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The Relationship Between Racial Identity Status Attitudes, Racism-Related Coping, and Mental Health Among Black Americans

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To date, few studies have examined how different strategies for coping with racism affect the mental health of Black Americans, and none have explored how racial identity status attitudes and racism-related coping affect mental health. This study sought to examine the relationship between racial identity status attitudes, the specific strategies used by Black Americans to cope with racism, and mental health outcomes. Participants were 233 Black adults, and cluster analysis identified four cluster groups that differed significantly with respect to the patterns of racial identity attitudes and racism-related coping strategies employed. Although the groups did not differ significantly in well-being, the group with predominantly high Internalization status attitudes and that used primarily Empowered Resistance racism-related coping strategies had the least psychological symptoms. Implications for mental health and research are discussed.

Keywords: racism-related coping, racial identity statuses, mental health

A number of indicators provide evidence of long-standing racial disparities in virtually all areas of American life, including physical and mental health, and unequal access to and quality of care (Blank, Dabady, & Citro, 2004; USDHHS, 2001). Research suggests that racial discrimination and racism may be directly and indirectly implicated in the development of physical illness as well as psychological distress in Black Americans (Paradies, 2006; Pieterse & Carter, 2007). The prevalence of racism (measured as race-related stress or as perceived discrimination) is high for Blacks, with between 40% and 98% of samples reporting exposure to racial discrimination (e.g., Carter, Forsyth, Mazzula, & Williams, 2005; Landrine & Klonoff, 1996; Sanders Thompson, 1996; Sellers & Shelton, 2003). Studies have found associations between racial discrimination and/or race-related stress and lower life satisfaction and well-being (e.g., Deitch et al., 2003), increased distress (e.g., Broman, Mavaddat, & Hsu, 2000; Jackson et al., 1996), emotional reactions (Carter & Reynolds, 2011; Carter & Forsyth, 2010), and psychological symptoms (e.g., Landrine & Klonoff, 1996; Kessler, Mickelson, & Williams, 1999; Klonoff, Landrine, & Ullman, 1999; Sanders Thompson, 1996).

Although four decades of research provides support for the notion that racism is experienced as a unique stressor for African Americans, and that the psychological and physiological impact of exposure to perceived discrimination is negative, race-related stress or discrimination typically accounts for only a small percentage of the variability in mental health outcomes in these studies (Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009). As a result, scholars have begun to examine a variety of mediating and moderating factors that might account for variability in psychological reactions to race-related stress. Racial identity and coping are two potential moderating variables that have received attention in the research literature. The purpose of the present study was to investigate the relationships between the racism-related coping styles specific to Black Americans, racial identity status attitudes, and psychological symptoms.

Coping With Racism

Research on coping, defined as efforts to manage external or internal demands that exceed one's resources (Folkman & Moskowitz, 2004), has tended to focus on how people cope with generic stressors that affect all people (i.e., death of loved ones, loss of employment, divorce) rather than specific race-related stressors. The small number of empirical studies that have examined how Black people cope with racial discrimination has typically relied on the use of generic coping measures that were created to measure strategies used to deal with general life stressors (Greer, 2007; Thomas, Witherspoon, & Speight, 2008). These studies, which have primarily examined the influence of approach and avoidant strategies assessed by generic coping measures, have had mixed results. In some studies, avoidant strategies were associated with lower life satisfaction (Utsey, Ponterotto, Reynolds, & Cancelli, 2000), negative emotions (Hyers, 2007), and distress (Smith, Stewart, Myers, & Latu, 2008). In other studies, avoidant strategies were associated with decreased symptoms, while approach coping was associated with increased symptoms (Sanders Thompson, 2006). The inconsistency in these results likely reflects

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differences in the coping measures used to assess situational as compared to dispositional coping styles, and the influence of unmeasured moderating variables. They may also reflect the use of generic coping measures in racism-related coping research. Just as scholars have argued that race-related stress is different from general stress, a number of scholars have suggested that generic coping measures cannot adequately capture the range of specific race-related coping strategies Blacks used to deal with racism (e.g., Brondolo, ver Halen, Pencille, Beatty, & Contrada, 2009; Harrell, 2000; Scott, 2003a; Smith et al., 2008).

At least one study found differences in the coping strategies Blacks use to cope with nonracial and racial stressors (Plummer & Slane, 1996), and another found differences in the strategies Blacks use to cope with racial discrimination as compared to Whites and Asian Americans (Sanders Thompson, 2006). Over the years, a number of descriptive and qualitative studies have examined how Blacks, in particular, cope with racism (e.g., Benkert & Peters, 2005; Daly, Jennings, Beckett, & Leashore, 1995; Evans, 1997; Feagin, 1991; Shorter-Gooden, 2004), and a small number of quantitative studies have begun to assess the influence of psychosocial variables such as racial identity (Greer, 2011; Neville, Heppner, & Wang, 1997; Utsey, Bolden, Lanier, & Williams, 2007: West, Donovan, & Roemer, 2010), racial socialization, and cultural orientation (Scott, 2003a, 2003b) on generic dispositional coping styles and on the generic situational strategies used to cope with racism among Black Americans. Recently, a coping measure has been developed to assess the specific Africultural coping strategies Blacks in America have developed over time to deal with stressors including racism (Utsey, Payne, Jackson, & Jones, 2002). To date, only one study has examined the use of Africultural coping to deal with racism-related stress (Lewis-Coles & Constantine, 2006), and this study did not assess the relative effectiveness of particular strategies with respect to mental health outcomes. While other studies have explored gendered racism and psychological health using the Africultural coping scale (e.g., Greer, 2011; Thomas et al., 2008), they did not explore race-related coping. One measure, the Racism-Related Coping Scale (Forsyth & Carter, 2011) currently exists to assess the specific racism-related coping strategies that Black Americans use to deal with racism. We used this measure in the current study since it is the only race-specific coping instrument found in the literature.

Racial Identity and Coping With Racism

A few scholars and researchers have begun to consider the role of group identity, such as racial or ethnic identity, as a factor in the relationships between racism and mental health outcomes, perceptions of discrimination, and preference for particular coping strategies (e.g., Franklin-Jackson & Carter, 2007; Neville et al., 1997; Pieterse & Carter, 2010; Sellers & Shelton, 2003). To date, no known study has examined the effect of the combination of racial identity and racism-related coping strategies of Blacks on the relationship between racism and mental health outcomes.

Racial identity refers to the psychological meaning one makes of one's racial group membership, the extent to which one psychologically identifies with or chooses not to identify with one's racial reference group, and the emotional, behavioral, and cognitive expressions of this identification (Carter, 1995; Helms, 1990). Helms (1994) characterized racial identity development as an ongoing process of ego differentiation wherein one's racial identity status attitudes shift from externally defined to internally defined statuses as a result of exposure to racial messages and experiences in the environment. One may hold that his or her race is not a salient aspect of his or her personality and, thus, is not invested in the culture of one's racial group (Preencounter). One may be confused about how or if race is an important aspect of his or her personality, and questions may arise due to some experience(s) with racism (Encounter). One may withdraw physically or psychologically into the cultural practices of his or her racial group in an idealized way at the outset and then make one's race-cultural worldview an important part of the self (Immersion-Emersion). Lastly, one may evolve such that race and culture become an integrated aspect of one's worldview that is consistent with one's personality and is grounded in the racial-cultural experiences of the person and racial group (Internalization).

Researchers have found that racial identity status attitudes are associated with preferences for particular coping strategies (e.g., Neville et al., 1997) and social change strategies (Watts, 1992). But, researchers have typically found that strong racial identity does not buffer the relationship between perceived discrimination and mental health for Blacks (e.g., Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003), and no known study has examined the association between the combination of racial identity status attitudes and racism-related coping as was done in the present investigation.

Researchers have found that certain aspects of racial identity influence perceptions of discrimination and/or the attribution of ambiguous life events and daily hassles to racism (Carter, 2007; Williams & Mohammed, 2009). Certain types of generic coping strategies have been associated with better mental health outcomes in dealing with racism, some studies suggest that racial and cultural variables may influence the selection of strategies used to cope with racism (e.g., Scott, 2003b), and there is preliminary evidence suggesting that the efficacy of particular strategies for coping with racism is influenced by individual differences. These conclusions suggest that there could be a complex interaction between racial identity and racism-related coping that affects the psychological impact of racism and discrimination, which has as yet received little attention in the literature. Therefore, the purpose of the present study was to examine the relationships between racial identity status attitudes and racism-related coping strategies and to determine whether they were associated with both positive (well-being) and negative (distress) psychological consequences of exposure to racism.

Method

Participants

Participants were 233 Black American adults (18+) recruited through an online survey. Participants' ages ranged from 18 to 72 years with a mean age of 33 (SD = 11.19). The majority of the participants were female (74.7%, n = 174), and identified as members of either the middle (42.9%, n = 100) working (18.9%, n = 44) or lower-middle (20.2%, n = 47) class. The participants were well educated, with most reporting that they had a graduate education (53.2%, n = 124), a college degree (25.8%, n = 60), or had completed some college-level coursework (18%, n = 42).

Approximately 45% of the participants identified as Christian (n = 107), including nondenominational Christians (23.6%, n = 55), Baptists (9.4%, n = 22), Protestants (5.2%, n = 12), Methodists (3.9%, n = 10), and other denominations (3.2%, n = 8). Participants' open-ended responses regarding their race-ethnicity were coded into six different categories. Most participants identified as African American (57.1%, n = 133), and although the vast majority of participants (84.1%, n = 196) were born in the United States, a fairly large number identified their ethnicity as Caribbean (30.5%, n = 71), African (6.4%, n = 15), or Afro-Latino (4.3%, n = 10).

Instruments

Specific racial incident questions. Participants were instructed to think of a "troubling situation where you feel that you were treated unfairly because of your race in the last 3 years." Subsequent questions provide descriptive, categorical information about the incidents by asking participants to respond to a series of four multiple-choice questions about the incident they thought of including: (1) where it took place, (2) who the perpetrator was, (3) what the perpetrator's race was, and (4) whether they would describe the incident as discrimination or harassment. They were instructed to respond to the remaining questions in the survey keeping this memorable incident in mind. Thus, responses to the subsequent instruments such as racism-related coping and mental health and well-being were associated with the respondent-driven incident.

Racism-Related Coping Scale. The RRCS (Forsyth & Carter, 2011) is a 59-item measure developed to assess the situational coping behaviors used to deal with and resist racism. Participants are instructed to check those items that describe behaviors they used to deal with a specific racist experience. Item responses are measured on a 4-point Likert scale, which assesses how much the participant used each behavior to deal with the situation they described (0 = *did not use*, 1 = *used a little*, 2 = *used a lot*, 3 = *used a great deal*). The measure has eight scales and as shown in Table 1, alpha coefficients were as follows: Bargaining (.80), Hypervigilance (.90), Social Support (.87), Confrontation (.87), Empowered Action (.87), Spiritual (.85), Racial Consciousness (.85), and Constrained Resistance (.81). Bargaining consists of primarily cognitive strategies focused on efforts to make sense of the experience, to examine one's own responsibility in bringing the incident about, and to change one's behavior in order to manage others' perceptions. Hypervigilant strategies are characterized by increased caution and sensitivity in interactions with others who are not Black, the use of avoidant strategies to evade future racially charged interactions, and cognitive preoccupation with the incident. Social Support strategies comprised a range of behaviors and cognitions intended to seek and provide support to oneself and to others. Confrontation consists of direct expression of anger and/or communication with the perpetrator of the incident. Empowered Action includes the channeling of community and/or legal resources to make those involved accountable for their actions. Spiritual strategies included seeking support from religious institutions and figures or in religious books and engaging in self-soothing or empowering spiritual practices such as meditation, prayer, and singing. Racial Consciousness includes efforts to connect with or express one's cultural heritage and history and to take action against racism. Constrained Resistance strategies include both passive (e.g., work-slowing strategies, use of drugs and alcohol) and active (e.g., use of intimidation) efforts to resist racism.

Table 1
*Sample Means and Standard Deviations for Racism-Related Coping, Racial Identity and Mental Health Variables (*N = *233)*

Variable	*M*	*SD*
Racism-Related Coping Scales		
Self-preservation strategies	31.00	14.60
Bargaining	3.51	2.29
Hypervigilance	4.57	4.01
Social Support	6.52	3.48
Direct action strategies	7.28	5.18
Confrontation	4.87	3.05
Empowered Action	2.41	2.67
Cultural resistance strategies	4.76	4.10
Spiritual	2.36	2.32
Racial Consciousness	2.39	2.18
Constrained Resistance	.97	1.71
Racial Identity Attitude Scales		
Preencounter	33.07	8.13
Encounter	14.94	4.08
Immersion	30.51	7.49
Internalization	56.18	6.46
Brief Symptom Inventory Scales		
Anxiety	8.66	4.71
Depression	9.46	5.29
Hostility	7.57	3.97
Somatisation	8.54	4.66
Interpersonal Sensitivity	6.76	3.95
Mental Health Inventory Scales		
Well-Being	43.89	12.83

Black Racial Identity Attitudes Scale. The RIAS-B (Helms & Parham, 1996). was created to measure Black peoples' racial attitudes toward members of their own racial group and members of the dominant (White) racial group. The 50-item measure is composed of four scales that assess racial status attitudes ranging from less mature and simplistic, to mature and complex. The measure is composed of four scales: Preencounter, Encounter, Immersion-Emersion, and Internalization. Participants respond to items using a 5-point Likert-type scale (5 = *strongly agree*, 1 = *strongly disagree*) to describe the extent to which they view the statements as accurate to their experience. Scores for each scale are calculated by summing the appropriate items. High scores indicate endorsement of the racial identity status attitudes that comprise the particular scale. Cronbach's alphas for the current sample were: Preencounter, .78, Encounter, .52, Immersion-Emersion, .78, and Internalization, .67 (see also Table 1). The RIAS-B has been used in a variety of studies that have provided evidence of construct, predictive, and concurrent validity (Carter, 2007; Franklin-Jackson & Carter, 2007).

Brief Symptom Inventory. The Brief Symptom Inventory (BSI; Derogatis, 1983) is a 53-item self-report inventory of psychological symptoms among psychiatric outpatients, medical patients, and community samples. The measure is a brief form of the SCL-90 and is composed of nine subscales: Somatisation (seven items), Depression (six items), Phobic Anxiety (five items), Obsessive-Compulsive (six items), Anxiety (six items), Interpersonal Sensitivity (four items), Paranoid Ideation (five items), Hos-

tility (five items), and Psychoticism (five items). Participants assess the extent to which they were distressed by each symptom listed in the last week on a 5-point Likert scale (0 = *not at all*, 1 = *a little bit*, 4 = *extremely*). Scores for each subscale are calculated by computing the average score for the items in the subscale. The current investigation used the Somatization (SOM), Anxiety (ANX), Depression (DEP), Interpersonal Sensitivity (I-S), and Hostility (HOS) scales. Specific subscales were selected based on symptoms that have been associated with racism in previous research. The Somatization subscale measures distress arising from perceptions of bodily dysfunction including cardiovascular, gastrointestinal, and respiratory complaints. The Depression subscale measures symptoms of clinical depression including dysphoric mood, lack of motivation or interest, feelings of hopelessness, and thoughts of suicide. The Anxiety subscale assesses symptoms such as nervousness, tension, panic attack, and feelings of terror. The Interpersonal Sensitivity subscale measures emotional sensitivity and self-consciousness in relation to others, and the Hostility subscale measures feelings of anger, irritability, and temper outbursts. Cronbach's alpha reliability coefficients' for the current sample were (also see Table 1): Anxiety, .90; Depression, .91; Hostility, .87; Somatization, .91; Interpersonal Sensitivity, .88; Psychological Distress, .97. The BSI has been used in a number of studies with Black American samples, but these studies have typically used either only the depression and anxiety subscales, or have used the general severity index, and few have reported internal consistency reliabilities. In those studies where alphas were reported, they were adequate (see, Sellers et al., 2003).

Mental Health Inventory. The MHI (Veit & Ware, 1983) was created to assess both psychological distress and well-being. The 38-item self-report measure is comprised of five different subscales, which comprise three indexes: psychological distress, well-being, and global mental health. The Psychological Well-Being index is composed of the General Positive Affect (11 items) and the Emotional Ties (two items) scales. The General Positive Affect scale assesses feelings of happiness, enjoyment, and interest in daily activities, a sense of calm and emotional stability, and positive feelings about life in general. The Emotional Ties scale assesses a sense of completeness, satisfaction, and emotional connection in an intimate relationship. The current study used only the Psychological Well-Being index as our measure of positive psychological outcome since we also had a measure of psychological symptoms. Participants respond to each item on a 6-point Likert scale (1 = *none of the time* to 6 = *all of the time*) to indicate how much they have experienced the symptoms indicated in the last 30 days. Scores for each scale are calculated by summing the appropriate items. High scores indicate higher levels of well-being. For the purpose of the current study, the scale was adjusted to specifically assess how participants felt after coping with the experience of racism they reported in the first portion of the study packet, rather than how they felt in the last 30 days. Researchers have employed the scale with Black samples suggesting that the measure is valid for this population (e.g., Franklin-Jackson & Carter, 2007; Pieterse & Carter, 2007). Cronbach's alpha for the current sample was .95 for the Well-Being index score.

Personal demographic sheet. The personal demographic sheet was developed for use in the current study to solicit descriptive information about participants' age, race, gender, ethnicity, social class, education level, religion, and place of birth. The selection of information included in the demographic sheet was guided by those demographic factors that have been found to cause significant within-group variation in previous studies.

Procedure

After receiving Institutional Review Board approval from the researchers' institution, data was collected by online survey. The study used a convenience sample drawn through snowball sampling procedures. Participants were recruited via links on African American interest listservs, social networking websites, and organizational e-mail lists serving primarily a northeastern United States population. In addition, the online survey was announced on a morning radio show on an African American radio station in a small northeastern city and the link was available on the show host's website. Potential participants were asked to recruit colleagues, friends, and family who met inclusion criteria for the study. The e-mail invitation letter included a link to the online survey. The link brought potential participants to the informed consent and participants' rights pages, followed by the survey questionnaire. The informed consent page indicated that consent would be indicated by answering the first question in the survey. In order to move from one page of the questionnaire to the next, participants had to answer every question on the previous page. Upon completing the questionnaire participants were automatically directed to a debriefing page that provided the contact information for participants who wanted to receive a summary of results of the study along with a restatement of resources included in the Informed Consent documents. Four hundred thirty-five people logged onto the online survey. Of these, 11 were removed because they did not meet the inclusion criteria (did not identify as Black/African American). Two hundred ninety-five of those who logged on completed the entire Racism-Related Coping Scale and were retained for factor analysis of the measure (see Forsyth, 2010 for additional information). Two hundred thirty-three participants completed all measures in the entire survey questionnaire.

Results

Preliminary Analyses

Sample means and standard deviations for the eight Racism-Related Coping scales, the four Racial Identity Attitudes scales, the six Basic Symptom Inventory subscales, and the Mental Health Inventory well-being index are provided in Table 1. A series of Multivariate Analyses of Variance (MANOVAs) were run to determine if there were differences between demographic groups on the racism-related coping scales and on the mental health outcome variables. There were no significant differences in mental health outcomes by Gender ($\Lambda = .972$; $F(1, 6) = 1.088$, $p > .05$) or SES ($\Lambda = .968$; $F(1, 6) = 1.247$, $p > .05$). There were no significant differences in coping strategies by gender ($\Lambda = .945$; $F(1, 8) = 1.641$, $p > .05$) or SES ($\Lambda = .937$; $F(1, 8) = 1.895$, $p > .05$). A second set of MANOVAs indicated that the different incident characteristics (location, perpetrator's relationship to the target, harassment vs. discrimination) were not associated with differences in psychological responses: Location ($\Lambda = .891$; $F(1, 42) = .578$, $p > .05$), Perpetrator ($\Lambda = .854$; $F(1, 42) = .787$, $p > .05$),

or Harassment/Discrimination ($\Lambda = .989$; $F(1, 6) = .402$, $p > .05$).

Cluster Analysis

Both racial identity and racism-related coping were conceptualized to be complex and multidimensional constructs. For example, while one particular racial identity status attitude may be dominant under particular circumstances or at a particular time, other previously manifested status attitudes are always potentially present, and therefore impact one's beliefs, attitudes, cognitions, and emotions to some degree. The practice of calculating multifaceted racial identity profiles for research participants, rather than simply assigning them to the single most dominant status, exemplifies advancement in the measurement of this concept (Helms, 1996; Carter, 1996). Therefore, to determine the effect of the combination of particular racism-related coping strategies and racial identity status attitudes on mental health outcomes, a hierarchical cluster analysis was conducted to create groups that capture patterns of dominant endorsement of racial identity status attitudes and racism-related coping strategies. This analysis was followed by a series of MANOVAs to determine if there were significant differences between the cluster groups on psychological symptoms and well-being.

Further reduction of data prior to running a cluster analysis is recommended in cases where some of the variables included in the analysis are highly intercorrelated while others are not (Borgen & Barnett, 1987). This type of imbalance can impact the proximity measures used in cluster analysis by weighting highly correlated variables more than those that are not highly correlated in the creation of clusters. Examination of correlation coefficients for the eight racism-related coping scales and the four racial identity status attitudes revealed highly significant correlations between all of the racism-related coping scales and a range of nonsignificant to moderately significant correlations between racial identity status attitude scales and racism-related coping scales (see Table 2). To promote equal weighting of variables in subsequent cluster analyses, a second-order factor analysis (PCA) was conducted with a varimax rotation to reduce the eight racism-related coping scales into subgroups.

The factor analysis of the eight racism-related coping scales yielded three factors with eigenvalues greater than 1.0 ($KMO = .897$, Bartlett's χ^2 (1, 28) = 938.43, $p < .001$), which accounted for 67% of the common variance. The results yielded the following racism-related coping subgroups. The first, Direct Action Strategies (eigenvalue = 1.88), was composed of two scales (Confrontation and Empowered Action) and accounted for 23.5% of the common variance ($\alpha = .90$). Cultural Resistance Strategies (eigenvalue = 1.76), was composed of two scales (Spiritual and Racial Consciousness), accounting for 21.9% of the common variance ($\alpha = .90$). Self-Preservation Strategies (eigenvalue = 1.74) was composed of three scales (Bargaining, Social Support, and Racial Hypervigilance) and accounted for 21.7% of the common variance ($\alpha = .94$). Constrained Resistance was the only subscale that did not load on any of the three factors.

To classify participants into different groups based on racial identity status attitudes and racism-related coping styles as reflected by the subgroups, a hierarchical cluster analysis using Ward's clustering method with squared Euclidean distance was conducted using the three racism-related coping subgroups and the four racial identity status attitudes as clustering variables. Scholars typically recommend the use of hierarchical cluster analysis when there is no a priori theoretical or empirical knowledge regarding the appropriate number of cluster groups to expect and where the sample size is relatively small (<250) (Borgen & Barnett, 1987; Rapkin & Luke, 1993). In the current study agglomerative hierarchical cluster analysis was used because there was no empirical knowledge available to inform the appropriate number of cluster groups to expect for the current population and variables. Since this method of cluster analysis is sensitive to scaling differences between variables, all variables included in the analysis were standardized using *Z*-scores.

The optimum number of clusters to retain was decided through examination of the agglomeration schedule, which provides a proximity coefficient (a measure of the within-group sum of squared errors; *SSW*) for each stage of the clustering procedure. A jump or large increase in the change in *SSW* from one stage to the next indicates that there has been a decrease in the proportion of variance accounted for by the combination of two clusters, and that

Table 2
Intercorrelations Among Racism-Related Coping Scales and Racial Identity

	HYP	CON	EMP	SOC	SPR	RES	BRG	RAC	PRE	ENC	IMM	INT
HYP	1.000											
CON	.499**	1.000										
EMP	.550**	.639**	1.000									
SOC	.715**	.581**	.619**	1.000								
SPR	.626**	.451**	.508**	.625**	1.000							
RES	.596**	.395**	.504**	.491**	.435**	1.000						
BRG	.655**	.477**	.491**	.711**	.531**	.442**	1.000					
RAC	.695**	.596**	.630**	.727**	.662**	.509**	.608**	1.000				
PRE	.019	−.071	−.086	.005	−.137*	.208**	.134*	−.104	1.000			
ENC	.412**	.232**	.165*	.362**	.178**	.258**	.231**	.351**	.196**	1.000		
IMM	.442**	.331**	.284**	.366**	.282**	.276**	.157*	.403**	−.148*	.604**	1.000	
INT	−.029	−.017	.078	.064	.121	−.066	.055	.093	−.152*	.071	.224**	1.000

Note: HYP = Hypervigilance; CON = Confrontation; EMP = Empowered Action; SOC = Social Support; SPR = Spiritual; RES = Constrained Resistance; BRG = Bargaining; RAC = Racial Consciousness; PRE = Preencounter; ENC = Encounter; IMM = Immersion; INT = Internalization.
* = $p < .05$. ** = $p < .01$.

the subsequent cluster grouping has resulted in greater within-cluster-group variability. There was a jump in the *SSW* when the third and fourth cluster groups were combined, and that the change in *SSW* at each subsequent stage continued to result in large increases in the *SSW*. This indicated that the four-cluster solution was a better fit for the data since it had less within-cluster-group variability than the three-cluster solution. In addition, each of the cluster groups in the four-cluster solution had an adequate number of cases for subsequent analyses, and one-way ANOVAs indicated that there were significant differences (ps $< .001$) between the four cluster groups across all of the clustering variables (Self-Preservation Strategies, $F(3, 229) = 160.248$; Direct Action Strategies, $F(3, 229) = 61.097$; Cultural Resistance Strategies $F(3, 229) = 212.549$; Preencounter $F(3, 229) = 20.683$; Encounter $F(3, 229) = 47.330$; Immersion $F(3, 229) = 57.5333$; Internalization $F(3, 229) = 13.478$). These observations suggested that the four-cluster solution maximized between-cluster-group differences on the variables, providing interpretable clusters and was therefore an appropriate fit for the data. Tables 3 and 4 contain standardized means and standard deviations of racial identity attitudes and racism-related coping strategies for each of the four cluster groups.

The first cluster group, Encounter-Bargaining ($n = 78$), was characterized by a fairly flat pattern of mean racial identity status attitude scores, with mean Preencounter, Encounter, and Immersion scores that were slightly higher than the sample mean. This group's highest mean scale racial identity score was on the Encounter scale [Figure 1]. The group's overall use of racism-related coping strategies was close to the sample mean. The pattern of racism-related coping revealed that the group relied primarily on Bargaining strategies, followed by Confrontation and Social Support, and relied least on Spiritual coping strategies to deal with racial encounters [Figure 2].

The second cluster group, Preencounter-Constrained Resistance ($n = 21$), was characterized by a differentiated pattern of mean racial identity status attitude scores, with mean Preencounter scores that were at least one standard deviation higher than the mean scores for the other cluster groups, and mean Encounter, Immersion, and Internalization scores that were significantly lower than the sample mean [Figure 1]. Their overall use of racism-related coping strategies was about one standard deviation below the sample mean on all of the coping strategies [Figure 2].

The third cluster group, Immersion-Cultural Hypervigilance ($n = 65$), was characterized by a moderately differentiated pattern of mean racial identity status attitude scores, with mean Encounter and Immersion scores that are higher than the sample mean scores. This group's highest mean racial identity score was on the Immersion scale [Figure 1]. Their overall use of racism-related coping strategies was at least one standard deviation above the sample mean on all of the coping strategies [Figure 2]. They relied primarily on Hypervigilant, Spiritual and Racially Conscious strategies, followed by Social Support strategies, and relied least on Confrontation to deal with racial encounters.

The fourth cluster group, Internalization-Empowered Confrontation ($n = 69$), was characterized by a moderately differentiated pattern of mean racial identity status attitude scores, with Preencounter, Encounter, and Immersion scores that are lower than the sample mean. This group's highest mean racial identity score was on the Internalization scale, although the group's mean score was only slightly higher than the sample mean [Figure 1]. The group's overall use of racism-related coping strategies was about average (close to the sample mean) on all of the coping strategies [Figure 2]. They relied primarily on Confrontation, followed by Empowered Action, Spiritual and Constrained Resistance strategies, followed by Hypervigilance, Spiritual and Empowered Action strategies, and relied least on Social Support to deal with racial encounters.

Differences Between Cluster Groups on Mental Health Outcomes

To determine whether there were differences between the different cluster groups with respect to mental health outcomes, a MANOVA was run with the cluster groups as independent variables and with well-being, anxiety, depression, hostility, somatisation, and interpersonal sensitivity as the dependent variables. Results of the omnibus test indicated that there were significant differences between the cluster groups across the mental health outcome variables, $\Lambda = .765$; $F(1, 18) = 3.498$; $p < .001$). Follow-up univariate post hoc comparisons were conducted using a Bonferroni correction (.05 divided by 6) to establish a modified significance level of .008. Cluster groups means and standard deviations for mental health outcomes are depicted in Table 5.

The post hoc comparisons found that the Encounter-Bargaining group experienced greater Anxiety ($p < .001$), Depression ($p < .002$), Hostility ($p < .001$), and Interpersonal Sensitivity ($p < .001$) than did those in the Internalization-Empowered Confronta-

Table 3
Cluster Group Means and Standard Deviations for Racial Identity Attitudes

Cluster group		PRE	ENC	IMM	INT
Encounter-Bargaining ($n = 78$)	*M*	53.44	55.56	54.23	51.38
	SD	9.95	7.08	7.64	8.69
Preencounter-Constrained Resistance ($n = 21$)	*M*	59.81	44.09	37.04	37.78
	SD	12.84	8.29	7.67	15.32
Immersion-Hypervigilant Cultural ($n = 65$)	*M*	48.04	53.99	55.87	50.62
	SD	8.55	9.15	8.46	8.81
Internalization-Empowered Confrontation ($n = 69$)	*M*	44.96	41.75	43.63	51.58
	SD	6.24	7.40	6.61	7.90
Total ($N = 233$)	*M*	50	50	50	50
	SD	10	10	10	10

Note. PRE = Preencounter; ENC = Encounter; IMM = Immersion; INT = Internalization.

Table 4
Cluster Group Means and Standard Deviations for Racism-Related Coping

Cluster group		HYP	CON	EMP	SOC	SPR	BRG	RAC	RES
Encounter-Bargaining (n = 78)	*M*	49.08	50.18	48.65	51.05	46.55	50.62	48.89	48.68
	SD	6.75	8.91	8.87	7.69	6.96	8.85	7.84	7.56
Preencounter-Constrained Resistance (n = 21)	*M*	41.45	38.89	42.39	39.35	41.46	40.31	39.66	45.16
	SD	5.31	6.68	3.01	4.94	4.81	6.18	1.65	2.09
Immersion-Hypervigilant Cultural (n = 65)	*M*	61.62	58.19	59.40	60.44	62.21	58.63	61.97	58.45
	SD	7.52	6.22	9.37	2.65	6.69	6.89	5.14	13.39
Internalization-Empowered Confrontation (n = 69)	*M*	42.68	45.45	44.98	42.23	44.99	44.11	43.13	45.01
	SD	4.59	8.86	6.07	7.66	5.79	7.79	5.17	1.89
Total (N = 233)	*M*	50	50	50	50	50	50	50	50
	SD	10	10	10	10	10	10	10	10

Note. HYP = Hypervigilance; CON = Confrontation; EMP = Empowered Action; SOC = Social Support; SPR = Spiritual; RES = Constrained Resistance; BRG = Bargaining; RAC = Racial Consciousness.

tion group. The Immersion-Cultural Hypervigilance group also experienced more Anxiety ($p < .001$), Depression ($p < .001$), Hostility ($p < .001$), Somatisation ($p < .001$), and Interpersonal Sensitivity ($p < .005$) than those in the Internalization-Empowered Confrontation group. There were no significant differences between the cluster groups in well-being.

Overall, these results suggest that the cluster group characterized by dominant Internalization racial identity status attitudes, lower-than-average overall use of coping strategies, and primary reliance on Confrontation was associated with the least intense psychological symptoms. Whereas both the cluster group characterized by dominant high Encounter racial identity status attitudes, average overall use of racism-related coping strategies, and a reliance on primarily Bargaining, and the cluster group characterized by high dominant Immersion racial identity status attitudes, higher-than-average overall use of racism-related coping strategies, were associated with the most intense psychological symptoms.

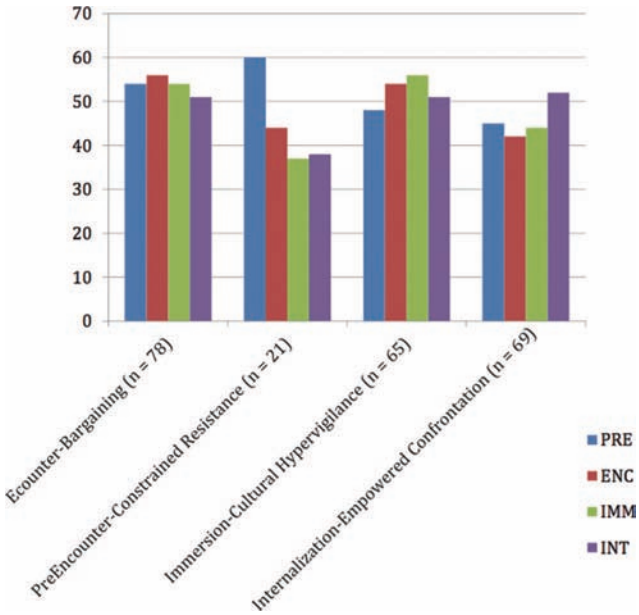

Figure 1. Cluster group racial identity patterns: PRE = Preencounter; ENC = Encounter; IMM = Immersion; INT = Internalization.

Discussion

This study examined the relationship between racism-related coping strategies and racial identity status attitudes and their combined association with psychological symptoms and well-being. Hierarchical cluster analysis resulted in a four-cluster solution: Encounter-Bargaining, Preencounter-Constrained Resistance, Immersion-Cultural Hypervigilance, and Internalization-Empowered Confrontation, which differed significantly from one another on each of the clustering variables. The results of a MANOVA indicated that there were significant differences between the groups in psychological symptoms, but no differences on well-being.

Overall, these results suggest that the combination of racial identity status attitudes and coping strategies used by the Internalization-Empowered Resistance cluster group were associated with the least intense psychological symptoms as compared to those used by the Encounter-Bargaining and Immersion-Cultural Hypervigilance cluster groups. The significant correlations found between mean racial identity status attitude scores and particular racism-related coping mean scale scores, as well as the different patterns of racial identity status attitudes and coping strategies observed in the clusters, provide information that is essential to interpreting what aspects of each cluster group contribute to differences in mental health outcomes.

Encounter-Bargaining Versus Internalization-Empowered Confrontation

The Encounter-Bargaining (EB) cluster group had significantly higher scores than the Internalization-Empowered Confrontation (IEC) group on Preencounter, Encounter, and Immersion status attitudes. The group's overall use of racism-related coping strategies was close to the sample mean but was significantly higher than the Internalization-Empowered Confrontation group. The pattern of racism-related coping revealed that the Encounter-Bargaining group relied primarily on Bargaining strategies, followed by Confrontation and Social Support to deal with racial encounters. They endorsed moderate use of Hypervigilance, Em-

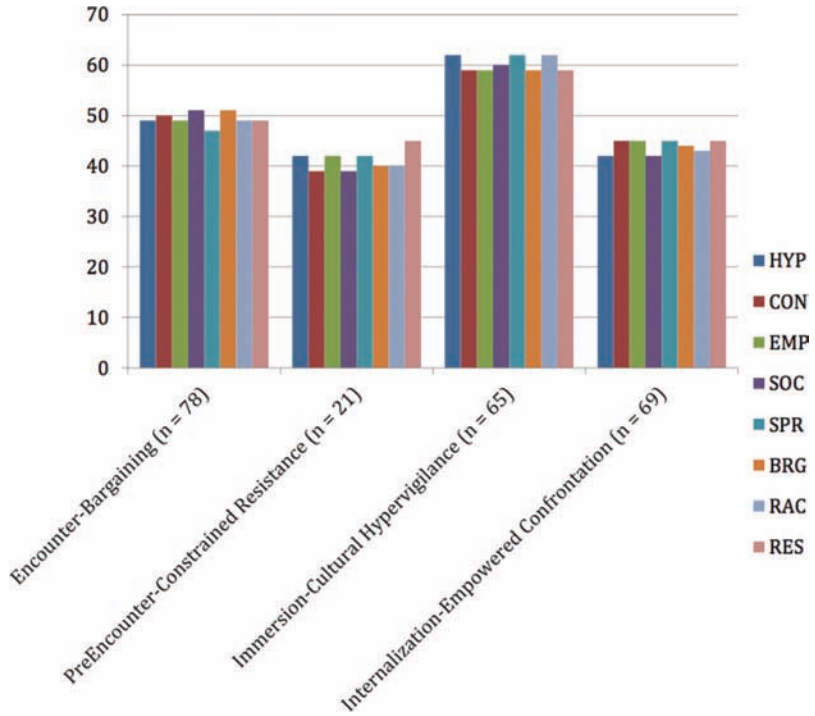

Figure 2. Cluster group racism-related coping patterns: HYP = Hypervigilance; CON = Confrontation; EMP = Empowered Action; SOC = Social Support; SPR = Spiritual; RES = Constrained Resistance; BRG = Bargaining; RAC = Racial Consciousness.

powered Action, Racial Consciousness, and Constrained Resistance, all of which they used equally, and they relied least on Spiritual coping strategies.

The combination of high Preencounter, Encounter, and Immersion status attitudes that characterize the EB group suggests a great deal of ambivalence about and struggle with one's racial identity. The fact that, for the EB group, endorsement of Preencounter and Immersion attitudes are virtually the same, attests to a significant struggle between old, more color-blind, and racially naive beliefs and attitudes and emergent feelings of potentially reactive pride and investment in identifying as Black. The predominance of the Encounter attitudes suggests that this struggle was brought about by increasing exposure to or awareness of racism, whether on an interpersonal, cultural, or institutional level. In contrast, the IEC group's lowest racial identity status attitude is Encounter, and the groups' scores on Preencounter and Internalization are also significantly lower than their scores on Internalization. This pattern of racial identity attitudes suggests that the participants in the IEC group have reached a greater sense of comfort and stability in their racial identity and are no longer struggling with the conflicts that seem to challenge those in the EB group. Since Preencounter, Encounter, and Immersion status attitudes have been associated with a variety of negative indices of psychological health in previous research (e.g., Franklin-Jackson & Carter, 2007; Mahalik, Pierre, & Wan, 2006; Munford, 1994; Pierre & Mahalik, 2005), it is likely that differences in the two groups' racial identity patterns

Table 5
Cluster Group Means and Standard Deviations for Mental Health Outcomes

Cluster group		ANX	DEP	HOS	SOM	SEN	WBG
Encounter-Bargaining (n = 78)	*M*	51.00	51.19	52.06	51.18	51.47	47.81
	SD	11.52	11.84	12.33	12.35	10.42	20.91
Preencounter-Constrained Resistance (n = 21)	*M*	47.29	47.78	47.37	49.25	47.59	43.84
	SD	6.10	7.94	6.10	7.45	7.61	20.41
Immersion-Hypervigilant Cultural (n = 65)	*M*	54.85	53.93	53.30	52.40	54.33	48.67
	SD	10.62	9.72	9.66	10.22	11.44	19.23
Internalization-Empowered Confrontation (n = 69)	*M*	45.12	45.62	45.36	46.63	44.99	55.60
	SD	4.89	6.14	5.55	5.92	5.52	18.13
Total (N = 233)	*M*	50	50	50	50	50	50
	SD	10	10	10	10	10	10

Note. ANX = Anxiety; DEP = Depression; HOS = Hostility; SOM = Somatisation; SEN = Interpersonal Sensitivity; WBG = Well-Being.

contributed to higher rates of anxiety, depression, hostility, and interpersonal sensitivity in the EB group.

It is possible that the comfort and stability of racial identity found in the IEC group provided them with greater facility in managing stressful racial interactions so that they result in less interpersonal conflict or so that the conflict is internalized less and therefore has less psychological impact. Their lower use of racism-related coping strategies could reflect that their strong racial identity allowed them to appraise the racial incident they reported as a challenge rather than as a threat to their sense of self, and that they felt able to master the situation. It also seems to indicate the exertion of less effort toward coping with racism and more focused use of a pattern of strategies (i.e., Confrontation, Empowered Action, Constrained Resistance, and Spiritual) composed primarily of direct and resistant actions to deal with racism. Their judicious use of Bargaining, Hypervigilance, and Racial Consciousness suggest that they might have the capacity to assess and manage racially ambiguous situations, and to effectively anticipate racism so that the coping strategies they rely on are more proactive than reactive. Their relatively low reliance on Social Support suggests that they may feel confident in their ability to handle racially charged situations.

In contrast, the EB group's primary reliance on Bargaining strategies to cope with racism is consistent with a combination of Encounter and Preencounter attitudes, and seems to indicate a lack of self-efficacy around dealing with racist incidents. It suggests that people in this group might have doubted their ability to discern racist incidents, and struggled with uncertainty about whether their own behavior played a role in the incident they reported. It is possible that, as a result, they focused on coping through efforts to manage how others perceived them. Their reliance on Bargaining might also reveal an attempt to deny the psychological and emotional significance of the incident by reframing it, focusing on positive aspects, and trying to have empathy for the perpetrator.

Given that Bargaining was among the racism-related coping strategies most highly correlated with each of the psychological symptoms, and that research has found that coping strategies characterized by self-doubt are associated with increased anxiety and distress (Smith et al., 2008), the EB group's primary reliance on this strategy likely contributed to the increased psychological distress they experienced as compared to the IEC group. While fairly high use of Confrontation may have allowed members of the EB group to directly express feelings of anger about the incident, direct confrontation is associated with the risk of greater interpersonal conflict (Brondolo et al., 2009). It is possible that this conflict was associated with greater psychological symptoms. Finally, the group's low reliance on Spiritual coping strategies is consistent with research that has found an inverse relationship between Encounter attitudes and intrinsic religious orientation (Sanchez & Carter, 2005), suggesting that people who endorse Encounter attitudes may be experiencing religious doubts that make it difficult for them to rely on spirituality to cope with racial issues.

Immersion-Cultural Hypervigilance Versus Internalization-Empowered Confrontation

The Immersion-Cultural Hypervigilance (ICH) group's most predominant racial identity score was on the Immersion scale, and it had significantly higher scores than the Internalization-Empowered Confrontation group on Preencounter, Encounter, and Immersion status attitudes. The group's overall use of racism-related coping strategies was at least one standard deviation above the sample mean, and was significantly higher than the Internalization-Empowered Confrontation group on all of the coping strategies.

The combination of primarily Encounter and Immersion racial identity status attitudes endorsed by the ICH group suggests that people in this group were experiencing a heightened awareness of race and racism along with a strong, but possibly reactive sense of connection with their racial group. While people who endorse strong Immersion attitudes appear to have great confidence and conviction in their racial heritage, scholars have suggested that their identification remains superficial and insecure. Associations between Immersion status attitudes and inferiority, anxiety, and low self-esteem seem to support this aspect of theory. Furthermore, some studies have found a relationship between Immersion status attitudes and negative problem appraisal (Neville et al., 1997), which suggests that Immersion may be associated with the use of less effective coping strategies. It is possible that their heightened awareness of racism, combined with a reactive connection to the racial group and potentially negative problem appraisal styles caused members of the ICH group to appraise their encounters with racism as a threat rather than as a challenge and to perhaps experience greater psychological distress as a result.

The pattern of coping strategies the ICH group relied on evidences a strong affinity for Black racial-cultural practices, coupled with a deep mistrust for people outside of the racial group that is consistent with the strong Afrocentric cultural beliefs associated with Immersion racial identity attitudes (Carter & Helms, 1987). The coping strategies employed in Racial Consciousness approximate the beliefs, cognitions, and behaviors assessed in measures of racial identity. The apparent failure of heavy reliance on this strategy to effectively minimize psychological symptoms for the ICH group is consistent with research that has found that although a sense of racial pride is often associated with well-being, it does not buffer the relationship between discrimination and distress or psychological symptoms (Brondolo et al., 2009). The high use of avoidant strategies to cope suggests that people in this cluster group likely experienced a heightened sense of fear and may indicate that the incidents reported by this group were experienced as so threatening that avoidance, withdrawal, and retreat were the natural response. Furthermore, it appears that the equally high use of Spiritual and Racial Consciousness coping strategies failed to offset the negative psychological consequences of relying so heavily on Hypervigilance.

What is perhaps most notable about the racism-related coping pattern employed by the ICH group is that they relied least on resistant strategies such as Confrontation, Empowered Action, and Constrained Resistance, all of which have in common the expression of anger in various forms (i.e., passive, active, direct, indirect). This is surprising, since research has found that Immersion status attitudes are associated with hostility (Carter, 1995), and that Immersion dominant racial identity patterns are related to greater anger expression and less anger control (Carter, Pieterse, & Smith, 2008). Qualitative research has shown that inability to confront the perpetrators of racism often results in negative psychological consequences including regret, rumination, lingering anger, and guilt (Feagin, 1991; Hyers, 2007). Quantitative research has also found that for Blacks, the endorsement of a combination of interracial

hostility and a tendency to suppress anger are associated with particularly high blood pressure (Gentry, 1985). Since Immersion attitudes are typically associated with hostility toward Whites, these results suggest that suppressing anger is particularly detrimental for people who endorse predominantly Immersion attitudes. It is possible that the ICH group's limited reliance on coping strategies that allow for the direct expression or channeling of anger into constructive and empowering action in the face of racism caused a great deal of distress for this group in particular. The results further suggest that while Spiritual coping was generally associated with increased well-being and decreased distress, and was not correlated with Hostility in previous analyses, it may not be an adequate coping strategy when it is not supplemented by more active efforts to directly address the incident.

Clinical Implications

The results of this study have a number of implications for mental health. They suggest that racial identity is an important internal resource that can influence how targets appraise racial incidents as well as the strategies they use to cope with them. Clients with predominantly Preencounter and Encounter attitudes will likely need assistance from the clinician in identifying and coming to terms with the influence of race and racism in stressful incidents, and will likely benefit from having their experiences validated by the clinician. Work with these clients, and with all clients regardless of racial identity, should emphasize helping them to trust their gut feelings about whether racism is operating in stressful incidents, and to work through their feelings of guilt, shame, or regret about how they handled the situation in order to ultimately minimize feelings of self-blame. One strategy that can help such clients to relinquish personal responsibility, thereby mitigating feelings of self-blame and denigration, would be to realistically explore the details of the situation and the potential consequences they might have faced had they taken direct action. It may be particularly important for the clinician to help the client identify ways that race or unconscious racism could be influencing the otherwise ambiguous situations or incidents that are particularly likely to elicit feelings of self-blame. Doing so could necessitate educating the client about the subtle dynamics of modern racism and race relations in the context of the history of racism in the United States.

Clients who endorse predominantly Immersion attitudes will likely benefit from help developing greater self-efficacy in racial interactions through exploring more flexible ways of negotiating race relations, and processing intense experiences and emotions about their past and current relationships with White people and dominant society in general. Furthermore, these clients should be assisted in integrating both positive and negative feelings about Black and White people, which will likely allow them to exercise more nuanced cross-race judgments about who they can trust and when. Helping clients to develop a strong identification with their racial group along with a complex understanding of the dynamics of race and racism may provide them with a sense of self-efficacy and agency in managing racial stressors. This increased self-efficacy should allow them to appraise racism as a challenge rather than a as a threat, thereby reducing it's psychological impact. Furthermore, it may help clients to be more judicious and strategic in the coping strategies they use.

It will be very important for clinicians to recognize the limitations of traditional coping strategies for dealing with racism. The typology of coping strategies in the Racism-Related Coping Scale could be used to guide the exploration of clients' idiosyncratic coping style. It might also assist clinicians to categorize and assess the potential efficacy of individual actions carried out by their clients. Clients might generally benefit from minimizing their use of Bargaining strategies and enhancing their use of Spiritual and Racial Consciousness strategies. While Empowered Action and Confrontation strategies may increase feelings of agency and self-efficacy, they may also have downsides that should be addressed in counseling. Clients who decide to take organizational or legal action may face disappointments, setbacks, or delays that can exacerbate psychological distress over time. Clients will likely need assistance in processing the emotions and effectively managing the interpersonal conflict that could arise as a result of using Confrontation strategies.

Clinicians should be sure to consider the positive and adaptive aspects of both Hypervigilant and Constrained Resistance strategies, as well as the drawbacks and consequences of habitual reliance on these strategies. Opportunities for greater reliance on Social Support strategies can be facilitated by offering group-level interventions such as support groups. Support groups can be particularly effective in allowing clients to share their experiences, to examine the efficacy of old racism-related coping strategies and brainstorm new strategies, and to express and experience validation of their feelings related to racial stressors. Finally, preventive interventions such as workshops that examine the efficacy of different coping strategies and encourage the development of more flexible and varied repertoires of coping styles can help Black Americans to proactively cope with and face racism.

Limitations

The results of the current study contribute to the existing research literature on the particular and unique strategies Black Americans use to cope with racism, the influence of racial identity status attitudes on the selection of racism-related coping strategies, and the effectiveness of combinations of racism-related coping strategies and racial identity status attitudes. Nevertheless, these results must be interpreted with caution in the context of certain limitations.

While a number of significant associations were found between the variables explored in the study, the use of a cross-sectional, correlational design limits the internal validity of the study, making it impossible to draw conclusions about causal relationships between these variables. As a result it is possible, for example, that the observed relationship between particular racism-related coping strategies and psychological outcomes indicates that increased distress and decreased well-being caused the selection of particular strategies rather than that the use of these strategies influenced psychological symptoms.

It is important to note that the racism-related coping scale is new and requires further study. Although preliminary construct validity has been established (see Forsyth, 2010 and Forsyth & Carter, 2011) and divergent validity was established through negative correlations between certain symptom and racial identity attitude scales and particular coping scales in the current study, significant correlations between the coping scales and distress could suggest

that these variables were confounded. Furthermore, the significant correlations between the racism-related coping scales indicate that there is not a great deal of differentiation between the strategies measured by each scale. Additional studies will be necessary in order to confirm the factor structure and validity of the measure.

It is also possible that unmeasured moderating or mediating variables contributed to the results. Stress and coping theory asserts that whether a stressor is appraised as threat, loss, or challenge and the extent of control a person perceives over the stressor all influence coping and emotional responses (Lazarus & Folkman, 1984). Since appraisal was not measured in the current study, it is not possible to determine what influence appraisal of the incident had on the coping strategies selected. The fact that participants were asked to a think of "memorable" incident where they were mistreated because of their race may have elicited the use of incidents that were appraised as more stressful as stimuli. It is also possible that other unmeasured aspects of the incidents, such as whether they were subtle or overt, direct or indirect, influenced coping and psychological symptoms.

Another limitation is that the data is self-reported and retrospective. While some have argued that self-report measures are preferable to objective measures for assessing internal psychological states such as cognitive and affective experiences (Lazarus, DeLongis, Folkman, & Gruen, 1985) that are captured in coping, identity, and symptoms and well-being scales, participants' responses to these measures are nevertheless susceptible to bias. Since social desirability was not measured in the current study, it is possible that participants overreported well-being, the use of certain racism-related coping strategies, and racial identity attitudes perceived to indicate positive psychological adaptation, and underreported psychological symptoms, distress, coping strategies and racial identity status attitudes that were perceived as negative. For example, some scholars argue that cultural proscriptions in the African American community against admitting vulnerability may lead to underreporting of the use of coping strategies such as seeking social support (Smith et al., 2008). At the same time, some scholars have argued that Internet-based research allows for greater anonymity (Gosling, Vazire, Srivastava, & John, 2004; Mathy, Kerr, & Haydin, 2003). As such, it is possible that the use of the Internet to collect data may have increased participants' perceived anonymity, thereby freeing them to be more honest and less influenced by social desirability in their responses.

Finally, two limitations affect the external validity and generalizability of the results beyond the current study sample. First, the distribution of responses to the coping scales and the racial identity status attitudes were skewed. As such, while the fact that significant results were found despite this limitation suggests that the relationships between the variables could be fairly robust, the results can nonetheless not be generalized beyond the current sample. The study population was a predominantly female, middle-class, and well-educated convenience sample drawn from listservs and organizational e-mail lists based primarily in the Northeast. Although significant differences were not found on coping or the mental health outcome variables by gender or social class, the sample in the current study cannot be said to be representative of other sectors of the Black American population. Furthermore, there is no way to account for self-selection bias that could be evident in the type of people who chose to complete the entire survey.

Nevertheless, the study results provide some important, albeit preliminary, information about the types of strategies Black Americans use to cope with racism, the potential effect of racial identity attitudes on the selection of certain strategies, and the utility of racism-related coping for particular people. This information could have implications for mental health practice with this population.

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