

Race Differences in Personality and Affect Between Older White and Black Patients: an Exploratory Study

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Abstract

Objective There is limited research focusing on the five-factor model (FFM) of personality among diverse older adults, particularly cancer patient populations. This study aimed to examine the association of personality traits, positive and negative affect, and health in White and Black older adults receiving outpatient treatment for various cancer types.

Design Data were collected from 150 patients (123 White and 27 Black patients), with a mean age of 65.38 years ($SD=7.72$). Participants were surveyed on personality traits, affect, physical and mental functioning, and demographic characteristics.

Results Analyses showed no significant race differences in the FFM of personality. However, Black patients reported significantly higher positive affect than White patients. Results further indicated that higher positive affect and lower negative affect were significant predictors of higher mental functioning for White patients. Neuroticism predicted worse mental functioning (lower vitality, social functioning, emotions, and mental health) in Black patients but not for the White patients.

Conclusion These findings suggest associations among identified sociocultural factors, personality, affect, and health. These characteristics may ultimately influence health outcomes and symptom management across various patient populations.

Keywords Psychology · Cancer · Mental health · Race differences · Social factors

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Introduction

Nearly one in five US residents will be >65 years of age, with a projected increase to 85 million by 2050 [1]. With this increase in the number of older adults, it is similarly estimated that the percentage of all cancers diagnosed in older adults and those from diverse race and ethnic populations, in the USA, will increase from 61 to 70 and 21 to 28 %, respectively [2]. Despite these trends, older adults and minorities are underrepresented in cancer research, which can ultimately lead to disparities in treatment and outcomes.

Studies identifying various behavioral, social, and biological factors for race differences in cancer incidence, morbidity, and mortality show additional unmeasured individual factors as indicators possibly explaining these differences [3, 4]. Behavioral factors that have received little attention are the effect of personality and positive and negative affect on the physical and mental functioning among older cancer patients from diverse race populations.

Personality, Affect, and Health

The five-factor model (FFM; e.g., neuroticism, extraversion, conscientiousness, agreeableness, and openness to experience) provides a framework for personality and health psychology research [5, 6]. Just as personality domains have been characterized in terms of two dimensions (e.g., high/low neuroticism), so too has the affect domain been characterized in terms of two dimensions (positive and negative affect) [7]. A number of studies have established the association between the FFM of personality and positive and negative affect [7, 8]. Costa and McCrae [9] found that neuroticism predicted negative affect in everyday life, whereas extraversion predicted positive affect over a 10-year span. When combined, these two psychological measures can account for both temperament and trait-like responses to stressors [7].

Theories, such as the Biopsychosocial Interactional Theory, which suggests behaviors, physiological, and emotional responses, are based on individual predispositions (e.g., personality and affect) which may be influenced by social contextual factors [2]. These characteristic adaptations may influence the duration and/or intensity of physiological stress responses (coping), thereby impacting the onset and/or exacerbation of the disease (cancer) [2]. Previous studies have identified the FFM of personality and affect as independent predictors of physical and mental health functioning among cancer patient populations [10–13]. Yet, despite this growing literature, there is the lack of (race) diversity among study samples, particularly the inclusion of older minorities.

Race and Personality

The study of race differences in personality and affect is often based in the cross-cultural psychology domain and is frequently associated with the replication of findings in remote or exotic regions of the world [14, 15]. In the USA, little attention has been given to potential race differences by mainstream psychology and is primarily studied in industrial psychology literature. The few studies exploring race differences in personality and affect have suggested the FFM of personality, and positive and negative affect are similarly distributed among race groups [14–17]. However, race has been identified as a predictor for a multiple psychological (e.g., depression and life satisfaction) [18, 19] and physical (e.g., hypertension) ailments among older adults as well as an indicator of reported health disparities [20, 21].

A systematic review of studies examining the relationship between personality and race among older cancer patients was conducted between 2000 to 2013 using PUBMED, PsychInfo, and MEDLINE databases. Search terms included *personality*, *five-factor model*, *ten-item personality inventory*, *affect* in combination with either *cancer*, *cancer patient(s)*, *older adult(s)*, *elderly*, *race*, and *race differences*. Results of this extensive literature search found only three studies that examined personality traits among cancer patients [22–24]. Findings from these studies were limited by: the lack of consistency in how personality was defined (not based on the FFM), wide range in patients' ages, and a lack of inclusion of diverse race groups to explore personality traits. To the authors' knowledge, no studies have assessed the association between age, race, personality, and physical and mental functioning in a sample of older cancer outpatients with varied malignancies.

This is the first paper to specifically focus on race differences on personality, affect, and the mental and physical health of older Black and White cancer patients. The primary objectives of this study were to examine similarities and differences of the FFM of personality traits and positive and negative affect between older Black and White adults receiving outpatient services, and determine the impact of specific

personality traits and positive and negative affect on the physical and mental functioning of these older adults. The cross-sectional methodological design of this exploratory investigation is important as this research has not been done among this patient population.

Methods

Participants

Data were analyzed from a multiyear study designed to examine data on psychosocial, behavioral, and cultural indicators on health among White ($n=123$) and Black patients ($n=27$) patients receiving outpatient treatment services at a National Cancer Institute-Designated Comprehensive Cancer Center. Analyses were conducted on patients who self-identified as White or Black, ≥ 55 years of age, had a pathologic diagnosis of cancer, experienced cancer-related pain for most days within the past 30 days and/or have a history of pain within the past 6 months, able to provide informed consent, and able to read and understand English. Patients who enrolled in a cancer-pain intervention or nonpharmacologic intervention within the past year, reported pain due to chronic medical condition (e.g., arthritis and diabetes) other than cancer-related pain were excluded from study participation. Data were collected through patient interviews on measures assessing personality traits, physical and mental functioning, and behavioral outcomes. This investigation was approved by the cancer center's Protocol Review Monitoring Committee and the university's Institutional Review Board (IRB).

Recruitment and Interview Process

Recruitment efforts and interviews were conducted among patients receiving treatment at the Psychosocial and Palliative Care, Clinical Research, or Infusion clinics at the cancer center. All patients were approached (and recruited) by a research assistant, during the patient's medical visit (waiting area or receiving chemotherapy), to determine their interest and eligibility for study participation. All interviews consisted of participants completing a series of questions assessing personality, pain, health, behavioral, social, and demographic characteristics. Each interview lasted approximately 45 min and was conducted in a private area in the clinic. Respondents were compensated for their participation in the study.

Measures

Personality The Ten-Item Personality Inventory (TIPI) contains two items for each of the FFM dimensions (neuroticism, extraversion, openness to experience, conscientiousness, and

agreeableness). Participants are asked to indicate the extent to which they agree or disagree with the ten statements, with one item representing each pole of the FFM dimensions. Items used a 7-point scale ranging from 1 = disagree strongly to 7 = agree strongly. Items are “extraverted, enthusiastic” and “reserved, quiet” (reversed) for extraversion, “sympathetic, warm” and “critical, quarrelsome” (reversed) for agreeableness, “dependable, self-disciplined” and “disorganized, careless” (reversed) for conscientiousness, “calm, emotionally stable” and “anxious, easily upset” (reversed) for neuroticism, and “open to new experiences, complex” and “conventional, uncreative” (reversed) for openness to experience. Scores are averaged for each factor of the FFM, with higher scores indicating stronger affirmation of the personality dimension (high scores indicate agree strongly = 7, low scores indicate strongly disagree = 1) [25]. Reliability and validity: coefficient alpha estimates of internal reliability were 0.72 for the five dimensions (ranging from 0.62 to 0.82) [25, 26]. Estimates of internal consistency in the present study returned low rates: extraversion (Cronbach’s $\alpha=0.67$), agreeableness ($\alpha=.16$), conscientiousness ($\alpha=0.63$), neuroticism ($\alpha=.43$), and openness ($\alpha=0.36$), reflecting the limited number of items making up the subscales. The TIPI has been validated in older adults [26], older cancer patients [27], and racially diverse samples [25].

Affect The Positive and Negative Affect Scale (PANAS) is a 20-item measure designed to assess self-reported mood states on two dimensions: positive and negative affect [7]. Each PANAS subscale (positive and negative) comprises of ten mood-related adjectives, assessed on a 5-point Likert-type scale (1 = very slightly or not at all to 5 = extremely), to determine the extent to which the patient has felt a certain emotion during the past month. Sample items from the PANAS are “enthusiastic” (positive affect) and “ashamed” (negative affect). Summed scores for each subscale were determined with higher scores for both the positive and negative affect indicating more of that mood state [7]. Reliability and validity: Cronbach’s alpha coefficients for various time reference periods range from 0.86 to 0.90 for the Positive Affect scale and 0.84 to 0.87 for the Negative Affect scale [7, 28]. Reliability analysis of the current study found Cronbach’s alpha for the Positive Affect and Negative Affect scales are 0.86 and 0.85, respectively. The PANAS has been validated in older adult [29], cancer patient [8, 30], and racially diverse [31, 32] study samples.

Health Variables The Medical Outcomes Study 12-Item Short-Form Health Survey (SF-12) is a 12-item questionnaire designed to assess eight dimensions of health: physical functioning, role physical, bodily pain, general health, vitality, social functioning, role emotional, and mental health [33]. For purposes of this investigation, two subscales, Physical

Component Summary score (PCS; physical functioning, role physical, bodily pain, and general health) and Mental Component Summary score (MCS; vitality, social functioning, role emotional, and mental health), were used to measure components of physical and mental functioning. Summed scores for each subscale were determined with higher scores indicating better physical and mental functioning. Reliability and validity: The SF-12 has good test–retest reliability (coefficients for subscales ranged from 0.67 to 0.89) [33]. In the current sample, coefficient alpha estimates of internal reliability are 0.84 for the PCS and 0.81 for the MCS.

A checklist of physical comorbidities assessed the presence of common medical illnesses (e.g., arthritis and diabetes mellitus) and symptoms. Type of cancer was similarly assessed with a single-item question asking participants the type of cancer doctor diagnosed with.

Demographic Characteristics Age was scored in a continuous format. Sex was treated as a dichotomous variable (male and female). Race was assessed via five nominal categories (White/Caucasian, Black/African American, Hispanic/Non-Caucasian, Asian/Pacific Islander, and other). While it is recognized that the term Black is a social construct to define race, and African American as an ethnic group within the Black race, the terms were combined as they are often used interchangeably with distinction made between the two. Therefore, those who self-identified as either Black or African American were included for study participation. This was similarly applicable to participants who self-identified as either Caucasian or White. Marital status included six nominal response choices: married, living as married, separated, divorced, single/never married, and widowed. Education was measured in a categorical format (<high school; \geq high school).

Analyses

Data analyses ($N=150$) were conducted in several steps. Descriptive analyses were calculated to provide a profile of the sample’s demographic (age, race, sex, education, and marital status), personality, affect, and clinical (type of cancer, number of chronic conditions, mental, and physical functioning) characteristics. A series of Spearman correlation coefficients ($p \leq 0.002$, given the number of comparisons) were calculated to determine the strength of the bivariate associations between the demographic, personality, affect, and clinical variables.

Given the small sample size of Black patients, Mann-Whitney U tests were calculated to determine differences in personality and affect variables between the Black and White patients.

Hierarchical linear regression analyses were calculated to determine if personality and affect predict physical and mental functioning while controlling for demographic and clinical

variables. Significant predictors of mental functioning were calculated after controlling for demographic and clinical variables. In step 1, age, sex, marital status, and education were added. The number of chronic conditions and type of cancer were added in step 2. The personality variables were added in step 3, with negative and positive affect included in step 4 of the model. Post-hoc analyses revealed the statistical power for this study was 0.87 for detecting a small effect, whereas the power exceeded 0.99 for the detection of a moderate to large effect size. Thus, there was more than adequate power (i.e., power ≥ 0.80) at all effect size levels. All analyses were performed using IBM SPSS Statistics 21.0.

Results

Demographic and Health Characteristics by Race

The sample consisted of older Black and White patients ($N=150$), with a mean age of 65.4 years ($SD=7.7$). More than half of the sample was female. The majority of participants (Black and White) had at least a 12th-grade education. Black patients were less likely to be married (45 %) than Whites (68 %). Breast, hematologic, and lung cancers were the most common diagnoses for both race groups. Black patients reported living with more chronic medical illnesses (in addition to the cancer diagnosis) than White patients. Other demographic and health characteristics are provided in Table 1.

Table 1 Demographic and clinical characteristics by race ($N=150$)

Variable	White ($n=123$) M \pm SD or n (%)	Black ($n=27$) M \pm SD or n (%)
Age	65.93 \pm 7.6	62.89 \pm 7.9
Sex (% female)	68 (55)	18 (67)
Marital status		
Married	83 (67.5)	12 (44.5)
Separated/divorced/widowed	33 (26.8)	9 (33.3)
Single	7 (5.7)	6 (22.2)
Education		
Less than high school	7 (5.6)	3 (11.1)
High school	24 (19.6)	7 (25.9)
Some college	45 (36.6)	9 (33.3)
College graduate/graduate degree	47 (38.3)	8 (29.6)
Health characteristics		
Self-reported health as “fair” or “poor”	53 (30.2)	12 (43.4)
Number of chronic conditions	2.6 \pm 2.2	3.1 \pm 2.1
Physical functioning (PCS)	30.2 \pm 9.4	32.0 \pm 10.7
Mental functioning (MCS)	47.3 \pm 11.4	48.8 \pm 12.7

Personality Traits by Race

Black and White patients reported comparable TIPI mean scores measuring the FFM of personality (Cohen's $d=0.21$). For Whites, openness to experience was the highest rated with a mean score of 4.56 \pm 1.18. Extraversion was the second highest reported personality trait followed by neuroticism, conscientiousness, and agreeableness. For Blacks, extraversion was the highest rated with a score of 4.88 \pm 1.31. Openness to experience was the second highest reported personality trait followed by agreeableness, neuroticism, and conscientiousness. No significant race differences were found for the individual personality traits.

Affect by Race

Black patients reported significantly higher positive affect than Whites ($U=1,109.5$, $p=0.02$). No significant race differences were found in reported negative affect between the race groups ($U=1,555$, $p=0.98$). An additional U test was calculated to determine possible significant race differences in specific items of positive affect. Table 2 shows that Black patients reported significantly higher presence of being excited, alert, inspired, determined, and attentive than Whites.

Hierarchical Linear Regressions

Significant predictors of physical and mental functioning for both race groups were calculated after controlling for important covariates (age, sex, education, marital status, number of chronic conditions, and type of cancer). As shown in Table 3, higher positive affect ($\beta=0.19$; 95 % CI=0.01 to 0.58; $p<0.05$) and lower negative affect ($\beta=-0.39$, 95 % CI=-0.99 to -0.35; $p<0.001$) were significant predictors of higher

Table 2 Positive affect items by race ($N=150$)

Variable	White ($n=123$) M \pm SD	Black ($n=27$) M \pm SD	p value ^b
Interested ^a	2.94 \pm 1.03	3.12 \pm 1.18	0.25
Excited	1.52 \pm 1.21	2.19 \pm 1.63	0.04*
Strong	2.67 \pm 1.17	2.88 \pm 1.31	0.28
Enthusiastic	2.28 \pm 1.22	2.58 \pm 1.45	0.18
Proud	2.49 \pm 1.36	2.92 \pm 1.55	0.07
Alert	2.80 \pm 1.01	3.31 \pm 1.01	<0.01*
Inspired	1.96 \pm 1.17	2.85 \pm 1.52	<0.001*
Determined	2.96 \pm 1.00	3.19 \pm 1.10	<0.01*
Attentive	2.74 \pm 0.95	3.19 \pm 1.02	0.01*
Active	2.25 \pm 1.27	2.08 \pm 1.44	0.53

^a Positive Affect Scale: 0 = very little or not at all to 4 = extremely

^b Statistical significance based on Mann-Whitney U test

Table 3 Summary of hierarchical analysis for variables predicting White patients’ mental health (N=127)

Variable	Model 1			Model 2			Model 3			Model 4		
	<i>B</i>	SE <i>B</i>	β	<i>B</i>	SE <i>B</i>	β	<i>B</i>	SE <i>B</i>	β	<i>B</i>	SE <i>B</i>	β
Age	0.32	0.15	0.21*	0.39	0.15	0.25*	0.36	0.15	0.23*	0.25	0.14	0.16
Gender	0.22	2.38	0.01	0.66	2.35	0.03	2.84	2.44	0.12	3.48	2.19	0.15
Marital status	-0.26	0.68	-0.04	-0.45	0.67	-0.07	-0.76	0.67	-0.12	-0.78	0.60	-0.12
Education	-0.27	0.52	-0.05	-0.56	0.53	-0.11	-0.47	0.53	-0.09	-0.44	0.48	-0.09
Comorbidities				-0.74	0.50	-0.15	-0.64	0.52	-0.13	-0.36	0.47	-0.07
Type of cancer				0.41	0.21	0.19*	0.26	0.22	0.19	0.14	0.20	0.07
Extraversion							2.35	0.95	0.26*	1.24	0.89	0.14
Agreeableness							-0.92	1.13	-0.08	-1.18	1.03	-0.10
Conscientiousness							-0.08	1.32	-0.01	-0.28	1.20	-0.02
Neuroticism							-1.88	1.15	-0.17	-0.61	1.06	-0.06
Openness to experience							-1.04	0.99	-0.11	-1.25	0.91	-0.13
Positive affect										0.23	0.14	0.19*
Negative affect										-0.67	0.16	-0.39***
<i>R</i> ²	0.05			0.11			0.18			0.35		
<i>F</i> for change in <i>R</i> ²	1.25			3.37*			1.73			12.44*		

mental functioning for White patients ($F(13, 94)=3.92, p<0.001$). None of FFM of personality traits were significant predictors of higher mental functioning among the White sample. For Blacks, lower neuroticism ($\beta=-0.74, 95\% \text{ CI}=-18.48 \text{ to } -2.47; p<0.05$) was a significant predictor of higher mental functioning ($F(13, 10)=3.71, p<0.05$). Being female ($p=0.055$) and higher positive affect ($p=0.054$) were marginally significant predictors of higher mental functioning in Black patients (Table 4). There were no significant predictors of physical functioning for either race group.

Discussion

This study examined possible race differences on the FFM of personality traits (neuroticism, extraversion, conscientiousness, agreeableness, and openness to experience) and affect among older Black and White cancer patients. This research is significant in that it is the first, to our knowledge, to examine race group differences in personality characteristics and affect among a sample of older cancer patients. Results showed similarities and differences in personality and affect among the two race groups. The potential impact of personality and positive and negative affect on the physical and mental functioning were similarly examined, with findings indicating that affect and personality, specifically neuroticism, affects the mental functioning of the older adults with cancer, supporting the Biopsychosocial Interactional Theory.

Race Differences in Personality

Data showed no significant group differences in the FFM of personality traits. These results corroborate with prior research showing no race differences in FFM of personality [14, 16, 17, 34]. Yet, considering the sample was relatively homogenous with regards to race may explain the lack of significant race differences in the FFM. This may support Costa and McCrae’s theory that personality trait structure, at the dimension level, is a universal construct among varying race groups [14]. Although encouraging, additional exploration of personality on a facet level (subdomain of each personality trait) would be advantageous in identifying possible race group differences. Lastly, assessing personality through other personality measures such as positive and negative affect may help to identify race differences in particular facets of personality.

Race Differences in Positive Affect

Results showed significant group differences in positive affect, with Black patients reporting significantly higher excitement, attentiveness, alertness, determination, and inspiration than Whites. Data on race differences in affect have shown mixed results. Several studies have found no significant differences in positive affect, while other data show Blacks reporting greater positive affect than Whites [31, 35]. These differences may be the result of some older Blacks having better external (social support) and internal (resiliency) resources than their White counterparts. Social support, as a positive resource system, may explain why Black patients

Table 4 Summary of hierarchical analysis for variables predicting Black patients' mental health ($N=27$)

Variable	Model 1			Model 2			Model 3			Model 4		
	<i>B</i>	SE <i>B</i>	β	<i>B</i>	SE <i>B</i>	β	<i>B</i>	SE <i>B</i>	β	<i>B</i>	SE <i>B</i>	β
Age	0.81	0.34	0.46*	0.81	0.33	0.46*	0.68	0.30	0.38*	0.39	0.28	0.22
Gender	7.14	5.10	0.27	10.22	5.28	0.39	12.70	4.56	0.49*	9.00	4.14	0.34
Marital status	0.21	1.37	0.03	-1.05	1.5	-0.15	-1.28	1.89	-0.18	0.47	1.74	0.07
Education	-.59	0.95	-0.12	-0.30	1.00	-0.06	-0.67	0.87	-0.14	-0.24	0.89	-0.05
Comorbidities				-2.49	1.43	-0.38	-2.74	1.62	-0.42	-1.46	1.59	-0.22
Type of cancer				-0.21	0.44	-0.09	-0.43	0.45	-0.19	0.22	0.39	-0.10
Extraversion							4.22	2.16	0.43	-0.52	2.61	-0.05
Agreeableness							-3.83	1.98	-0.32	2.73	3.51	0.23
Conscientiousness							1.31	3.37	0.08	2.92	3.13	0.18
Neuroticism							-6.01	2.85	-0.42*	-10.47	3.59	-0.74*
Openness to experience							-4.12	2.52	-0.38	-0.28	2.71	-0.03
Positive affect										1.64	0.75	1.18
Negative affect										1.43	0.96	0.74
R^2	0.34			0.44			0.72			0.83		
<i>F</i> for change in R^2	2.39			1.62			2.29			3.31		

reported higher positive affect than White patients. This support may involve greater frequency, a larger social (of contacts) and (positive) supportive network of fictive kin (unrelated individuals who have an emotional closeness similar to a family member) than Whites.

Social support may also provide a protective effect from the lack of material resources and subsequent psychological stress. This “buffering hypothesis” can be applied to this study’s sample of older cancer patients. Studies exploring social support given to the sick and elderly, particularly among older racial minorities, have regularly reported large amounts of tangible support from their social support network [36–38]. As a result, this type of social support despite the lack of material resources may moderate stress effects and have positive physical implications for the patient [36].

In addition to social support, Black patients may have reported higher positive affect due to better coping skills. The concept of John Henryism shows a strong behavioral predisposition of some Black patients to actively cope with a lifetime of inequality from the Jim Crow era to the present discrimination and racial segregation in the USA [39, 40]. While this may not be applicable to all Blacks, there is the notion the cumulative inequality experienced by some minorities throughout their lifespan may foster a profound internal strength and unwavering support system. Furthermore, this coping mechanism may be attributed to the crossover phenomenon, where an older minority embodies a combination of genetic heartiness, psychological strength, and successful coping skills [41]. These strengths may diminish the negative impact of cancer and aging thus resulting in higher positive affect among Black patients.

Predictors of Mental Functioning

Finding the association between positive and negative affect and personality is consistent with prior research showing the association with affect being associated with fewer reported symptoms and better self-reported health among cancer patients [8, 30]. This and other studies have shown an inverse association between high neuroticism and lower mental functioning of cancer patients [8, 11]. Of interest was the finding that neuroticism predicted worse mental functioning (lower vitality, social functioning, emotions, and mental health) in Black patients only. This finding suggests that focusing on particular traits distinctive by race group may provide direction in clinical efforts addressing the mental functioning (and outcomes) of older cancer patients, particularly those from diverse race populations.

Limitations

Although the study demonstrated significant findings regarding personality traits and affect among older Black and White cancer patients, there were some limitations that must be acknowledged. First, the small sample of Black patients is a limitation. However, this study aimed to include non-White participants and to initiate dialogue on race differences in personality and affect. Second, this was a cross-sectional study therefore changes over time in personality could not be determined. Furthermore, personality was measured after diagnosis. Although personality traits should theoretically be consistent over time, possible changes in personality triggered by a diagnosis of cancer, such as higher neuroticism and lower

positive affect, may occur [42]. It would have been useful to have an assessment of personality traits prior to (cancer) diagnosis to control for any possible changes post-diagnosis. Additionally, measuring intra-individual variations in personality through repeated measures may have resulted in more accurate reported personality traits. Another limitation is the small amount of variance accounted for in the regression models. Additional factors such as social support, depression, and prognosis should therefore be considered in the prediction of physical and mental functioning. Finally, there was concern of the psychometric integrity including low reliability with shortened measures of personality (i.e., TIPI). Furthermore, the data was collected by self-report and not verified by patient medical records resulting in potential reporting bias such as social desirability.

This is the first study, to our knowledge, that examined personality among a sample of older Black adults with cancer. While findings are exclusive to this study, our sample was not diverse with regards to other race groups. Because the majority of the sample was White and well-educated, our ability to generalize the findings to other cancer patient populations is limited. In addition, this sample may not be representative of Black and White older adults with cancer. However, the representativeness of the sample was enhanced because participants were recruited at random and from a large comprehensive cancer center. Finally, the selection criteria for study participation included all cancer types. Therefore, these results cannot necessarily be generalized to studies focusing on a specific cancer diagnosis. This limitation can, however be viewed as a strength in that the study explored the personality traits of a diverse sample (regarding diagnosis) of older cancer patients.

Conclusions

Research on the FFM of personality and affect among older cancer patients, particularly older minority patients is limited. This exploratory study is unique in that it includes a sample of older Black, although small, cancer patients, a population that has historically been excluded from personality research. Given the increase of the older adult population, older minority population, and cancer incidence within these populations, this research is timely. Findings from this study warrant further exploration of the influence personality has on the lived experiences of older cancer patients from diverse racial groups, and to address a gap in the literature that has focused primarily on younger White individuals with cancer. Future studies should include Hispanic and Asian participants in addition to including a more representative sample of Black participants. Studying older racially diverse patients will provide important (data) information on those whom are most at risk for a cancer diagnosis.

Clinical Implications

Findings from this study have several implications for clinical practice. First, they highlight the importance of addressing individual factors, such as personality and affect that may impede optimal symptom management, while improving overall quality of life. Recognizing the influence personality characteristics have in health outcomes allows clinicians and researchers to identify patient behaviors that may lead to informed preventive strategies, intervention methods, and policy initiatives.

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Conflict of Interest Dr. Krok and Dr. Baker declare that they have no conflict of interest.

Informed Consent All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all patients for being included in the study.

Animal or Human Studies Disclosure No animal or human studies were carried out by the authors for this article.

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