

The Role of Coping Strategies in Understanding the Effects of Institutional Racism on Mental Health Outcomes for African American Men

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Abstract

The purpose of this study was to examine coping strategies as moderators of the effects of institutional racism on psychological outcomes for a sample of 283 self-identified African American men. We hypothesized that the use of strategies that have been conceptualized as adaptive (e.g., spirituality, problem-oriented coping) would influence the severity of institutional racism on psychological symptoms, such that more frequent use would be associated with less severe symptoms. Furthermore, we hypothesized that more frequent use of avoidant strategies (e.g., substance use, disengagement) would be associated with greater severity of psychological symptoms in relation to exposure to institutional racism. Moderated hierarchical regression analyses were performed to test these hypotheses. Statistically significant main effects revealed that coping strategies that involved more self-reliance were associated with greater severity in mental health symptoms. A statistically significant interaction effect was also revealed, which suggested that greater reliance on spirituality was associated with increased symptoms

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of interpersonal sensitivity in relation to experiences of institutional racism. Implications of the findings are discussed.

Keywords

racism, African American men, mental health, psychological well-being

Previous literature on racism has documented deleterious effects on the overall health and well-being of African Americans (e.g., Greer, 2011; S. P. Harrell, 2000; Outlaw, 1993). Findings from previous studies have revealed a myriad of adverse racism-related mental health consequences that include high levels of distress, anxiety, depression (e.g., Britt-Spells, Slebodnik, Sands, & Rollock, 2016; Greer, Laseter, & Asiamah, 2009), as well as low life satisfaction and persistent concerns regarding physical safety (Pieterse, Todd, Neville, & Carter, 2012). Factors that mitigate the effects of racism on mental health for African American populations (e.g., age, racial identity, racial socialization) have also received consistent empirical attention over the years (e.g., Fischer & Shaw, 1999; Greer & Spalding, 2017; H. L. Jones, Cross, & DeFour, 2007). Despite these advances in empirical knowledge, gaps remain in understanding African American men's experiences of racism, as well factors that influence racism-related mental health outcomes for members of this population. In a recent report of The National Center for Health Statistics (2015), African American men were two times more likely to report feeling that "everything is an effort" compared with non-Hispanic White American men. They also reported greater frequencies of sadness, hopelessness, and worthlessness in comparison with White American men (National Center for Health Statistics, 2015).

While genetic predispositions and forms of trauma have been shown to contribute to the onset of depression and other mental health symptoms for African American men (Greer, Brondolo, Amuzu, & Kaur, 2018), members of this population have commonly reported frequent experiences of institutional racism (e.g., Bennett, Merritt, Edwards, & Sollers, 2004; Bulhan, 1985; Essed, 1991; Franklin & Boyd-Franklin, 2000; Greer et al., 2009), which has been linked to severe psychological distress (e.g., Britt-Spells et al., 2016). However, few studies have been implemented to determine the effects of institutional racism on specific psychological symptoms for African American men. Studies are also needed to pinpoint the ways in which their efforts to cope might mitigate these effects. The current study was designed to address these gaps in literature.

Racism as a Chronic Stressor

Racism has been defined as systems of domination, power, and privilege (Greer, 2011; J. M. Jones, 1997), in which the attitudes and ideologies held by members of racially privileged groups lead to forms of social exclusion, lack of access to resources, as well as to the thwarting of rights and civil liberties for persons of color (e.g., voter suppression; Essed, 1991). J. M. Jones (1997), in his tripartite model, argued that institutional racism occurs when policies and practices that are embedded within institutions function to disadvantage and/or exclude persons on the basis of race. Because institutional settings generally function as systems, discrimination can occur in both overt (e.g., denial of employment) and subtle (e.g., racial microaggressions) ways. Pratto, Sidanius, and Levin (2006) argued that inequality occurring within institutions is a major source of societal hierarchies on the basis of race and other social identities (e.g., gender, sexual orientation). In particular, institutions entail systems that are able to generate widespread societal impacts. If discriminatory policies and practices are embedded within a system, discriminatory attitudes and behaviors often get recycled. Pratto et al. (2006) further explained, “when individuals or groups try to fight [discrimination], institutions typically defend their discriminatory practices as part of defending the institution itself” (p. 277). Thus, it can be particularly challenging to address racism experienced within institutional settings.

Stress theory has often been utilized to conceptualize the ways experiences of racism can contribute to adverse health consequences for members of African American populations. In transactional theory (Lazarus & Folkman, 1984), stress is defined as the product of poor person-environment fit in which situations are appraised by individuals as taxing and/or as exceeding their available resources. S. P. Harrell (2000), borrowing from the transactional theory, defined race-related stress as interactions occurring between the person and environment that are perceived as race-related, and as exceeding available resources to address, manage, or endure. As institutional racism is a form of chronic stress for many African American men, they are persistently at risk for harmful psychological and somatic consequences associated with this type of racism (Kwate & Goodman, 2015; Schulz et al., 2006; Utsey, 1997).

African American Men and Institutional Racism

Previous studies have consistently demonstrated that African American men have experienced racial discrimination within education, health care, law enforcement, and legal systems (e.g., Greer et al., 2009; Utsey, 1997). In

addition, they are often stereotyped as criminals, and as physically violent, menacing, and aggressive (e.g., Greer et al., 2009; Hall, 2001). These denigrating stereotypes have been shown to be deeply ingrained within American culture, and are evident by African American men's experiences of racial profiling, as well as by common social behaviors that are displayed by strangers when African American men are encountered in public places (e.g., purse clutching; Feagin, Vera, & Imani, 1996; Franklin & Boyd-Franklin, 2000). High rates of incarcerated African American men tend to reinforce the societal perception of them as criminals. According to recent Census data, African American men comprise 12.7% of the U.S. population of all men in the United States, at nearly 21 million persons (U.S. Census Bureau, 2017). However, they make up over 30% of all inmates at federal and state correctional facilities across the nation (Bureau of Justice Statistics, 2019).

Some scholars have linked the percentage of African American men in prisons not only to the perception of them as criminals but also to aggressive policing tactics, as well as to the overwhelming presence of law enforcement in predominantly African American neighborhoods (e.g., Brunson, 2007; Brunson & Miller, 2006). Findings from previous research have demonstrated that African American men are more aggressively targeted by law enforcement compared with White Americans in their own neighborhoods (e.g., Barlow & Hickman-Barlow, 2002; Brunson & Miller, 2006; Skolnick, 1994). Compared with White American men, African American men are disproportionately subject to unprovoked police contacts and are frequently the victims of police misconduct, including threats of violence, and verbal and physical assaults (e.g., Brunson & Pegram 2018; Hurst, Frank, & Browning, 2000; Welch, 2007). Brunson and Miller (2006) found that even though young (13- to 19-year-old) African American females in urban communities were often stopped for curfew and truancy violations, young African American males were frequently stopped by law enforcement during any time of day, and were often searched, and suspected of committing crimes. Furthermore, recent high-profile killings of African American males by police officers have highlighted the effects of being defined as and responded to as threatening, menacing assailants (Bor, Venkataramani, Williams, & Tsai, 2018).

Coping Strategies

Coping is conceptualized as individual efforts to manage, alleviate, and/or to resolve life challenges and difficulties (Lazarus & Folkman, 1984). As theorized by Lazarus and Folkman (1984), primary appraisals of incidents (i.e., immediate cognitive and affective reactions) interact with secondary

appraisals (i.e., coping efforts) to influence one's overall level of stress and psychological outcomes. It has been previously established in research that exposure to forms of racism are automatically appraised as negative and stressful among populations of African Americans (e.g., Fischer & Shaw, 1999; Harper et al., 2011; Outlaw, 1993). Therefore, managing these experiences can entail the need to expend considerably high levels of emotional and cognitive energy (Bulhan, 1985; Pierce, 1988).

Few studies have been conducted to determine the ways in which African American men cope with global experiences of institutional racism (e.g., Greer & Chwalisz, 2007; Greer et al., 2009; Utsey, 1997). Most studies were designed to pinpoint efforts used within a single, specific setting, such as higher education (e.g., Fleming, 1984; Greer & Chwalisz, 2007), health care (e.g., Greer, 2010), and law enforcement (e.g., Brunson, 2007; Brunson & Miller, 2006). Studies on specific settings have contributed to understanding the unique environmental contexts within which African American men have needed to manage or address racism-related experiences. However, this approach has contributed to a lack of understanding of the ways in which African American men confront institutional racism across multiple settings and contexts. In particular, many African American men likely encounter multiple incidences of institutional racism in different settings within a single day (e.g., Mosley, Owen, Rostosky, & Reese, 2017). Therefore, efforts to manage, alleviate, or endure the consequences of these incidents entails the constant need to adjust to the enduring demands of institutional environments, which can contribute to severe psychological distress (e.g., Mosley et al., 2017).

General experiences of racism have been examined among African American men. These studies have also generally been designed to determine the influence of gender in understanding racism-related coping responses (e.g., Greer et al., 2009). For instance, in some studies, African American women have been shown to utilize emotion-based strategies to address racism (e.g., Greer, 2011; Shorter-Gooden, 2004), while some evidence suggests that African American men engage in more problem solving to address racism (e.g., Mosley et al., 2017); albeit they are less likely to seek social support compared with African American women (e.g., Mincey, Alfonso, Hackney, & Luque, 2015). Lewis-Coles and Constantine (2006) reported a similar pattern of findings in the use of religious coping to address racism-related experiences. They found that African American women utilized greater deferring (i.e., waiting on a Higher Power to intervene) and collaborative religious coping (i.e., the individual and a Higher Power are responsible for resolution) than men in their sample. Men reported greater use of

self-directing religious problem solving (i.e., reliance on self for resolution) than women (Lewis-Coles & Constantine, 2006).

Matthews, Powell-Hammond, Nuru-Jeter, Cole-Lewis, and Melvin (2013) suggested that the internalization of traditional values associated with masculinity appears to generally influence the ways in which African American men cope with racism. In their recent study, the authors reported a positive relationship between self-reliance and depressive symptoms for men who actively addressed racism. Among this group of men, they further found that John Henryism (i.e., meeting the demands of the environment through hard work) influenced the effect of exposure to racism on depressive symptoms, such that greater use of this high-effort strategy was associated with less symptoms of depression. While this finding suggested that high active coping yielded benefits on mental health, the authors cautioned that long-term high effort coping with racism may be detrimental to overall health. Still African American men who choose not to address incidents of racism are also at risk for experiencing poor mental health (e.g., Matthews et al., 2013).

Current Study

The current study was designed to examine the role of coping strategies in understanding the effects of institutional racism on psychological symptoms (i.e., anxiety, depression, somatization, interpersonal sensitivity, and obsessive-compulsive) in a sample of African American men. We hypothesized that coping efforts would moderate the effects of institutional racism on psychological outcomes, such that greater use of strategies that would be considered active or adaptive (e.g., reliance on others, spirituality) would be associated with less severe psychological symptoms. We further hypothesized that greater use of strategies considered forms of avoidance or disengagement (e.g., mental disengagement, substance use) would be associated with greater severity in psychological symptoms in relation to endorsement of chronic experiences of institutional racism.

Method

Participants

Participants were 283 self-identified African American men who were recruited from the Southeastern region of the United States. They ranged in age from 18 to 73 years ($M = 30.99$, $SD = 16.95$). One hundred and eighty-three participants were recruited from a large, predominantly White university, while 100 participants were recruited from a large, outpatient medical facility. Participants

Table 1. Summary of Background Characteristics by Study Site (N = 283).

| Background variable | College (n = 183) | Outpatient Facility (n = 100) |
|----------------------------------|-------------------|-------------------------------|
| Mean age (SD) | 20.90 (4.44) | 49.44 (15.8) |
| Educational achievement | | |
| High school | 88 | 52 |
| College or some college complete | 95 | 48 |
| Insurance | | |
| Insurance coverage | 172 | 74 |
| Uninsured | 11 | 26 |
| Employment status | | |
| Employed | 84 | 51 |
| Unemployed | 99 | 49 |

Note: Employed = full-time or part-time employment.

from the outpatient clinic were part of a larger study designed to examine the effects of provider racial biases on hypertension management and treatment adherence. Data from this subsample were previously published (Greer, 2016). However, African American men in the current investigation were not included in the previously published study. A summary of participant demographics by recruitment site is depicted in Table 1.

Measures

Institutional racism. Experiences of institutional racism were assessed using the Index of Race-Related Stress-Brief version (IRRS-B; Utsey, 1999). The measure consists of 22 items designed to capture individual, institutional, and cultural forms of racism-related experiences for African Americans. For the purposes of this study, we used only the scores for the institutional racism subscale. Institutional racism refers to policies and practices that are embedded within institutions that negatively affect persons on the basis of race (J. M. Jones, 1997). The institutional racism scale consists of six items. A sample item from this scale reads, “You were refused an apartment or other housing, [sic] you suspect it was because you’re Black.” Items are answered on a 5-point Likert-type scale, ranging from 0 (*this never happened to me*) to 4 (*this event happened and I was extremely upset*). The measure is scored by summing across items that correspond to institutional racism. Higher scores on the scale reflect both frequency of exposure as well as higher levels of stress associated with institutional racism.

The IRRS-B (Utsey, 1999) is a brief version of the 46-item IRRS (Utsey & Ponterotto, 1996) and was validated with 264 self-identified African American adults (207 women and 92 men) who were recruited from several colleges, universities, and communities in the Northeastern region of the United States. For the institutional racism scale, Utsey (1999) reported a Cronbach's alpha of .69 in the initial validation of the IRRS-B scores. The shorter prototype was derived via performing an exploratory factor analysis on a previous validation sample for the IRRS (Utsey, 1999). The confirmatory factor analysis on the 22-item IRRS measure indicated that the three-factor model showed an adequate fit based on aggregation of the items for each subscale (goodness of fit = .92; adjusted goodness of fit = .88; Utsey, 1999). Convergent validity has been supported based on positive and significant correlations between subscales of the IRRS-B, and Racism and Life Experiences Scale-Revised (S. P. Harrell, 1994; Utsey, 1999). Criterion validity was tested via a group-difference approach in which a sample of White American adults were instructed to respond to items by indicating their own experience of each incident described in the items. These scores were compared with scores for the validation sample. The results revealed that African Americans endorsed significantly greater exposure to types of racism compared with White American adults.

Coping strategies. The Coping Orientation to Problems Experienced Inventory (COPE; Carver, Scheier, & Weintraub, 1989) was used to assess efforts in managing institutional racism. The COPE was designed to capture multiple dimensions of coping behaviors for nonclinical adult populations. The measure is composed of 60 items, and can be utilized to assess dispositional styles of coping (i.e., stable or trait-like behaviors) and those that are situational (i.e., strategies employed to manage specific types of stressors). We utilized the situational version of the COPE, as we were interested in measuring strategies that were used specifically to address incidents of institutional racism. Carver et al. (1989) noted that, for the situational version, instructions should be adapted to encourage participants to consider specific events or situations while responding to the items. For the current study, participants were instructed to respond to each item in a manner that was consistent with the ways in which they addressed and/or managed incidents of institutional racism across multiple settings (e.g., school, work, employment, and housing).

The COPE consists of 15 scales. The standard scoring protocol entails summing across items that correspond to the 15 scales that Carver et al. (1989) theorized measured forms of emotion-focused coping (i.e., Acceptance, Positive Reinterpretation and Growth, Religion, Denial, and Seeking

Emotional Support), problem-focused coping (i.e., Suppression of Competing Activities, Seeking Instrumental Social Support, Active Coping, Planning, and Restraint), and those that reflected disengagement or avoidance (i.e., Substance Use, Focusing On and Venting of Emotions, Behavioral Disengagement, Humor, and Mental Disengagement). Sample items include, "I put my trust in God (Religion)," "I use alcohol and drugs to make myself feel better (Substance Use)," "I sleep more than usual" (Mental Disengagement), and "I try to come up with a strategy about what to do" (Planning). Items are answered on a Likert-type scale, with response options that range from 1 (*I didn't do this at all*) to 4 (*I did this a lot*). Higher scores reflect more frequent use of a specific coping strategy.

Going beyond the initial validation work reported by Carver et al. (1989), Greer (2007) developed an alternate latent structure and scoring protocol for the COPE that has been demonstrated to be more culturally congruent with African American populations compared with Carver et al.'s (1989) original latent structure. This alternate structure and scoring protocol was used in the current study. Greer (2007) created four composite scores for the COPE that were consistent with African-centered values (e.g., spirituality, interdependence), and based on previous research findings on coping strategies found commonly used by many African Americans (e.g., Daly, Jennings, Beckett, & Leashore, 1995; Utsey, Adams, & Bolden, 2000). The four composite scales were created by combining specific COPE scales, and were labeled (a) "Interconnectedness" (i.e., composed of Focusing On and Venting of Emotions, Seeking Support for Instrumental Reasons, and Seeking Support for Emotional Reasons subscales); (b) "Problem-Oriented Coping" (i.e., composed of Active Coping, Suppression of Competing Activities, Positive Reinterpretation and Growth, and Humor subscales); (c) "Spirituality" (i.e., composed of Religion, Planning, Restraint, and Acceptance subscales); (d) and "Disengagement" (i.e., comprised of Denial, Behavioral Disengagement, Mental Disengagement, and Substance Use subscales). Interconnectedness consisted of 12 items, while problem-oriented coping, spirituality and disengagement composite scales were composed of 16 items each.

Greer (2007) compared the original COPE latent structure with the alternative latent structure via CFA. The original factor structure consisted of three latent factors, while the alternate latent structure consisted of four latent factors. The four-factor model yielded a low root mean square error of approximation value of .04, and a high value for comparative fit index at .92, and a Tucker-Lewis index value of .90, as well as an standardized root mean square residual of .07, and an expected cross-validation index of 1.23 (Greer, 2007). Greer's typology has been used in previous investigations to examine coping strategies among African Americans (e.g., Lewis, Williams, Peppers,

& Gadson, 2017; Williams & Lewis, 2019). In Lewis et al. (2017), Greer's alternate coping strategies were tested as mediators of the effects of gendered racial microaggressions on mental and physical health outcomes for African American women. The results demonstrated that the disengagement composite significantly mediated the effect of gendered racism on mental health, such that greater experiences of gendered racism were associated with greater disengagement. Disengagement was further demonstrated to yield a significant, inverse effect on mental health (Lewis et al., 2017). Greer (2007) reported Cronbach's alphas for the scores of interconnectedness, problem-oriented coping, spirituality, and disengagement composite scales as .88, .80, .80, and .74, respectively.

Psychological outcomes. The Hopkins Symptom Checklist-58 (HSCL-58; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) was used to assess psychological outcomes. The HSCL is a 58-item measure that was designed to assess psychiatric symptoms for nonclinical adult populations. Five subscales make-up the scale: obsessive-compulsiveness, interpersonal sensitivity, depression, somatization, and anxiety. Each item is a brief description of a specific psychiatric symptom, and is endorsed on a 4-point Likert-type scale to indicate the degree of severity of symptoms experienced, with item response options range from 0 (*not at all*) to 3 (*extremely*). Sample items include, "Having to avoid certain places or activities because they frighten you" (anxiety), "Feeling no interest in things" (depression), "Heavy feelings in your arms or legs" (somatization), "Temper outbursts you could not control" (interpersonal sensitivity), and "Having to check and double-check what you do" (obsessive-compulsive). Scores are generated by summing across items that correspond with each of the five subscales. High scores reflect endorsement of severe symptoms.

Cronbach's alphas for scores of each scale were reported as .87 for obsessive-compulsiveness, .85 for interpersonal sensitivity, .86 for depression, .87 for somatization, and .84 for anxiety (Derogatis et al., 1974). Derogatis et al. (1974) validated the HSCL using a series of factor analytic procedures with samples of outpatient and psychiatric adults and identified a five-factor solution reflective of the named subscales. The overall factor structure of the HSCL-58 has been supported in previous investigations with African American populations (e.g., Greer, 2011; Greer et al., 2009). Convergent validity was based on high congruence between the HSCL and ratings by psychiatrists of 837 clinical patients (Derogatis, Lipman, Covi, Rickels, & Uhlenhuth, 1970).

Demographic background. A demographic questionnaire was created for the investigation to solicit information regarding participant age, highest level of educational attainment, employment, and medical insurance coverage status.

Procedures

Participants were recruited from undergraduate courses in psychology, African American studies, engineering, and business. The university's institutional review board approved the study prior to data collection. The informed consent process was conducted with students. The measures were administered in paper-pencil format, with an average completion time of 23 minutes. Measures were not counterbalanced but presented in the same order for all participants. Students were compensated with extra credit or research credit in their courses in exchange for their participation.

The outpatient medical facility serves a large population of patients diagnosed with chronic disease and illnesses. Approximately 70% of the patients are African American. Participants from the clinic were recruited via querying the electronic medical records system to identify those who were eligible to participate in the investigation. Querying of the medical records system was performed in accordance with the Health Insurance Portability and Accountability Act and was in compliance with federal privacy laws for medical information. Patients were eligible to participate in the study if they were 18 years or older, and self-identified as African American, while patients were excluded if they were members of other racial and ethnic groups, and if they possessed current and/or previous psychiatric diagnoses. Patients who met criteria for inclusion were mailed invitation packets to participate in the study. Packets included a letter of invitation, a reply card, and a postage paid envelope. Patients were instructed to indicate on the reply form whether they were interested in participating in the study, and to include a telephone number for contact. Research assistants contacted the patients who returned the reply form and expressed interest in participating to schedule a home visit. All research assistants self-identified as African American and female, and were graduate students in clinical psychology. They conducted all home visits and administered the survey measures during the visits. Survey measures were administered in paper-pencil format, with an average completion time of 30 minutes. None of the items needed to be read aloud to patients, indicating that literacy was not a barrier in the completion of study measures. Patients were informed of their rights regarding participation in the study. Patients received a \$25 gift card to a local retail store for their participation.

Data Analytic Strategy

Pearson correlations were performed to determine the bivariate relationships between the main study variables. Hierarchical regression analyses were performed to test the study hypotheses. A power analysis was performed prior to conducting the regression analyses (Faul, Erdfelder, Buchner, & Lang, 2009). Power was set at 80%, and alpha at .05, with an effect size, Cohen's d , set at 0.25. A minimum sample size of 86 was needed to test the study hypotheses, with critical $F(14, 71) = 1.83$. The four alternate COPE strategies were tested as moderators, with institutional racism as the predictor of mental health symptoms. Prior to conducting the analyses, some background variables were dummy coded. Specifically, employment status was dichotomized (0 = unemployed, 1 = employed, full-time or part-time), along with educational achievement (0 = high school, 1 = college), insurance status (0 = uninsured, 1 = insured), and study site (0 = outpatient facility, 1 = college setting). Age was tested as a continuous variable.

All continuous predictors were centered prior to performing the analyses in order to minimize multicollinearity (Aiken & West, 1991). Background variables were entered on the first step to control for their effects, followed by institutional racism on the second step. Coping strategies were entered into the analyses on the third step, followed by interactions on the fourth and final step (i.e., Institutional Racism \times Interconnectedness, Institutional Racism \times Spirituality, Institutional Racism \times Problem-Oriented Coping, and Institutional Racism \times Disengagement). The outcome variables were scales of the HSCL (i.e., somatization, anxiety, depression, interpersonal sensitivity, and obsessive-compulsive).

Results

Descriptive Analyses

Intercorrelations, along with means and standard deviations, and Cronbach's alphas for the main study variables, are depicted in Table 2. There were no missing data or outliers. The data met all assumptions for normality.

Regression Analyses

A summary of the results of the regression analyses is depicted in Table 3. The hypotheses were tested in Step 4. There was no evidence of multicollinearity, and the assumption of homoscedasticity was met.

Table 2. Means, Standard Deviations, and Intercorrelations for Institutional Racism, Coping Strategies, and Psychological Symptoms ($N = 283$).

| Variables | M (SD) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|------------------------------|--------------|------|-------|--------|-----|------|-------|-------|-------|-------|-----|
| 1. Institutional Racism | 12.67 (4.51) | — | | | | | | | | | |
| 2. Interconnectedness | 29.96 (7.20) | .06 | — | | | | | | | | |
| 3. Spirituality | 42.46 (7.83) | .06 | .40** | — | | | | | | | |
| 4. Problem-Oriented Coping | 40.90 (6.75) | .02 | .46** | .65** | — | | | | | | |
| 5. Disengagement | 30.23 (8.58) | -.00 | .10 | -.27** | .08 | — | | | | | |
| 6. Obsessive-Compulsive | 7.17 (5.97) | -.03 | -.03 | .11 | .01 | -.04 | — | | | | |
| 7. Interpersonal Sensitivity | 4.99 (4.21) | .09 | -.06 | .18* | .08 | -.02 | .70** | — | | | |
| 8. Depression | 6.52 (6.25) | .14* | -.12* | .06 | .01 | -.05 | .75** | .75** | — | | |
| 9. Anxiety | 2.19 (3.09) | .16* | -.11 | .01 | .07 | -.03 | .65** | .60** | .73** | — | |
| 10. Somatization | 5.68 (5.38) | .12* | .17** | .05 | .02 | -.02 | .71** | .63** | .71** | .70** | — |
| | | | .88 | .80 | .80 | .74 | .88 | .77 | .85 | .78 | .81 |

Note: Reliability estimate of the scores for the respective scale are on the diagonal.

* $p < .05$. ** $p < .01$.

Table 3. Moderated Regression Analyses Predicting Psychological Symptoms From Background Variables, Institutional Racism, Coping Strategies, and Interactions Between Institutional Racism and Coping Strategies ($N = 283$).

| Variables | B | SE of B | β | sr^2 | R^2 | ΔR^2 | ΔF |
|--------------------------------|-------|---------|---------|--------|-------|--------------|------------|
| <i>Somatization</i> | | | | | | | |
| Step 1 | | | | | | | |
| Site | 0.57 | 1.15 | .05 | <.01 | .01 | <.01 | 0.47 |
| Age | 0.00 | 0.03 | .01 | <.01 | | | |
| Education | -0.68 | 0.67 | -.06 | <.01 | | | |
| Employment status | 0.32 | 0.66 | .03 | <.01 | | | |
| Insurance status | -0.70 | 0.73 | -.06 | <.01 | | | |
| Step 2 | | | | | | | |
| Site | -0.38 | 1.24 | -.03 | <.01 | .02 | .01 | 1.06 |
| Age | 0.00 | 0.03 | .00 | <.01 | | | |
| Education | -0.67 | 0.66 | -.06 | <.01 | | | |
| Employment status | 0.31 | 0.66 | .03 | <.01 | | | |
| Insurance status | -0.67 | 0.73 | -.06 | <.01 | | | |
| IR | 0.17 | 0.09 | .14* | <.01 | | | |
| Step 3 | | | | | | | |
| Site | -0.22 | 1.29 | -.02 | <.01 | .07 | .05 | 2.12* |
| Age | 0.00 | 0.03 | .00 | <.01 | | | |
| Education | -0.89 | 0.65 | -.08 | <.01 | | | |
| Employment status | 0.46 | 0.65 | .04 | <.01 | | | |
| Insurance status | -0.50 | 0.71 | -.04 | <.01 | | | |
| IR | 0.18 | 0.09 | .15* | <.01 | | | |
| Interconnectedness | -0.19 | 0.05 | -.26*** | <.05 | | | |
| Spirituality | 0.07 | 0.06 | .11 | <.01 | | | |
| Problem-oriented coping | 0.04 | 0.07 | .05 | <.01 | | | |
| Disengagement | 0.2 | 0.04 | .04 | <.01 | | | |
| Step 4 | | | | | | | |
| Site | -0.81 | 1.32 | -.07 | <.01 | .10 | .03 | 2.00* |
| Age | 0.01 | 0.03 | .04 | <.01 | | | |
| Education | -0.78 | 0.66 | -.07 | <.01 | | | |
| Employment status | 0.44 | 0.65 | .04 | <.01 | | | |
| Insurance status | -0.49 | 0.72 | -.04 | <.02 | | | |
| Institutional Racism (IR) | 0.24 | 0.10 | .20* | <.05 | | | |
| Interconnectedness | -0.20 | 0.05 | -.27*** | <.03 | | | |
| Spirituality | 0.05 | 0.06 | .08 | <.01 | | | |
| Problem-oriented coping | 0.06 | 0.07 | .07 | <.01 | | | |
| Disengagement | 0.03 | 0.04 | .04 | <.01 | | | |
| IR \times Interconnectedness | -0.01 | 0.01 | -.03 | <.01 | | | |

(continued)

Table 3. (continued)

| Variables | B | SE of B | β | sr^2 | R^2 | ΔR^2 | ΔF |
|-------------------------------------|-------|---------|---------|--------|-------|--------------|------------|
| IR \times Spirituality | 0.00 | 0.01 | .02 | <.01 | | | |
| IR \times Problem-oriented coping | 0.02 | 0.02 | .11 | <.01 | | | |
| IR \times Disengagement | -0.02 | 0.01 | -.13 | <.01 | | | |
| <i>Interpersonal Sensitivity</i> | | | | | | | |
| Step 1 | | | | | | | |
| Site | 0.11 | 0.89 | .01 | <.01 | .02 | <.01 | 1.24 |
| Age | 0.01 | 0.03 | .06 | <.01 | | | |
| Education | 0.92 | 0.52 | .11 | <.01 | | | |
| Employment status | 0.28 | 0.51 | .03 | <.01 | | | |
| Insurance status | -0.69 | 0.57 | -.07 | <.01 | | | |
| Step 2 | | | | | | | |
| Site | -0.99 | 0.94 | -.11 | <.01 | .05 | .03 | 2.57** |
| Age | 0.01 | 0.03 | .04 | <.01 | | | |
| Education | 0.93 | 0.51 | -.11 | <.01 | | | |
| Employment status | 0.28 | 0.51 | .03 | <.01 | | | |
| Insurance status | -0.65 | 0.56 | -.07 | <.01 | | | |
| IR | 0.02 | 0.07 | .21** | <.03 | | | |
| Step 3 | | | | | | | |
| Site | -0.64 | 0.99 | -.07 | <.01 | .09 | .04 | 2.78** |
| Age | 0.01 | 0.03 | .03 | <.01 | | | |
| Education | 0.79 | 0.51 | .09 | <.01 | | | |
| Employment status | 0.31 | 0.50 | .04 | <.01 | | | |
| Insurance status | -0.44 | 0.56 | -.05 | <.02 | | | |
| IR | 0.17 | 0.07 | .18* | <.02 | | | |
| Interconnectedness | -0.10 | 0.04 | -.16* | <.02 | | | |
| Spirituality | 0.13 | 0.05 | .25** | <.02 | | | |
| Problem-oriented coping | -0.03 | 0.05 | -.05 | <.01 | | | |
| Disengagement | 0.05 | 0.03 | .09 | <.01 | | | |
| Step 4 | | | | | | | |
| Site | -0.96 | 1.02 | -.11 | <.01 | .12 | .03 | 2.55** |
| Age | 0.02 | 0.03 | .07 | <.01 | | | |
| Education | 0.89 | 0.51 | .11 | <.01 | | | |
| Employment status | 0.34 | 0.50 | .04 | <.01 | | | |
| Insurance status | -0.51 | 0.56 | -.05 | <.01 | | | |
| IR | 0.22 | 0.07 | .23** | <.03 | | | |
| Interconnectedness | -0.10 | 0.04 | -.18* | <.02 | | | |
| Spirituality | 0.11 | 0.05 | .21* | <.02 | | | |

(continued)

Table 3. (continued)

| Variables | B | SE of B | β | sr^2 | R^2 | ΔR^2 | ΔF |
|-------------------------------------|-------|---------|---------|--------|-------|--------------|------------|
| Problem-oriented coping | -0.02 | 0.05 | -.03 | <.01 | | | |
| Disengagement | 0.05 | 0.03 | .10 | <.01 | | | |
| IR \times Interconnectedness | -0.01 | 0.01 | -.06 | <.01 | | | |
| IR \times Spirituality | 0.02 | 0.01 | .18* | <.01 | | | |
| IR \times Problem-oriented coping | 0.00 | 0.01 | -.02 | <.01 | | | |
| IR \times Disengagement | 0.00 | 0.01 | -.03 | <.01 | | | |
| <i>Depression</i> | | | | | | | |
| Step 1 | | | | | | | |
| Site | -0.90 | 1.32 | -.07 | <.01 | .02 | <.01 | .98 |
| Age | -0.02 | 0.04 | -.05 | <.01 | | | |
| Education | 0.73 | 0.77 | .06 | <.01 | | | |
| Employment status | 1.14 | 0.76 | .09 | <.01 | | | |
| Insurance status | -0.33 | 0.85 | -.02 | <.01 | | | |
| Step 2 | | | | | | | |
| Site | -2.90 | 1.41 | -.22* | <.01 | .06 | .04 | 3.08** |
| Age | -0.02 | 0.037 | -.06 | <.01 | | | |
| Education | 0.75 | 0.75 | .06 | <.01 | | | |
| Employment status | 1.13 | 0.75 | .09 | <.01 | | | |
| Insurance status | -0.26 | 0.83 | -.02 | <.01 | | | |
| IR | 0.36 | 0.10 | .26*** | <.05 | | | |
| Step 3 | | | | | | | |
| Site | -3.00 | 1.48 | -.23* | <.01 | .09 | .03 | 2.64** |
| Age | -0.02 | 0.04 | -.05 | <.01 | | | |
| Education | 0.61 | 0.75 | .05 | <.01 | | | |
| Employment status | 1.26 | 0.74 | .10 | <.01 | | | |
| Insurance status | -0.19 | 0.83 | -.01 | <.01 | | | |
| IR | 0.39 | 0.11 | .28*** | <.05 | | | |
| Interconnectedness | -0.16 | 0.06 | -.18* | <.02 | | | |
| Spirituality | 0.03 | 0.07 | .04 | <.01 | | | |
| Problem-oriented coping | 0.01 | 0.08 | .01 | <.01 | | | |
| Disengagement | 0.02 | 0.05 | .03 | <.01 | | | |
| Step 4 | | | | | | | |
| Site | -3.38 | 1.52 | -.26* | <.02 | .10 | .01 | 2.07* |
| Age | -0.01 | 0.04 | -.02 | <.01 | | | |
| Education | 0.71 | 0.76 | .06 | <.01 | | | |
| Employment status | 1.25 | 0.75 | .10 | <.01 | | | |
| Insurance status | -0.23 | 0.84 | -.02 | <.01 | | | |
| IR | 0.44 | 0.11 | .21*** | <.05 | | | |

(continued)

Table 3. (continued)

| Variables | B | SE of B | β | sr^2 | R^2 | ΔR^2 | ΔF |
|-------------------------------------|-------|---------|---------|--------|-------|--------------|------------|
| Interconnectedness | -0.16 | 0.06 | -.19* | <.03 | | | |
| Spirituality | 0.02 | 0.07 | .02 | <.01 | | | |
| Problem-oriented coping | 0.02 | 0.08 | .03 | <.01 | | | |
| Disengagement | 0.03 | 0.05 | .04 | <.01 | | | |
| IR \times Interconnectedness | -0.01 | 0.01 | -.02 | <.01 | | | |
| IR \times Spirituality | 0.01 | 0.02 | .04 | <.01 | | | |
| IR \times Problem-oriented coping | 0.01 | 0.02 | .06 | <.01 | | | |
| IR \times Disengagement | -0.01 | 0.01 | -.06 | <.01 | | | |
| | | Anxiety | | | | | |
| Step 1 | | | | | | | |
| Site | 0.07 | 0.66 | .01 | <.01 | .01 | <.01 | 0.41 |
| Age | 0.00 | 0.02 | .01 | <.01 | | | |
| Education | 0.14 | 0.38 | .02 | <.01 | | | |
| Employment status | 0.35 | 0.38 | .06 | <.01 | | | |
| Insurance status | -0.37 | 0.42 | -.05 | <.01 | | | |
| Step 2 | | | | | | | |
| Site | -0.41 | 0.71 | -.06 | <.01 | .02 | .01 | 0.83 |
| Age | 0.00 | 0.02 | .01 | <.01 | | | |
| Education | 0.14 | 0.38 | .02 | <.01 | | | |
| Employment Status | 0.35 | 0.28 | .06 | <.01 | | | |
| Insurance Status | -0.35 | 0.42 | -.05 | <.01 | | | |
| IR | 0.09 | 0.05 | .12 | <.01 | | | |
| Step 3 | | | | | | | |
| Site | -0.50 | 0.75 | -.08 | <.01 | .02 | .01 | 1.44 |
| Age | 0.00 | 0.02 | .00 | <.01 | | | |
| Education | 0.04 | 0.38 | .01 | <.01 | | | |
| Employment status | 0.41 | 0.38 | .07 | <.01 | | | |
| Insurance status | -0.33 | 0.42 | -.05 | <.01 | | | |
| IR | 0.10 | 0.05 | .14 | <.01 | | | |
| Interconnectedness | -0.07 | 0.03 | -.17* | <.02 | | | |
| Spirituality | -.04 | 0.04 | -.10 | <.01 | | | |
| Problem-oriented coping | 0.09 | 0.04 | .19* | <.02 | | | |
| Disengagement | -0.01 | 0.03 | -.03 | <.01 | | | |
| Step 4 | | | | | | | |
| Site | -0.72 | 0.77 | -.11 | <.01 | .11 | .09 | 2.15* |
| Age | 0.01 | 0.02 | .04 | <.01 | | | |
| Education | 0.13 | 0.38 | .02 | <.01 | | | |
| Employment status | 0.39 | 0.38 | .06 | <.01 | | | |

(continued)

Table 3. (continued)

| Variables | B | SE of B | β | sr^2 | R^2 | ΔR^2 | ΔF |
|-------------------------------------|-------|---------|---------|--------|-------|--------------|------------|
| Insurance status | -0.37 | 0.12 | -.05 | <.01 | | | |
| IR | 0.14 | 0.06 | .20* | <.02 | | | |
| Interconnectedness | -0.08 | 0.03 | -.19* | <.02 | | | |
| Spirituality | -0.05 | 0.04 | -.12 | <.01 | | | |
| Problem-oriented coping | 0.10 | 0.04 | .21* | <.02 | | | |
| Disengagement | -0.01 | 0.03 | -.03 | <.01 | | | |
| IR \times Interconnectedness | 0.00 | 0.01 | -.05 | <.01 | | | |
| IR \times Spirituality | 0.00 | 0.01 | .05 | <.01 | | | |
| IR \times Problem-oriented coping | 0.01 | 0.01 | .12 | <.01 | | | |
| IR \times Disengagement | -0.01 | 0.01 | -.07 | <.01 | | | |
| <i>Obsessive-Compulsive</i> | | | | | | | |
| Step 1 | | | | | | | |
| Site | 0.34 | 1.26 | .03 | <.01 | .01 | <.01 | .98 |
| Age | 0.05 | 0.04 | .15 | <.01 | | | |
| Education | 0.36 | 0.73 | .03 | <.01 | | | |
| Employment status | 0.34 | 0.73 | .03 | <.01 | | | |
| Insurance status | 0.12 | 0.81 | .01 | <.01 | | | |
| Step 2 | | | | | | | |
| Site | -1.14 | 1.35 | -.09 | <.01 | .02 | .01 | 1.37 |
| Age | 0.05 | 0.04 | .14 | <.01 | | | |
| Education | 0.37 | 0.73 | .03 | <.01 | | | |
| Employment status | 0.33 | 0.72 | .03 | <.01 | | | |
| Insurance status | 0.17 | 0.79 | .01 | <.01 | | | |
| IR | 0.27 | 0.10 | .20 | <.03 | | | |
| Step 3 | | | | | | | |
| Site | -1.13 | 1.43 | -.09 | <.01 | .02 | .01 | 1.73 |
| Age | 0.05 | 0.04 | .15 | <.01 | | | |
| Education | 0.34 | 0.73 | .03 | <.01 | | | |
| Employment status | 0.36 | 0.72 | .03 | <.01 | | | |
| Insurance status | 0.27 | 0.80 | .02 | <.01 | | | |
| IR | 0.27 | 0.10 | .21* | <.02 | | | |
| Interconnectedness | -0.07 | 0.06 | -.09 | <.01 | | | |
| Spirituality | 0.10 | 0.07 | .13 | <.01 | | | |
| Problem-oriented coping | -0.09 | 0.08 | -.10 | <.01 | | | |
| Disengagement | 0.06 | 0.05 | .08 | <.01 | | | |
| Step 4 | | | | | | | |
| Site | -1.41 | 1.48 | -.11 | <.01 | .07 | .05 | 2.17* |
| Age | 0.06 | 0.04 | .17 | <.01 | | | |

(continued)

Table 3. (continued)

| Variables | B | SE of B | β | sr^2 | R^2 | ΔR^2 | ΔF |
|-------------------------------------|-------|---------|---------|--------|-------|--------------|------------|
| Education | 0.43 | 0.74 | .04 | <.01 | | | |
| Employment status | 0.39 | 0.73 | .03 | <.01 | | | |
| Insurance status | 0.30 | 0.81 | .02 | <.01 | | | |
| IR | 0.30 | 0.11 | .23** | <.03 | | | |
| Interconnectedness | -0.08 | 0.06 | -.10 | <.01 | | | |
| Spirituality | 0.09 | 0.07 | .12 | <.01 | | | |
| Problem-oriented coping | -0.08 | 0.08 | -.09 | <.01 | | | |
| Disengagement | 0.05 | 0.05 | .08 | <.01 | | | |
| IR \times Interconnectedness | -0.01 | 0.01 | -.05 | <.01 | | | |
| IR \times Spirituality | -0.00 | 0.01 | -.00 | <.01 | | | |
| IR \times Problem-oriented coping | 0.01 | 0.02 | .07 | <.01 | | | |
| IR \times Disengagement | -0.01 | 0.01 | .08 | <.01 | | | |

Note: SE = standard error; IR = institutional racism.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Somatization. For somatization, only Steps 3 and 4 were statistically significant: Step 1: Demographics, $F(5, 277) = 0.47, p = .79, R^2 = .01$; Step 2: Institutional racism, $F(6, 276) = 1.06, p = .38, \Delta R^2 = .01$; Step 3: Coping strategies, $F(10, 272) = 2.12, p = .02, \Delta R^2 = .05$; Step 4: Interactions, $F(14, 268) = 2.00, p = .02, \Delta R^2 = .03$. Interconnectedness as a coping strategy was the strongest predictor in the fourth and final step, followed by institutional racism. The effect for interconnectedness was an inverse predictor of somatization, which suggested that low reliance on this coping strategy was associated with increased somatization. The effect for institutional racism was positive, suggesting that frequent experiences of institutional racism were associated with greater somatization. None of the interactions were statistically significant in the last step.

Interpersonal sensitivity. For interpersonal sensitivity, Steps 2 through 4 were statistically significant: Step 1: Demographics, $F(5, 277) = 1.24, p = .29, R^2 = < .001$; Step 2: Institutional racism, $F(6, 276) = 2.57, p = .02, \Delta R^2 = .05$; Step 3: Coping strategies, $F(10, 272) = 2.78, p < .001, \Delta R^2 = .09$; Step 4: Interactions, $F(14, 268) = 2.55, p < .001, \Delta R^2 = .12$. On step four, a significant main effect of institutional racism was observed, and was the strongest predictor of this outcome, followed by spirituality and interconnectedness. The positive effect for institutional racism and spirituality suggested that an increase in reliance on these strategies were associated with greater

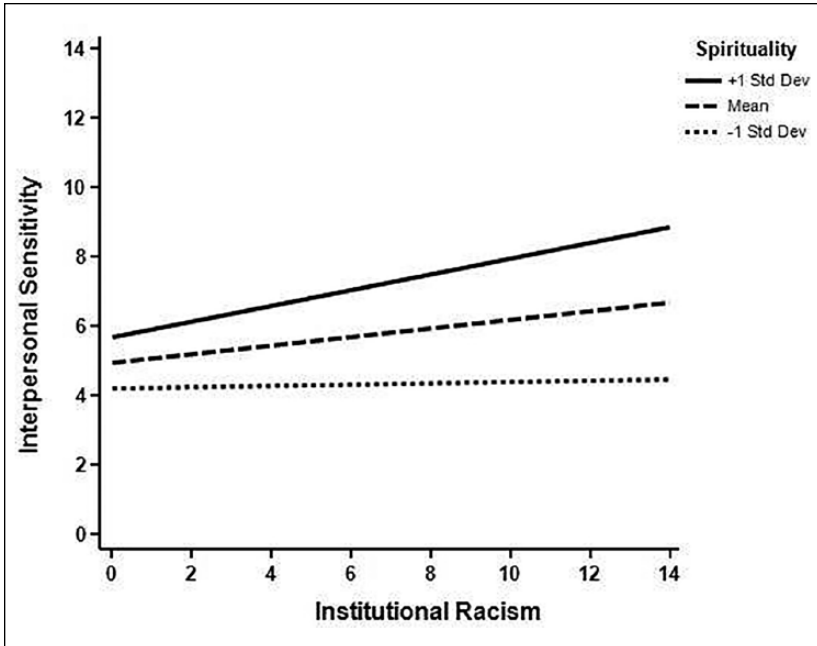


Figure 1. Plot of interaction between institutional racism and spirituality in predicting interpersonal sensitivity ($N = 283$).

Note: Interpersonal sensitivity increased with greater use of spirituality to cope with institutional racism.

experiences of interpersonal sensitivity. The significant, inverse effect for interconnectedness on the fourth step suggested that an increase in the use of this strategy was associated with less interpersonal sensitivity.

In addition, a significant interaction was revealed on the final step between institutional racism and spirituality in predicting interpersonal sensitivity. Simple slope analyses were performed to further examine the interaction. Effects were plotted at low ($SD = -1$), mean ($SD = 0$), and high ($SD = +1$) levels of spirituality (see Figure 1). The analyses revealed that the slope for low spirituality was not statistically significant from zero, $t(279) = 0.26, p = .78$, while the slope for high, $t(279) = 2.86, p = .001$, and mean levels of spirituality, $t(279) = 2.26, p = .02$, were statistically significant from zero, with a Cohen's f^2 value of 0.06. The direction of these effects suggested that African American men who endorsed mean and high levels of use of spirituality experienced severe more interpersonal sensitivity symptoms in relation to increased exposure to institutional racism.

Depression. In predicting depression, steps two through four were statistically significant: Step 1: Demographics, $F(5, 277) = 0.98, p = .42, R^2 < .001$; Step 2: Institutional racism, $F(6, 276) = 3.08, p = .00, \Delta R^2 = .04$; Step 3: Coping strategies, $F(10, 272) = 2.64, p < .001, \Delta R^2 = .03$; Step 4 Interactions, $F(14, 268) = 2.07, p = .01, \Delta R^2 = .01$. On the fourth and final step, institutional racism was the strongest predictor of this outcome, followed by study site and interconnectedness. The effect for institutional racism was positive, suggesting that frequent experiences of this form of racism was associated with an increase in depressive symptoms. The effect for interconnectedness was negative which suggested that low use of this strategy was related to an increase in depression. The inverse direction of the effect for study site suggested that patients from the outpatient setting endorsed greater symptoms of depression than college students.

Anxiety. For anxiety symptoms, only Step 4 was statistically significant: Step 1: Demographics, $F(5, 277) = 0.41, p = .84, R^2 < .001$; Step 2: Institutional racism, $F(6, 276) = 0.83, p = .54, \Delta R^2 = .04$; Step 3: Coping strategies, $F(10, 272) = 1.44, p = .16, \Delta R^2 = .01$; Step 4: Interactions, $F(14, 268) = 2.15, p = .01, \Delta R^2 = .09$. On the fourth step, problem-oriented coping was revealed to be the strongest predictor. The positive direction of the effect suggested that greater use of this strategy was associated with higher levels of anxiety. The results also revealed a positive effect for institutional racism and a negative effect for interconnectedness in predicting this outcome. The positive effect for institutional racism suggested that an increase in these experiences was associated with higher levels of anxiety. Furthermore, the negative effect for interconnectedness suggested that low use of this strategy was associated with an increase in anxiety.

Obsessive-compulsive. A similar pattern of results were revealed for obsessive-compulsive symptoms, in which only the fourth step was statistically significant. Step 1: Demographics, $F(5, 277) = 0.43, p = .84, R^2 < .001$; Step 2: Institutional racism, $F(6, 276) = 1.32, p = .25, \Delta R^2 = .01$; Step 3: Coping strategies, $F(10, 272) = 1.73, p = .07, \Delta R^2 = .01$; Step 4: Interactions, $F(14, 268) = 2.15, p = .01, \Delta R^2 = .05$. Institutional racism was the only significant predictor of this outcome on the fourth and final step of the analyses. The main effect was positive which suggested that greater experiences of institutional racism were associated with an increase in obsessive-compulsive symptoms.

Discussion

The purpose of this study was to test coping strategies as qualifiers of the effects of institutional racism on psychological symptoms for a sample of

African American men. We initially hypothesized that adaptive coping strategies (i.e., problem-oriented coping, spirituality, and interconnectedness) would moderate the effects of institutional racism on anxiety, interpersonal sensitivity, depression, obsessive-compulsive, and somatization symptoms for African American men, such that greater use of these efforts would be associated with less severe symptoms. We further expected greater use of disengagement strategies, or those less adaptive, to be associated with greater severity in psychological symptoms in relation to more exposure to institutional racism. The findings partially supported our hypotheses.

On the fourth and final step of the regression analyses, institutional racism was found to be a positive predictor of all psychological symptoms. These findings are consistent with some previously published investigations in which the adverse mental health impacts of racism have been demonstrated for African American men (e.g., Britt-Spells et al., 2016; Greer et al., 2009; Matthews et al., 2013; Utsey, 1997). Main effects were also revealed in the prediction of psychological symptoms on the fourth step of the regression analyses. Specifically, interconnectedness was found to have an inverse, significant effect on all symptoms, with the exception of obsessive-compulsive symptoms. These findings suggested that persons who engaged in less reliance on others for emotional and instrumental social support (e.g., financial assistance) may have experienced negative mental health impacts. This particular finding is consistent with previously published studies in which it has been found that reliance on forms of social support has served as a buffer to negative mental health outcomes for some populations of African American men (e.g., Fries-Britt & Griffin, 2007; Harper et al., 2011).

Contrary to expectations, we found a positive effect for problem-oriented coping in predicting anxiety. The problem-oriented composite scale entailed behaviors that are also indicative of self-reliance, such as humor, and individual efforts to resolve difficulties. Thus, although we, as well as other theorists (e.g., Carver et al., 1989), have conceptualized problem-focused coping efforts as having potentially adaptive influences, our finding suggests that such individual efforts may not be effective in reducing the severity of negative mental health symptoms. In addition, our findings revealed an inverse significant effect for study site in predicting depression, which suggested that men from the outpatient medical setting endorsed this symptom more than college students. Men from the outpatient facility were older than the college men. Thus, our findings suggest that additional investigations are needed to understand the contributors to depressive symptoms for older African American men.

Spirituality was also found to have a positive effect in predicting interpersonal sensitivity. We also found an interaction between institutional racism

and spirituality in predicting this outcome. The main effect of spirituality is best interpreted within the context of the interaction. Overall, these results were inconsistent with our hypotheses. Simple slope analyses revealed that greater use of spirituality was associated with greater interpersonal sensitivity symptoms in relation to exposure to institutional racism. Derogatis et al. (1974) described the interpersonal sensitivity scale as comprising items that capture feelings of personal inadequacy and inferiority, in addition to self-consciousness and discomfort in social interactions. In considering some of the behaviors that comprised the spirituality composite scale (e.g., restraint, acceptance), it may be possible that reliance on a Higher Power might raise some feelings of inadequacy and self-consciousness in relation to managing a systemic, chronic stressor as institutional racism. Greer (2011) examined the role of culture-specific coping strategies in understanding the effects of individual level racism-related stress on mental health outcomes for African American women. The findings revealed an interaction between individual racism and ritual-centered coping, such that greater use of this strategy was associated with greater severity of these symptoms in relation to frequent experiences of racism. Greer (2011) reasoned that the findings may be related to underlying emotional processes that are involved in the reliance on spiritual faith and related rituals in coping with racism. Specifically, reliance on spirituality and associated rituals can entail relinquishing one's personal power to a Higher Power, and can further entail acceptance of the limits of one's own power to resolve problems and challenges (e.g., Cole & Pargament, 1999). However, Mattis (2002) noted that African Americans are often socialized to be self-reliant and to address difficulties alone. Therefore, internal conflict may potentially arise between one's spiritual "surrender" and internalized messages regarding the need to address problems on one's own (e.g., Mattis, 2002). It is plausible that African American men in our study experienced a similar phenomenon in the use of spirituality to manage institutional racism. The use of spirituality may have evoked internalized messages regarding the need to be self-reliant in addressing difficulties, thereby potentially creating internal conflict and thus increasing negative psychological symptoms as opposed to alleviating them. Additional studies are needed to clarify the role of spirituality in coping with institutional racism for African American men.

Implications

A strength of this investigation was the inclusion of both a college student sample and a sample of men from a community-based medical setting, which allowed for a broader understanding of the ways in which African American

men cope with institutional racism, as well as related mental health impacts. We also examined coping strategies that have been demonstrated to be culturally congruent with African American populations (e.g., Greer, 2007). The inclusion of cultural coping strategies represents an additional strength of our investigation.

Our results indicated that spirituality was a significant moderator of the effects of institutional racism on interpersonal sensitivity, such that greater use of spirituality was associated with greater interpersonal sensitivity symptoms. This finding supports the need to focus intervention efforts in promoting interconnectedness as a coping strategy to better deal with racism, opposed to ones focused on self-reliance. Based on our findings, it is possible that clinical interventions focused on helping African American men establish and/or connect with a support system may better mitigate the mental health effects of institutional racism. Furthermore, improving interpersonal effectiveness skills for this population may overall improve the well-being of African American men, and help them better manage the deleterious effects of racism.

Limitations

A few limitations should be considered in understanding the results of our study. We utilized a cross-sectional design; therefore, we were unable to examine long-term use of coping strategies and the potential influence on psychological outcomes associated with institutional racism. We also included African American men from two settings (i.e., college setting and outpatient medical setting) and in the Southeastern region of the United States. Therefore, our findings may not generalize to African American men in other settings and in other geographic locations. We also tested institutional racism only. African American men are likely negatively affected by other forms of racism (e.g., individual, cultural) and in other aspects of health beyond mental health. The measures were also administered in the same order; thus, order effects may have influenced the findings in this study. Last, we relied on self-report of experiences of institutional racism and coping behaviors in our investigation.

Future Research and Practice

Our findings imply that future studies should address the various ways in which African American men both experience and cope with racism. Our findings further imply that mental health professionals should assist African American men in determining the overall effectiveness of the strategies that they might employ when addressing institutional racism. Coping with institutional

racism-related experiences can entail encounters with systemic bureaucracies in which race-based social hierarchies are maintained or reinforced (Pratto et al., 2006). Thus, mental health professionals should work to assist African American men in determining ways to develop social support networks and connect them to resources in their communities (e.g., legal, local advocacy services) that might serve to alleviate difficulties associated with their experiences of institutional racism-related incidents (Greer et al., 2018).

Conclusion

African American men are frequently exposed to institutional racism, and thus are particularly vulnerable to the emotional and psychological effects associated with their experiences. Our findings indicate that self-reliance and individual-level efforts in coping with racism may serve to increase psychological symptoms as opposed to alleviating symptoms. Findings from this study further demonstrate that the effects of institutional racism on interpersonal sensitivity may be moderated by spirituality, such that greater use of this coping strategy appears to be associated with severe mental health symptoms. This particular finding suggests that African American men may experience enhanced self-consciousness in social contexts following incidents of institutional racism. Future research investigations should be designed to continue to understand the ways in which African American men manage institutional racism in order to pinpoint coping strategies that may prove effective in alleviating adverse mental health symptoms that are associated with this form of social inequality.


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