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When (passive) acceptance hurts: Race-based coping moderates the association between racial discrimination and mental health outcomes among Black Americans

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Abstract

There is growing evidence that general coping plays a role in the degree to which racial discrimination is associated with mental health symptoms (e.g., posttraumatic stress, depressive symptoms) for people of color. Relatively less is known about the role that race-based coping may play in the associations between racial discrimination and mental health for Black Americans.

Objective: In this study, we examined whether posttraumatic stress and depressive symptoms differed based on race-based coping style and tested whether these responses moderated associations between racial discrimination and posttraumatic stress.

Method: Black American adults (n=401; 56.1% women, $\bar{x}$ age=44.02) were recruited from a community hospital setting. Based on a measure assessing race-based coping style, participants were classified as having either a passive, moderate, or active response style.

Results: First, we found that posttraumatic stress (F=5.56, p<.01) and depressive (F=4.49, p=.01) symptom severity differed based on race-based coping classification, with more severe symptoms found for the passive vs. active group. Second, we found that race-based coping moderated racial discrimination's associations with posttraumatic stress (R^2 =.02, F=4.08, p=.02) and depressive (R^2 =.02, F=3.26, p=.04) symptoms such that the associations between racial discrimination and symptom severity were only significant for the passive and moderate (but not active) groups.

Conclusions: These results suggest that for Black Americans, coping with racism actively (vs. passively) may buffer the association between racial discrimination and psychological symptom severity.

Keywords

posttraumatic stress; depression; racial discrimination; coping; Black American mental health

A growing body of work has begun to examine the role of coping as a factor that may mitigate or exacerbate associations between racial discrimination and mental health in racial

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minorities (Brondolo et al., 2009). Based on theories of stress and coping (Clark et al., 1999; Lazarus, 1966), the rationale for this work rests on the premise that how individuals respond to general stress (e.g., using active or passive strategies) may play a role in the degree to which they experience subsequent psychological distress. Although comprehensive reviews of discrimination and associated variables have found some support for active (vs. passive) coping serving as a buffer in the association between discrimination and mental health, many studies find null or contradictory results (DeLapp & Williams, 2019; Pascoe & Smart Richman, 2009). One factor that may be contributing to the largely null findings is that the majority of the included measures assessed coping in response to general (i.e., race and non-race-based) stressors. However, racial discrimination is theorized to be a particularly pernicious stressor in part because it is a complex phenomenon that occurs in a larger, sociopolitical context (Brondolo et al., 2009). As opposed to non-race-based stressors, responding to race-based unfair treatment may require unique considerations (e.g., social consequences of speaking out) to determine the utility of using active or passive coping approaches.

There is considerable theoretical support for the idea that active race-based coping (e.g., taking action against injustice) may be associated with better outcomes. Based on critical consciousness theory (Freire, 1970), and consistent with theories of racial identity development (Cross & Vandiver, 2001), scholars theorize that being able to critically examine social factors contributing to one's conditions is necessary for meaningful change to occur (Jemal, 2017). Thus, actively working to dismantle racial hierarchies is considered a necessary part of one's liberation and wellbeing (Gilster, 2012). In line with this, Forsyth and Carter (2014) found that empowered action responses to discrimination (e.g., organizing a protest) were associated with less psychological symptoms, whereas more passive approaches (e.g., telling self it was not that bad, avoiding White people) were associated with more distress. Similarly, Utsey et al. (2000) found that using avoidant strategies to cope with racism was associated with lower self-esteem and life satisfaction in a sample of Black students. Although there is support for the protective role of active behavioral coping, results in the literature have been somewhat inconsistent. For example, Wei et al. (2010) found that for Black Americans, responding to discrimination using active advocacy strategies (e.g., doing something to try to stop discrimination) was associated with higher self-esteem, but not associated with depression. In line with this, Utsey et al. (2000) found that using problem-focused strategies was not associated with life satisfaction. One potential reason for the inconsistent findings is the benefits or risks of certain behavioral responses to unfair treatment may differ by context. For example, in the context of low community or social support, engagement in anti-racist activity may confer greater risk for racial battle fatigue (i.e., exhaustion related to being confronted with chronic racial stress; Smith et al., 2016). Thus, it may be important to also take into consideration other forms of active race-based coping, such as seeking social support.

Community and connectedness have been noted as particularly important cultural values for many Black Americans (Baldwin & Hopkins, 1990). In line with this, previous work has found that more passive (versus active) responding to unfair treatment, including not disclosing discrimination, was associated with significant higher odds of various psychiatric disorders (McLaughlin et al., 2010) and more severe dissociative symptoms (Polanco-

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Roman et al., 2016). Subsequently, engaging with others in the face of racial discrimination has been theorized to be protective vis-à-vis its placement of the discriminatory event in a cultural context (Grills et al., 2016; Harrell, 2000). Indeed, there is some qualitative support for the idea that discussing racist incidents can be helpful (e.g., Hudson et al., 2016; Swim et al., 2003). In terms of buffering effects of general coping (i.e., not specifically in race-based coping), Gaylord-Harden and Cunningham (2009) found that communalistic coping was associated with higher anxiety in the face of racial discrimination, while emotional debriefing or spiritually-centered coping had no moderating effects. Thus, although there is some preliminary qualitative and theoretical support for active coping strategies serving as a buffer in the association between mental health and well-being, empirical research is mixed and has yet to support these findings regarding race-specific coping in Black adults (e.g., Seaton et al., 2014).

Although it may seem counterintuitive, speaking out about racism may have negative consequences, including unique consequences that differ based on the racial context and timing. As noted by Noh et al. (1999), forbearance regarding the discussion of racism experiences may reduce distress by reducing the frequency of direct hostilities. For example, given known differences in White and Black individuals' awareness of racism (Carter & Murphy, 2015) speaking out about racism may lead to invalidation and subsequent racial tension (Sue et al., 2007). Doing so may also be perceived as a violation of expectations of strength and resilience in the face of stress (e.g., John Henryism, Strong Black Womanhood; Hudson et al., 2016; Watson & Hunter, 2015). Furthermore, as articulated by Utsey et al. (2000), it is possible that discussing racially discriminatory experiences may confer greater risk to psychological distress, as individuals may engage in ineffective co-rumination (Carlucci et al., 2018). Thus, passive social strategies may be counterintuitively effective in certain contexts.

Taken together, there are mixed findings in the research literature about the degree to which active (e.g., doing something about discrimination, talking to others) and passive (e.g., accepting discrimination, keeping it to oneself) race-based coping styles are differentially associated with psychological outcomes and whether they buffer the effect of racial discrimination on symptoms. Examining psychological symptoms that Black Americans are more likely to experience with higher severity and chronicity, including posttraumatic stress (Benítez et al., 2014) and depressive symptoms (González et al., 2010), is particularly important. Furthermore, given that most studies on race-based coping use youth or college samples (Brandolo et al., 2009), it is necessary to examine these associations among adult community populations. Doing so contributes to representation of diverse samples of Black Americans in clinical science research (Polo et al., 2018) and increases our ability to develop culturally informed etiological theories of psychopathology integrating race-related coping (Neblett, 2019).

Thus, to address notable gaps in the literature in a community sample of Black Americans, we conducted this study to answer two questions: a) Does race-based coping predict differences in severity of posttraumatic stress and depressive symptoms? and b) Does race-based coping buffer associations between racial discrimination frequency and symptom severity? Because our sample consisted of older, mostly lower-SES Black adults, who,

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in addition to discrimination, have experienced considerable general stress and trauma, we hypothesized that having an active response style would be associated with lower symptomology and that it would buffer associations between racial discrimination frequency and symptoms. Specifically, we predicted that even accounting for traumatic experiences, the magnitude of associations between racial discrimination and symptoms would be smaller for individuals with active (versus passive) response styles.

Method

Procedure

Participants were recruited from waiting rooms of a publicly funded hospital in Atlanta, GA as part of a larger study on the risk factors for the development of posttraumatic stress risk factors (see Gillespie et al., 2009 for additional details regarding study procedures). Data were collected from January 2006 through August 2008. Recruitment was not narrowed down to specific criteria and individuals were approached by trained research assistants without regard for any phenotypic criteria. To be eligible for participation, subjects had to be at least 18 years old and able to give informed consent. After signing the informed consent form, a 45- to 60-minute interview was administered with questionnaires regarding trauma history and psychological variables. Participants received $15 to compensate them for their time. All study procedures were approved by the Emory University and Grady Health System institutional review boards and were carried out in accordance with the provisions of the World Medical Association Declaration of Helsinki.

Participants

The current sample included 401 adults (56.1% women) who identified as Black or African American and ranged from 18 to 78 years old ($M = 44.35$, $SD = 13.01$). In terms of education, 22.2% reported obtaining less than a high school education, 43.9% reported completing high school or obtaining a GED, and 33.2% reported completing additional education beyond high school. In terms of income, 41.9% reported an income of less than $500/month, 25.2% reported an income of less than $999/month, and 29.9% reported an income of $1000 or more per month. About half (48%) of participants reported being employed, 28.6% reported receiving assistance due to a disability, and 23.4% reported being unemployed. On average, participants reported experiencing 3.30 ($SD = 2.34$) different types of traumatic events (e.g., sexual assault, natural disaster, exposure to violence) and 3.05 ($SD = 2.65$) types of racism-related incidents.

Measures

Demographic information, including sex, age, race and ethnicity, education, employment and income was assessed using an internally-developed form.

Experiences of Discrimination (EOD; Krieger et al., 2005).—The EOD is a psychometrically validated measure of experiences of discrimination originally developed in the context of a large, public health study examining a racially diverse community sample of adults. We used two subscales of the EOD that assess frequency of experiencing racial discrimination and response to unfair treatment. For frequency, participants were first

asked, “Have you ever experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior in any of the following situations because of your race, ethnicity, or color?” and then instructed to indicate the frequency of experiencing discrimination regarding nine different situations (e.g., school, work) using a scale of *0* (never) to *3* (four or more times). This measure had high internal consistency in our sample (α = .84).

To assess race-based coping using the response to unfair treatment subscale of the EOD, participants were asked two dichotomously scored questions. The instruction was, “If you feel you have been treated unfairly, do you usually…” and for the first item, participants were asked to choose between the choices “accept it as a fact of life” or “try to do something about it,” and in the second item, they were asked to choose between the choices of “talk to other people about it” or “keep it to yourself.” Based on their responses to these items, participants were classified as either: passive (accept it and do not talk about it; 12.4% of sample), moderate (either accept it and talk about it or do something and not talk about it; 37.1% of sample), or active (do something and talk about it 50.5% of sample).

Modified Posttraumatic Stress Disorder Symptom Scale (mPSS; Coffey et al., 1998).—The mPSS is a 17-item measure used to assess posttraumatic stress symptoms based on DSM–IV–TR (American Psychiatric Association, 2000) criteria and has demonstrated adequate reliability and validity (Coffey et al., 1998). Additional validation studies found that the mPSS was associated with general psychological distress and clinician-administered diagnostic assessments of PTSD (Ruglass et al., 2014). Participants indicated the degree to which they experienced symptoms such as “persistently been making efforts to avoid thoughts or feelings associated” regarding traumatic experiences on a scale of *0* (not at all) to *3* (five or more times a week). Scores were summed to create a total score. The mPSS demonstrated high internal consistency in our sample (α = .92).

Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996).—The BDI-II is a 21-item measure used to assess depressive symptoms and has demonstrated adequate reliability, convergent validity (e.g., associated with general health indices; Arnau, Meagher, Norris, & Bramson, 2001) and criterion validity (i.e., higher scores for individuals diagnosed with major depressive disorder; Grothe et al., 2005). For each item, participants indicated which of four statements best described how they had been feeling over the past two weeks. Each statement had a corresponding score, ranging from 0 (e.g., *“I do not feel sad”*) to 3 (e.g., *“I am so sad or unhappy that I can’t stand it”*). The scores were summed to create a total severity score. The BDI had high internal consistency in our sample (α = .93).

Traumatic Events Inventory (TEI) (Schwartz et al., 2005).—The TEI is a 19-item screening instrument for lifetime history of traumatic experiences. Participants were asked to indicate the number of times they experienced various traumatic incidents, including physical and sexual abuse, experiencing violence, and other traumatic. Previous work has demonstrated that this measure is associated with more severe symptoms of relevant constructs such as PTSD symptoms (Gillespie et al., 2009).

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Data Analytic Plan

We first conducted preliminary analyses to determine basic descriptive data and examine the correlations among the main study variables. Then, to assess differences in posttraumatic stress and depressive symptoms based on response to unfair treatment classification, we ran two Analysis of Variance (ANOVA) tests and Tukey's honest significant difference (HSD) procedure to determine specific group differences. Finally, to test whether response to unfair treatment moderated the association between racial discrimination and psychopathology outcomes, we used the PROCESS SPSS macro (Hayes, 2018) which utilized ordinary least squares regression to determine whether the association between racial discrimination and symptoms is contingent on response to unfair treatment. Based on a sample size of 401 and two predictors, we had sufficient statistical power to detect predicted effects (Faul, Erdfelder, Lang, & Buchner, 2007). Bootstrapping was completed with 10,000 random samples to determine the 95% confidence intervals for each effect. To probe statistically significant interaction effects after examining the R^2 value, we used the PROCESS procedure to quantify whether the relationship between racial discrimination and our two outcomes differed depending on response to unfair treatment classification. We used indicator coding (i.e., comparing the effect of passive vs. moderate and passive vs. active) because we were specifically interested in whether the moderate and active groups differed compared to the passive group. Continuous variables were centered in these analyses and frequency of traumatic experiences was included as a covariate in all analyses.

Results

Preliminary Results

As expected, we found that experiencing more frequent racial discrimination was associated with more severe mental health symptoms. Specifically, we found that racial discrimination frequency was associated with more severe posttraumatic stress ($r = .25$, $p <.01$) and depressive symptoms ($r = .19$, $p < .01$).

Group Differences

The results of our first ANOVA indicated that posttraumatic stress symptoms differed based on response to unfair treatment classification, $F(2, 385) = 5.56$, $p = .004$ (see Figure 1). To determine the specific group differences, we followed up using Tukey's HSD and found that the passive group reported higher levels of posttraumatic stress symptoms ($M = 16.80$, $SD = 13.47$) compared to the active group ($M = 10.51$, $SD = 11.56$; $p = .004$), but that the moderate group did not differ significantly compared to the other two groups ($M = 12.66$, $SD = 12.07$). The results of an ANCOVA demonstrated that the effect of response to unfair treatment remained significant even when age, sex, education, employment, income, racial discrimination, and trauma experiences were included in the model (see Supplemental Table 1). From this set of covariates, only trauma and racial discrimination significantly predicted PTSD symptoms.

Our second ANOVA indicated that depressive symptoms also differed based on response to unfair treatment classification, $F(2, 371) = 4.49$, $p = .012$. Follow-up tests using Tukey's HSD indicated that for depressive symptoms, both the passive ($M = 16.76$, $SD = 12.10$)

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and moderate group (*M* = 15.34, *SD* = 13.03) reported greater symptoms compared to the active group (*M* = 12.11, *SD* = 11.09; $p = .044$), but the moderate and passive groups did not differ. The results of an ANCOVA demonstrated that the effect of response to unfair treatment remained significant even when age, sex, education, employment, income, racial discrimination, and trauma experiences were included in the model (see Supplemental Table 2). From this set of covariates, trauma, racial discrimination, income, and sex predicted depressive symptoms.

Moderation

In our first model examining posttraumatic stress as an outcome, we found that racial discrimination ($b_1 = 4.15$, $t = 4.25$, $p < .001$), the passive vs. active comparison ($b_3 = -2.54$, $t = -3.23$, $p = .001$), and their interaction ($b_5 = -3.15$, $t = -2.78$, $p = .006$) accounted for significant variance even with trauma exposure ($b_6 = 9.13$, $t = 7.51$, $p < .001$) in the model. The moderate vs. passive comparison and its interaction with racial discrimination, however, were not statistically significant. Following up on the moderating effect of response to unfair treatment ($R^2 = .02$, $F = 4.08$, $p = .017$), we found that the racial discrimination and posttraumatic stress association was significant for the passive ($\theta_{x \to y} = 7.90$, $t = 3.45$, $p = .006$) and moderate ($\theta_{x \to y} = 3.57$, $t = 3.56$, $p = .009$), but not for active group ($\theta_{x \to y} = 1.01$, $t = .92$, $p = .36$; see Figure 2a). This pattern of results held when age, sex, education, income, and employment were added to the model (see Supplemental Table 3)

In our second model examining depressive symptoms as an outcome, we found that racial discrimination ($b_1 = 3.84$, $t = 4.14$, $p < .001$), the passive vs. active comparison ($b_3 = -2.55$, $t = -3.09$, $p = .002$), and their interaction ($b_5 = -2.98$, $t = -1.19$, $p = .012$) accounted for significant variance in depressive symptoms even with trauma exposure ($b_6 = 7.31$, $t = 5.66$, $p < .001$) in the model. In line with the first set of results, the moderate vs. passive comparison and its interaction with racial discrimination, were not statistically significant. Following up on the moderating effect of response to unfair treatment ($R^2 = .02$, $F = 3.26$, $p = .039$), we found that the racial discrimination and depressive symptom association was significant for the passive ($\theta_{x \to y} = 5.60$ $t = 2.35$, $p = .019$) and moderate groups ($\theta_{x \to y} = 4.23$, $t = 2.98$, $p = .003$), but not for active individuals ($\theta_{x \to y} = .44$, $t = .38$, $p = .70$; see Figure 2b). This pattern of results held when age, sex, education, income, and employment were added to the model (see Supplemental Table 4)

Discussion

The overall goal for this study was to understand the role of differential responses to unfair treatment in the association between experiences of racial discrimination and psychological symptoms among Black Americans. Our results support a growing body of primarily theoretical research denoting the potential buffering effects of using active race-based coping strategies. As research has shown that Black Americans use a variety of coping strategies and skills to counter the effects of racial discrimination, with mixed implications for mental health (Carlucci et al. 2018; Forsyth & Carter, 2014), the current study provides further insight into the effectiveness of certain coping strategies to combat the insidious effects of experiencing racial discrimination.

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Results from the current study extend previous research in several important ways. First, we found evidence that the severity of posttraumatic stress and depressive symptoms differed based on how individuals responded to unfair treatment, with more severe symptoms found for Black American individuals who used passive (vs. active) coping strategies. Notably, these results were found among an understudied community population of Black Americans of primarily low socioeconomic status, further highlighting the importance of conducting research on the utilization of coping strategies in marginalized communities that experience a disparate amount of stressful life adversities. Second, our research findings demonstrated that race-based coping moderated the association between racial discrimination and posttraumatic stress and depressive symptoms, such that these associations were only significant for groups that utilized passive and moderate coping strategies. These findings supported our hypothesis that active race-based coping is associated with lower mental health symptoms and serves as a buffer in the relation between racial discrimination experiences and mental health symptoms, even when accounting for lifetime history of trauma exposure. These results underscore the need for greater attention to the potential effectiveness of proactive coping strategies, such as seeking out social support and personally addressing experiences of racial discrimination.

Consistent with Lazarus and Folkman's transactional stress model (1984) as well as the culturally-relevant stress and coping model by Clark and colleagues (1999), our findings demonstrate that Black Americans utilize coping resources and assets to combat the potential toll of racism-related stress. Given that the aforementioned conceptual frameworks keenly note the ways in which chronic experiences of stressors require high cognitive, emotional, and physiological demand on body systems, our findings indicate that the use of coping strategies that address racism-related stressors directly and actively, instead of utilizing suppressive strategies, are effective in attenuating psychological symptoms. This is consistent with previous research finding that for Black women in college, general active (versus passive) coping (i.e., not race-related) can have a buffering effect on psychological symptoms in the face of racial discrimination (West et al., 2010). The current findings are also nuanced when considering critical consciousness (Freire, 1970) as well as Africentric coping (Watson-Singleton et al., 2020) frameworks in populations that experience a multitude of stressors. Within critical consciousness theory, *conceptualization* of one's oppression is equally as important as *action* in responses to injustice. Taking this into consideration and also acknowledging the history of collective resistance to injustice by Black communities over time in the U.S. (French et al., 2020), the healing possibilities of taking action against racial oppression, while also having supportive social circles to process these experiences of racism collectively is evident. Jones and colleagues' (2020) overview of the current state of research on the effects of racial discrimination discussed accumulating evidence for "racially attuned collective coping," which includes approach-oriented coping behaviors (i.e., acts of collectivism, intergroup support, civic engagement) to aid in the healing process from racial discrimination. Future research is needed in marginalized populations that takes into consideration the cultural relevancy of utilizing certain coping strategies within social contexts of oppression.

The identification of potential buffers on the impact of racial discrimination can inform intervention practices. Our findings provide novel, preliminary support that introducing

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components of activism and engagement with social support networks in treatment goals should be explored as factors that could reduce the deleterious effects of racial discrimination among Black American adults. Prior to engaging in this work, it may be worthwhile to conduct comprehensive case conceptualizations that involve developing hypotheses about the proximal and distal factors that may have contributed to clients' current coping strategies, including previous traumatic experiences and other identity-based stressors. Furthermore, it is necessary for clinicians to incorporate numerous factors in the dialogue with clients regarding engaging in activism such as the particular circumstances of the individual (e.g., relative power in workplace, social support) to assess benefits of this intervention in light of potential psychological and interpersonal costs. While activism and behavioral activation activities that include social engagement as treatment goals are compatible with existing treatment models like Cognitive Behavioral Therapy, our findings also support consideration of incorporating culturally-relevant and critical consciousness-based therapy models. For example, the Critical Consciousness of Anti-Black Racism intervention model (Mosley et al., 2020), provides guidelines for a dual-approach to therapeutic interventions and gives specific guidance to engage with cognitions related to racial discrimination, in addition to specifically encouraging activism as a treatment component where therapy can be a space for recovery and regeneration for these activities. While promising, additional research is necessary to understand how activism and social support as a treatment component for racism-related stress impacts mental health outcomes in a treatment setting. Notably, the type of coping strategies that will be effective to deter the effects of racial discrimination may vary by the context in which the racial injustice occurs (i.e., at work, in public, etc.). This could further denote the importance of acknowledging cultural context within the use of flexible coping strategies in treatment. We also acknowledge that due to the structural nature of racism, a fundamental remedy to the effects of racial discrimination does not lie within individual level interventions alone but at policy and system-level changes. The best practices to navigate around a myriad of oppressive social and contextual situations in the U.S will have to include multi-level approaches to intervention.

Limitations and Future Directions

Although the current study has several strengths, some study limitations should be noted. The current study is limited by a cross-sectional design. Given that depression and posttraumatic stress symptomatology are closely related to endorsing feelings of hopelessness and decreased motivation, it may be that depression symptoms result in more passive coping mechanisms. In addition, other factors may predict the development of specific coping strategies, such as religious coping, racial socialization or racial identity (Hayward & Krause, 2015) which are unexplored in this manuscript. It is also possible that using an active coping strategy to unfair treatment may have deleterious short-term but not long-term consequences. Thus, longitudinal and experimental research using more rigorous methods (e.g., daily diary) is necessary to determine the direction of the relationships between racial discrimination, coping responses to unfair treatment, and mental health outcomes. Second, our use of archival data from 2006 to 2008 limits our ability to generalize to the current racial context. It is possible that an increase in the formal recognition of other types of racial discrimination (Sue et al., 2007) and heightened visibility of racial justice

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movements such as the Black Lives Matter movement may have implications for the ways in which Black individuals perceive and respond to racial discrimination (Watson-Singleton et al., 2020). Replication of this work in samples that were recruited more recently is necessary. Third, while demonstrating high reliability and validity, the response to unfair treatment subscale of the Experiences of Discrimination Scale is limited in scope. Future literature should include the use of more comprehensive, multifaceted measures of racism-related coping (Forsyth & Carter, 2014). One major advantage of using such comprehensive measures is the inclusion of multiple indicators of active or passive coping styles and spiritual coping, a particularly salient method of coping with racial discrimination among Black Americans (Shorter-Gooden, 2004; Utsey, et al., 2000). Fourth, a strength of our study was the use of well-validated quantitative measurements of racial discrimination, coping, and mental health symptoms, but based on inconsistent findings in the literature on optimal coping strategies mixed-methods research is also needed to truly gain a better grasp of when, why, and how Black Americans utilize different coping strategies when faced with racism. For example, Brondolo et al. (2005) found that situational context predicted differential use of coping strategies and Mallett and Swim (2009) found recall biases in the reported coping strategies. Future research could use qualitative research methods to understand use of coping strategies that may not fit in stress-coping models that were developed within a Eurocentric framework; emphasizing individual level coping strategies over collectivistic coping strategies. In addition, using ecological momentary assessment methodology may allow us to identify whether trait assessments of coping map on to situational coping (Schwartz et al., 1999) and better understand the nuanced contextual factors that differentially predict the use of distinct coping strategies. Finally, although our main hypotheses were supported even when numerous demographic variables were included as covariates, there was some evidence that sex and income may be relevant particularly when considering depressive symptoms. More research is needed to explicate the role of other types of stressors (e.g., experiences of sexism and financial stress in addition to racial discrimination) in understanding depressive symptoms.

Conclusion

The present study adds to a growing body of evidence demonstrating the negative impact of racial discrimination on health and well-being among Black Americans. By examining the role of race-based coping, our research findings give rise to social justice relevant research to address racial health inequities in a sociopolitical climate of unrest. Our findings also support the need for continued research examining the protective nature of active race-based coping and the exploration of culturally tailored interventions that utilize strengths-based approaches to promote healing from racism experiences. The continued inequity of social power and opportunity in Black American populations within the U.S. is rooted in historical and contemporary racial injustice. Therefore, our current research study findings support the vital need for future research that both affirms the Black experience within the U.S. and aids in combatting racial injustice.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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This study found that responding to racial discrimination using active (versus passive) strategies reduced the positive association between racial discrimination and psychological symptom severity for Black Americans. These findings provide novel, preliminary support that introducing components of activism and engagement with social support networks in treatment goals may be effective at reducing the negative effects of racial discrimination among Black Americans. Although ending systemic racism is ultimately the most effective solution, these findings nevertheless support the incorporation of culturally-relevant and critical consciousness-based therapy models when working with Black American clients.

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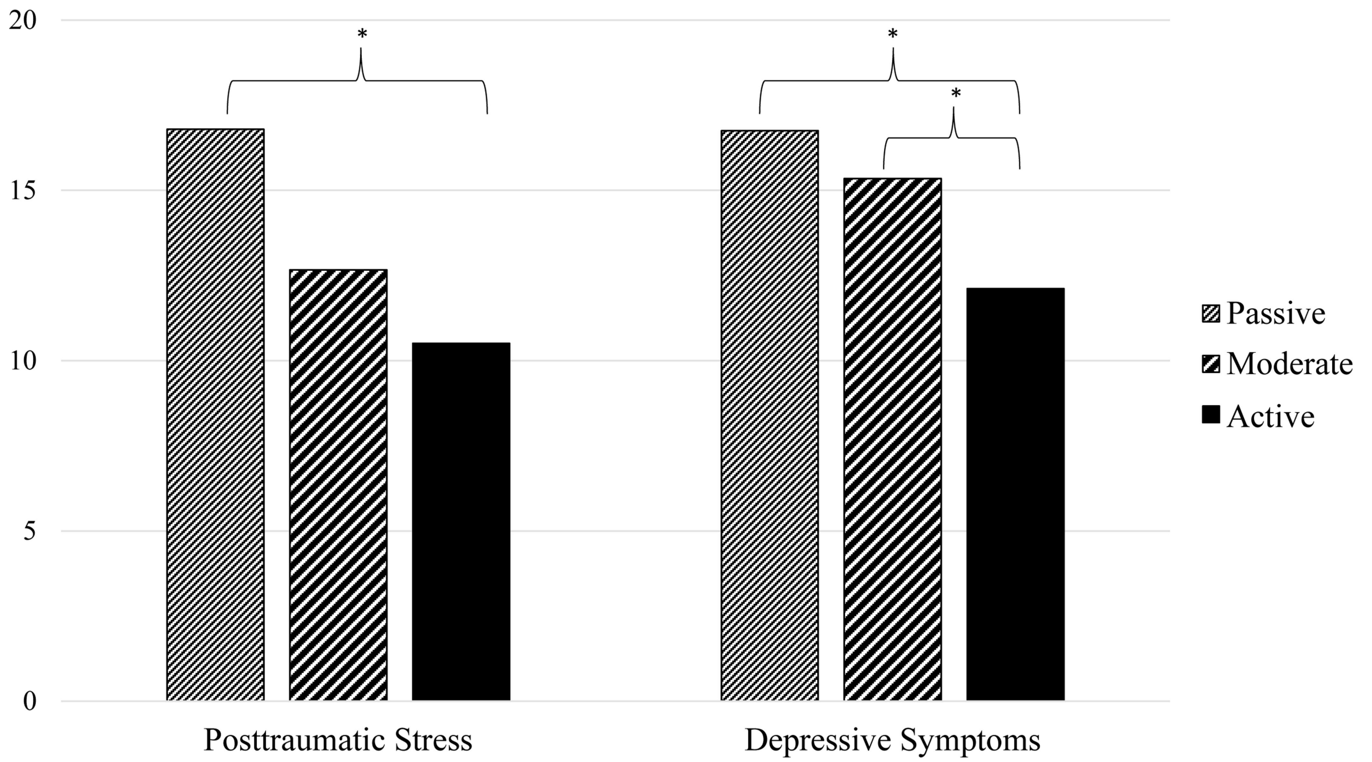

Figure 1.
Differences in outcomes based on response to unfair treatment classification
Note. * $p < .05$

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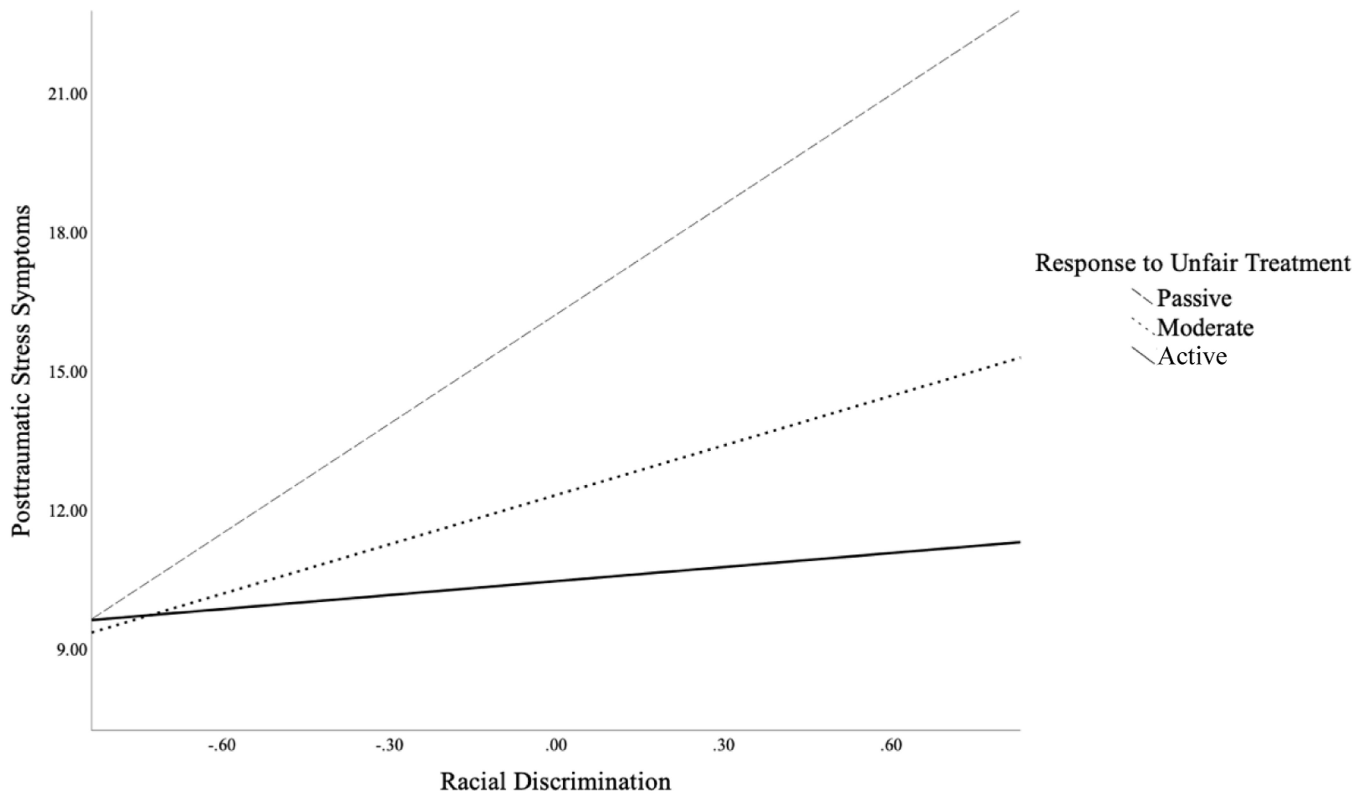

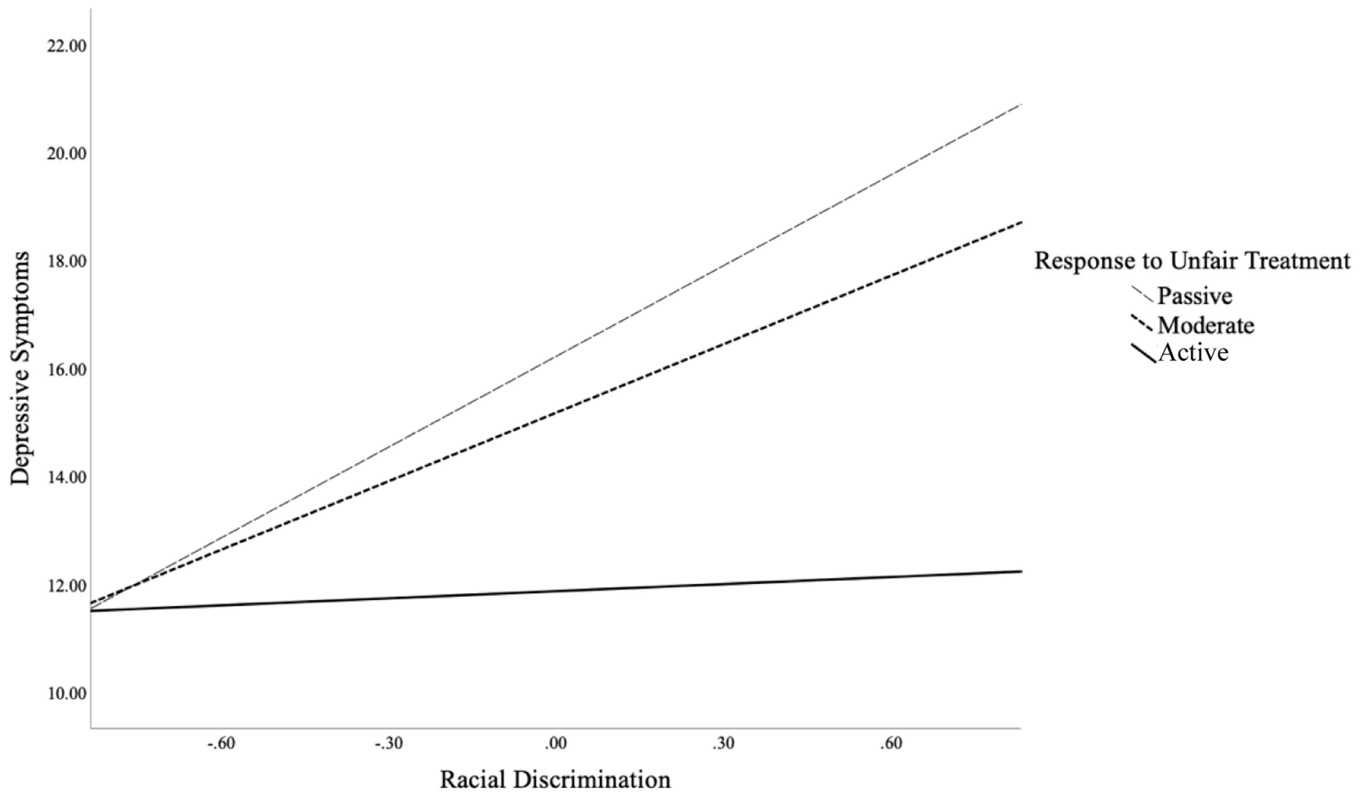

Figure 2.

A) Conditional effect of racial discrimination on posttraumatic stress based on response to unfair treatment classification

B) Conditional effect of racial discrimination on depressive symptoms based on response to unfair treatment classification

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