Italian Republic. Available online: <https://www.gazzettaufficiale.it/eli/id/2020/03/08/20A01522/sg> (accessed on 3 November 2022).
3. Dpcm 3 December 2020 n. 301 Official Journal of the Italian Republic. Available online: <https://www.gazzettaufficiale.it/eli/id/2020/12/03/20A06767/sg> (accessed on 3 November 2022).
4. Dpcm 22 April 2021 n. 52 Official Journal of the Italian Republic. Available online: <https://www.gazzettaufficiale.it/eli/id/2021/04/22/21G00064/sg> (accessed on 3 November 2022).
5. Leung, C.M.C.; Ho, M.K.; Bharwani, A.A.; Cogo-Moreira, H.; Wang, Y.; Chow, M.S.C.; Fan, X.; Galea, S.; Leung, G.M.; Ni, M.Y. Mental Disorders Following COVID-19 and Other Epidemics: A Systematic Review and Meta-Analysis. *Transl. Psychiatry* **2022**, *12*, 1–12. [[CrossRef](#)] [[PubMed](#)]
6. Boden, M.; Zimmerman, L.; Azevedo, K.J.; Ruzek, J.I.; Gala, S.; Abdel, M.H.S.; Cohen, N.; Walser, R.; Mahtani, N.D.; Hoggatt, K.J.; et al. Addressing the mental health impact of COVID-19 through population health. *Clin. Psychol. Rev.* **2021**, *85*, 102006. [[CrossRef](#)] [[PubMed](#)]
7. Brooks, S.K.; Webster, R.K.; Smith, L.E.; Woodland, L.; Wessely, S.; Greenberg, N.; Rubin, G.J. The psychological impact of quarantine and how to reduce it: Rapid review of the evidence. *SSRN* **2020**, *395*, 10227. [[CrossRef](#)]
8. Torales, J.; O’Higgins, M.; Castaldelli-Maia, J.M.; Ventriglio, A. The outbreak of COVID-19 coronavirus and its impact on global mental health. *Int. J. Soc. Psychiatry* **2020**, *66*, 317–320. [[CrossRef](#)] [[PubMed](#)]
9. Xiong, J.; Lipsitz, O.; Nasri, F.; Lui, L.M.W.; Gill, H.; Phan, L.; Chen-Li, D.; Iacobucci, M.; Ho, R.; Majeed, A.; et al. Impact of COVID-19 pandemic on mental health in the general population: A systematic review. *J. Affect. Disord.* **2020**, *277*, 55–64. [[CrossRef](#)] [[PubMed](#)]
10. Beam, C.R.; Kim, A.J. Psychological sequelae of social isolation and loneliness might be a larger problem in young adults than older adults. *Psychol. Trauma Theory Res. Pract. Policy* **2020**, *12*, S58. [[CrossRef](#)] [[PubMed](#)]
11. Fana, M.; Torrejón Pérez, S.; Fernández-Macías, E. Employment impact of Covid-19 crisis: From short term effects to long terms prospects. *J. Ind. Bus. Econ.* **2020**, *47*, 391–410. [[CrossRef](#)]
12. Puers, A.S. COVID-19, Youth Employment, and Mental Health in Italy. European Student Think Tank. Available online: <https://esthinktank.com/2021/06/24/covid-19-youth-employment-and-mental-health-in-italy/> (accessed on 26 August 2021).

13. Khawar, M.B.; Abbasi, M.H.; Hussain, S.; Riaz, M.; Rafiq, M.; Mehmood, R.; Farooq, A. Psychological impacts of COVID-19 and satisfaction from online classes: Disturbance in daily routine and prevalence of depression, stress, and anxiety among students of Pakistan. *Heliyon* **2021**, *7*, e07030. [CrossRef] [PubMed]
14. Mazza, C.; Ricci, E.; Biondi, S.; Colasanti, M.; Ferracuti, S.; Napoli, C.; Roma, P. A Nationwide Survey of Psychological Distress among Italian People during the COVID-19 Pandemic: Immediate Psychological Responses and Associated Factors. *Int. J. Environ. Res. Public Health* **2020**, *17*, 3165. [CrossRef]
15. ILGA-Europe. Annual Review of the Human Rights Situation of Lesbian, Gay, Bisexual, Trans and Intersex People in Europe and Central Asia. 2022. Available online: <https://www.ilga-europe.org/annualreview/2022> (accessed on 3 November 2022).
16. Flores, A.R.; The Williams Institute. Social Acceptance of LGBTI People in 175 Countries and Locations 1981 to 2020. Available online: <https://williamsinstitute.law.ucla.edu/publications/global-acceptance-index-lgbt/> (accessed on 3 November 2022).
17. Chamber of Deputies. DDL 4 November 2020, Measures against Discrimination and Violence on the Basis of Sex, Gender, Sexual Orientation, Gender Identity, and Disability, n. 2005. Available online: <http://www.senato.it/leg/18/BGT/Schede/Ddliter/53457.htm#> (accessed on 3 November 2022).
18. Organisation for Economic Co-operation and Development (OECD). Society at a Glance 2019: OECD Social Indicators. OECD Publishing. Available online: [https://doi.org/10.1787/soc\\_glance-2019-en](https://doi.org/10.1787/soc_glance-2019-en) (accessed on 3 November 2022).
19. European Commission. Special Eurobarometer 493. Discrimination in the European Union. Directorate-General for Communication. 2019. Available online: <https://doi.org/10.2838/5155> (accessed on 3 November 2022).
20. Italian Constitutional Court. Sentence n. 180/2017. Available online: <https://www.cortecostituzionale.it/actionSchedaPronuncia.do?anno=2017&numero=180> (accessed on 26 November 2022).
21. Istituto Superiore di Sanità (ISS); Ufficio Nazionale Antidiscriminazioni Razziali—Presidenza del Consiglio dei Ministri (UNAR). Infotrans—Gender Identity Rights and Protection. 2020. Available online: <https://www.infotrans.it/> (accessed on 3 November 2022).
22. SIGIS. Il Percorso in Pillole. Available online: <https://www.sigis.info/mappametro/> (accessed on 4 November 2022).
23. Carpenter, M. The human rights of intersex people: Addressing harmful practices and rhetoric of change. *Reprod. Health Matters* **2016**, *24*, 74–84. [CrossRef]
24. Creighton, S.; Minto, C. Managing intersex. *BMJ* **2001**, *323*, 1264–1265. [CrossRef] [PubMed]
25. Minto, C.L.; Liao, L.M.; Woodhouse, C.R.; Ransley, P.G.; Creighton, S.M. The effect of clitoral surgery on sexual outcome in individuals who have intersex conditions with ambiguous genitalia: A cross-sectional study. *Lancet* **2003**, *361*, 1252–1257. [CrossRef] [PubMed]
26. Bauer, M.; Truffer, D.; Crocetti, D. Intersex human rights. *Int. J. Hum. Rights* **2019**, *24*, 724–749. [CrossRef]
27. Lebow, J.L. Family in the Age of COVID-19. *Fam. Process* **2020**, *59*, 309–312. [CrossRef]
28. Smith, S.K. Transgender and Gender Nonbinary Persons' Health and Well-Being: Reducing Minority Stress to Improve Well-Being. *Creat. Nurs.* **2020**, *26*, 88–95. [CrossRef]
29. Soigné, H.; Kriegel, L.; Dollmann, J. The impact of the COVID-19 pandemic on risk perceptions: Differences between ethnic groups in Germany. *Eur. Soc.* **2020**, *23*, S289–S306. [CrossRef]
30. Rothman, S.; Gunturu, S.; Korenis, P. The mental health impact of the COVID-19 epidemic on immigrants and racial and ethnic minorities. *QJM Int. J. Med.* **2020**, *113*, 779–782. [CrossRef] [PubMed]
31. Gouvernet, B.; Bonierbale, M. Bio-psychosocial study on the impact of the COVID-19 lockdown on depression and anxiety in a sample of 1753 French-speaking subjects. *Encephale* **2022**, *48*, 118–124. [CrossRef]
32. Peterson, Z.D.; Vaughan, E.L.; Carver, D.N. Sexual identity and psychological reactions to COVID-19. *Traumatology* **2021**, *27*, 6–13. [CrossRef]
33. Phillips Ii, G.; Felt, D.; Ruprecht, M.M.; Wang, X.; Xu, J.; Pérez-Bill, E.; Bagnarol, R.M.; Roth, J.; Curry, C.W.; Beach, L.B. Addressing the Disproportionate Impacts of the COVID-19 Pandemic on Sexual and Gender Minority Populations in the United States: Actions Toward Equity. *LGBT Health* **2020**, *7*, 279–282. [CrossRef]
34. Meyer, I.H. Minority Stress and Mental Health in Gay Men. *J. Health Soc. Behav.* **1995**, *36*, 38. [CrossRef] [PubMed]
35. Meyer, I.H. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychol. Bull.* **2003**, *129*, 674–697. [CrossRef] [PubMed]
36. Sanchez, T.H.; Zlotorzynska, M.; Rai, M.; Baral, S.D. Characterizing the impact of COVID-19 on men who have sex with men across the United States in April 2020. *AIDS Behav.* **2020**, *24*, 2024–2032. [CrossRef] [PubMed]
37. Silliman, C.R.I.; Bosk, E.A. Vulnerable Youth and the COVID-19 Pandemic. *Pediatrics* **2020**, *146*, e20201306. [CrossRef]
38. The Lancet HIV. Lockdown fears for key populations. *Lancet HIV* **2020**, *7*, e373. [CrossRef]
39. Salerno, J.P.; Devadas, J.; Pease, M.; Nketia, B.; Fish, J.N. Sexual and Gender Minority Stress Amid the COVID-19 Pandemic: Implications for LGBTQ Young Persons' Mental Health and Well-Being. *Public Health Rep.* **2020**, *135*, 721–727. [CrossRef]
40. Gato, J.; Barrientos, J.; Tasker, F.; Miscioscia, M.; Cerqueira-Santos, E.; Malmquist, A.; Seabra, D.; Leal, D.; Houghton, M.; Poli, M.; et al. Psychosocial effects of the COVID-19 pandemic and mental health among LGBTQ+ young adults: A cross-cultural comparison across six nations. *J. Homosex.* **2021**, *68*, 612–630. [CrossRef]
41. Malmquist, A.; Bredenberg, C.; Melin, J.; Wurm, M.; Tasker, F.; Gato, J. Queers in quarantine: Young LGBTQ+ people's experiences during the COVID-19 pandemic in Sweden. *Scand. J. Psychol.* **2022**. [CrossRef]
42. Gonzales, G.; de Mola, E.L.; Gavulic, K.A.; McKay, T.; Purcell, C. Mental health needs among lesbian, gay, bisexual, and transgender college students during the COVID-19 pandemic. *J. Adolesc. Health* **2020**, *67*, 645–648. [CrossRef]

43. Konnoth, C. Supporting LGBT communities in the COVID-19 pandemic. In *COVID-19 Policy Playbook: Legal Recommendations for a Safer, More Equitable Future*; Burriss, S., de Guia, S., Gable, L., Levin, D.E., Parmet, W.E., Terry, N.P., Eds.; Public Health Law Watch: Boston, MA, USA, 15 February 2021; Available online: <https://ssrn.com/abstract=3809468> (accessed on 15 February 2021).
44. Mattei, G.; Russo, T.; Addabbo, T.; Galeazzi, G.M. The COVID-19 recession might increase discriminating attitudes toward LGBT people and mental health problems due to minority stress. *Int. J. Soc. Psychiatry* **2021**, *67*, 400–401. [[CrossRef](#)] [[PubMed](#)]
45. Mirabella, M.; Senofonte, G.; Giovanardi, G.; Lingiardi, V.; Fortunato, A.; Lombardo, F.; Speranza, A.M. Psychological Well-Being of Trans\* People in Italy During the COVID-19 Pandemic: Critical Issues and Personal Experiences. *Sex Res. Social Policy* **2021**, 1–11. [[CrossRef](#)] [[PubMed](#)]
46. Diener, E. Subjective well-being: The science of happiness and a proposal for a national index. *Am. Psychol.* **2000**, *55*, 34–43. [[CrossRef](#)] [[PubMed](#)]
47. Erikson, E.H. *Youth: Fidelity and Diversity in Youth: Change & Challenge*; Basic Books, Inc.: New York, NY, USA, 1963; pp. 1–23.
48. Vleioras, G.; Bosma, H.A. Are identity styles important for psychological well-being? *J. Adolesc.* **2005**, *28*, 397–409. [[CrossRef](#)]
49. McCrae, R.R. Controlling neuroticism in the measurement of stress. *Stress Med.* **1990**, *6*, 237–241. [[CrossRef](#)]
50. Schmutte, P.S.; Ryff, C.D. Personality and well-being: Reexamining methods and meanings. *J. Pers. Soc. Psychol.* **1997**, *73*, 549–559. [[CrossRef](#)]
51. Lavasani, M.G.; Borhanzadeh, S.; Afzali, L.; Hejazi, E. The Relationship between Perceived Parenting Styles, Social Support with Psychological Well-Being. *Procedia Soc. Behav. Sci.* **2011**, *15*, 1852–1856. [[CrossRef](#)]
52. Shaw, D.S.; Criss, M.M.; Schonberg, M.A.; Beck, J.E. The Development of Family Hierarchies and Their Relation to Children's Conduct Problems. *Dev. Psychopathol.* **2004**, *16*, 483–500. [[CrossRef](#)]
53. Wickrama KA, S.; Lorenz, F.O.; Conger, R.D. Parental Support and Adolescent Physical Health Status: A Latent Growth-Curve Analysis. *J. Health Soc. Behav.* **1997**, *38*, 149–163. [[CrossRef](#)]
54. Carr, D. The Fulfillment of Career Dreams at Midlife: Does It Matter for Women's Mental Health? *J. Health Soc. Behav.* **1997**, *38*, 331–344. [[CrossRef](#)] [[PubMed](#)]
55. Lindfors, P.; Berntsson, L.; Lundberg, U. Total Workload as Related to Psychological Well-Being and Symptoms in Full-Time Employed Female and Male White-Collar Workers. *Int. J. Behav. Med.* **2006**, *13*, 131–137. [[CrossRef](#)] [[PubMed](#)]
56. Goldberg, L.R. The structure of phenotypic personality traits. *Am. Psychol.* **1993**, *48*, 26–34. [[CrossRef](#)]
57. McCrae, R.R.; Costa, P.T. Validation of the five-factor model of personality across instruments and observers. *J. Personal. Soc. Psychol.* **1987**, *52*, 81. [[CrossRef](#)] [[PubMed](#)]
58. Campbell-Sills, L.; Cohan, S.L.; Stein, M.B. Relationship of resilience to personality, coping, and psychiatric symptoms in young adults. *Behav. Res. Ther.* **2006**, *44*, 585–599. [[CrossRef](#)] [[PubMed](#)]
59. Komulainen, E.; Meskanen, K.; Lipsanen, J.; Lahti, J.M.; Jylhä, P.; Melartin, T.; Ekelund, J. The effect of personality on daily life emotional processes. *PLoS ONE* **2014**, *9*, e110907. [[CrossRef](#)]
60. Schneider, T.R. The role of neuroticism on psychological and physiological stress responses. *J. Exp. Soc. Psychol.* **2004**, *40*, 795–804. [[CrossRef](#)]
61. DeNeve, K.M.; Cooper, H. The happy personality: A meta-analysis of 137 personality traits and subjective well-being. *Psychol. Bull.* **1998**, *124*, 197. [[CrossRef](#)] [[PubMed](#)]
62. Hao, R.; Dong, H.; Zhang, R.; Li, P.; Zhang, P.; Hu, J.; Zhang, M. The relationship between neuroticism fit and general well-being: The mediating effect of psychological resilience. *Front. Psychol.* **2019**, *10*, 2219. [[CrossRef](#)]
63. Roelofs, J.; Huibers, M.; Peeters, F.; Arntz, A.; van Os, J. Rumination and Worrying as Possible Mediators in the Relation between Neuroticism and Symptoms of Depression and Anxiety in Clinically Depressed Individuals. *Behav. Res.* **2008**, *46*, 1283–1289. [[CrossRef](#)]
64. Sobol-Kwapinska, M. Calm down—It's only neuroticism. Time perspectives as moderators and mediators of the relationship between neuroticism and well-being. *Personal. Individ. Differ.* **2016**, *94*, 64–71. [[CrossRef](#)]
65. Liu, C.; Chen, L.; Chen, S. Influence of Neuroticism on Depressive Symptoms Among Chinese Adolescents: The Mediation Effects of Cognitive Emotion Regulation Strategies. *Front. Psychiatry* **2020**, *11*, 420. [[CrossRef](#)] [[PubMed](#)]
66. Wang, L.; Shi, Z.; Li, H. Neuroticism, Extraversion, Emotion Regulation, Negative Affect and Positive Affect: The Mediating Roles of Reappraisal and Suppression. *Soc. Behav. Personal. Int. J.* **2009**, *37*, 193–194. [[CrossRef](#)]
67. Trnka, R.; Čábelková, I. Neuroticism across cultures: Macro-level insights into the worldwide distribution of neuroticism. In *Neuroticism: Characteristics, Impact on Job Performance and Health Outcomes*; Di Fabio, A., Ed.; Nova Science Publishers: New York, NY, USA, 2016; pp. 161–185.
68. Widiger, T.A.; Mullins-Sweatt, S.N. Five-factor model of personality disorder: A proposal for DSM-V. *Annu. Rev. Clin. Psychol.* **2009**, *5*, 197–220. [[CrossRef](#)] [[PubMed](#)]
69. Dalton III, W.T.; Frick-Horbury, D.; Kitzmann, K.M. Young adults' retrospective reports of parenting by mothers and fathers: Associations with current relationship quality. *J. Gen. Psychol.* **2006**, *133*, 5–18. [[CrossRef](#)]
70. Levine, S. Psychological and social aspects of resilience: A synthesis of risks and resources. *Dialogues Clin. Neurosci.* **2003**, *5*, 273–280. [[CrossRef](#)]
71. Noble, T.; McGrath, H. Wellbeing and resilience in young people and the role of positive relationships. In *Positive Relationships*; Springer: Dordrecht, The Netherlands, 2012; pp. 17–33.
72. Masten, A.S. Ordinary magic: Resilience processes in development. *Am. Psychol.* **2001**, *56*, 227. [[CrossRef](#)]
73. Bonanno, G.A.; Wortman, C.B.; Nesse, R.M. Prospective patterns of resilience and maladjustment during widowhood. *Psychol. Aging* **2004**, *19*, 260. [[CrossRef](#)]

74. Masten, A.S. Ordinary magic: Lessons from research on resilience in human development. *Educ. Can.* **2009**, *49*, 28–32.
75. Connor, K.M.; Davidson, J.R. Development of a new resilience scale: The Connor-Davidson resilience scale (CD-RISC). *Depress. Anxiety* **2003**, *18*, 76–82. [[CrossRef](#)]
76. Neighmond, P. Home However, Not Safe, Some LGBTQ Young People Face Rejection From Families in Lockdown. NPR. Available online: <https://www.npr.org/sections/health-shots/2020/05/17/856090474/home-but-not-safe-some-lgbtq-young-people-face-rejection-from-families-in-lockdo?t=1630005639617> (accessed on 26 August 2021).
77. Gattamorta, K.; Salerno, J.P.; Roman Laporte, R. Family Rejection during COVID-19: Effects on Sexual and Gender Minority Stress and Mental Health among LGBTQ University Students. *LGBTQ+ Fam. Interdiscip. J.* **2022**, *18*, 1–14. [[CrossRef](#)]
78. Dishion, T.; Forgatch, M.; Chamberlain, P.; Pelham, W.E. The Oregon model of behavior family therapy: From intervention design to promoting large-scale system change. *Behav. Ther.* **2016**, *47*, 812–837. [[CrossRef](#)] [[PubMed](#)]
79. Fish, J.N.; McInroy, L.B.; Pacey, M.S.; Williams, N.D.; Henderson, S.; Levine, D.S.; Edsall, R.N. “I’m kinda stuck at home with unsupportive parents right now”: LGBTQ youths’ experiences with COVID-19 and the importance of online support. *J. Adolesc. Health* **2020**, *67*, 450–452. [[CrossRef](#)] [[PubMed](#)]
80. Suen, Y.T.; Chan, R.; Wong, E.M.Y. Effects of general and sexual minority-specific covid-19-related stressors on the mental health of lesbian, gay, and bisexual people in Hong Kong. *Psychiatry Res.* **2020**, *292*, 113365. [[CrossRef](#)] [[PubMed](#)]
81. McEwing, E. Delivering Culturally Competent Care to the Lesbian, Gay, Bisexual, And Transgender (LGBT) Population: Education for Nursing Students. *Nurse Educ. Today* **2020**, *94*, 104573. [[CrossRef](#)]
82. Lim, F.A.; Brown, D.V.; Justin Kim, S.M. Addressing Health Care Disparities in the Lesbian, Gay, Bisexual, and Transgender Population: A Review of Best Practices. *AJN Am. J. Nurs.* **2014**, *114*, 24–34. [[CrossRef](#)]
83. Barrientos, J.; Guzmán-González, M.; Urzúa, A.; Ulloa, F. Psychosocial impact of COVID-19 pandemic on LGBT people in Chile. *Sexologies* **2021**, *30*, e35–e41. [[CrossRef](#)]
84. Gato, J.; Leal, D.; Seabra, D. When home is not a safe haven: Effects of the COVID-19 pandemic on LGBTQ adolescents and young adults in Portugal. *Psicologia* **2020**, *34*, 89–100. [[CrossRef](#)]
85. Bojanowska, A.; Zalewska, A.M. Subjective well-being among teenagers of different ages: The role of emotional reactivity and social support from various sources. *Stud. Psychol.* **2011**, *49*, 5–21. [[CrossRef](#)]
86. Lynskey, M.T.; Fergusson, D.M. Factors protecting against the development of adjustment difficulties in young adults exposed to childhood sexual abuse. *Child Abus. Negl.* **1997**, *21*, 1177–1190. [[CrossRef](#)]
87. McCrae, R.R.; Costa, P.T., Jr.; Martin, T.A. The NEO-PI-3: A more readable Revised. NEO Personality Inventory. *J. Personal. Assess.* **2005**, *84*, 261–270. [[CrossRef](#)]
88. Fossati, L.; Ciancaleoni, M. *NEO-PI-3-NEO Personality Inventory-3 (Italian Validation)*; Hogrefe Editore: Firenze, Italy, 2014.
89. Costa, P.T.; McCrae, R.R. Four ways five factors are basic. *Pers. Individ. Dif.* **1992**, *13*, 653–665. [[CrossRef](#)]
90. Pala, A.N.; Dell’Amore, F.; Steca, P.; Clinton, L.; Sandfort, T.; Rael, C. Validation of the Minority Stress Scale among Italian gay and bisexual men. *Psychol. Sex. Orientat. Gend.* **2017**, *4*, 451–459.
91. Lovibond, S.H.; Lovibond, P.F. *Manual for the Depression Anxiety & Stress Scales*, 2nd ed.; Sydney, Psychology Foundation: Sydney, Australia, 1995.
92. Bottesi, G.; Ghisi, M.; Altoè, G.; Conforti, E.; Melli, G.; Sica, C. The Italian version of the Depression Anxiety Stress Scales-21: Factor structure and psychometric properties on community and clinical samples. *Compr. Psychiatry* **2015**, *60*, 170–181. [[CrossRef](#)] [[PubMed](#)]
93. R Core Team. *R: A Language and Environment for Statistical Computing (3.6.3)* [Computer software], R Foundation for Statistical Computing: Vienna, Austria. Available online: <https://www.r-project.org/> (accessed on 3 November 2022).
94. RStudio Team. *RStudio: Integrated Development for R (1.2.5033-1)* [Computer Software], RStudio, Inc.: Boston, MA, USA. Available online: <http://www.rstudio.com/> (accessed on 3 November 2022).
95. The Jamovi Project. *Jamovi (1.8.2)* [Computer Software]. Available online: <https://www.jamovi.org/> (accessed on 3 November 2022).
96. Snapp, S.D.; Watson, R.J.; Russell, S.T.; Diaz, R.M.; Ryan, C. Social support networks for LGBT young adults: Low cost strategies for positive adjustment. *Fam. Relat.* **2015**, *64*, 420–430. [[CrossRef](#)]
97. Testa, R.J.; Habarth, J.; Peta, J.; Balsam, K.; Bockting, W. Development of the gender minority stress and resilience measure. *Psychol. Sex. Orientat. Gend. Divers.* **2015**, *2*, 65–77. [[CrossRef](#)]
98. Scandurra, C.; Pennasilico, A.; Esposito, C.; Mezza, F.; Vitelli, R.; Bochicchio, V.; Maldonato, N.M.; Amodio, A.L. Minority Stress and Mental Health in Italian Bisexual People. *Soc. Sci.* **2020**, *9*, 46. [[CrossRef](#)]
99. Kelleher, C. Minority stress and health: Implications for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people. *Couns. Psychol. Q.* **2009**, *22*, 373–379. [[CrossRef](#)]
100. Mink, M.D.; Lindley, L.L.; Weinstein, A.A. Stress, Stigma, and Sexual Minority Status: The Intersectional Ecology Model of LGBTQ Health. *J. Gay Lesbian Soc. Serv.* **2014**, *26*, 502–521. [[CrossRef](#)]
101. Newcomb, M.E.; Mustanski, B. Internalized homophobia and internalizing mental health problems: A meta-analytic review. *Clin. Psychol. Rev.* **2010**, *30*, 1019–1029. [[CrossRef](#)]
102. Clarke, D. Neuroticism: Moderator or mediator in the relation between locus of control and depression? *Pers. Individ. Dif.* **2004**, *37*, 245–258. [[CrossRef](#)]
103. Calvo, V.; Cusinato, M.; Meneghet, N.; Miscioscia, M. Perceived Social Support Mediates the Negative Impact of Insecure Attachment Orientations on Internalized Homophobia in Gay Men. *J. Homosex.* **2021**, *13*, 2266–2284. [[CrossRef](#)] [[PubMed](#)]