What Would You Do? Racial Differences in Mental Health Coping Strategies

by
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ABSTRACT

Personal mental health coping mechanisms are both social and individual behaviors that relieve stress and other negative emotions. They are considered alternative to formal coping strategies due to the fact that they are not used under the guide of a mental health professional or in combination with therapy and medicine. Evidence shows that overall, black Americans use formal mental health therapy and medicine the least compared to other races and ethnicities, especially whites. What is lacking in the literature is an understanding of willingness to utilize traditional mental health services, as well as alternative coping strategies, both across different races/ethnicities and across different groups of blacks. Using a 2022 survey of Houston, Texas residents, I explore racial and ethnic differences in both formal and personal coping mechanisms, such as exercise, social networks, and religion through binary logistic regressions. The main finding of this study is that the largest differences in willingness to use coping strategies (both traditional and personal) varies more across racial groups rather than within the black community. Also, more than other racial groups, blacks are more likely to utilize religious services as a mental health strategy. This paper provides foundations for future policy and research concerning willingness to use mental health services and coping strategies both across racial groups and within the black community.

Key Words: *Black, Black Americans, mental health, equity, inequality, mental health coping mechanisms, racial disparities*

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Health, both physical and mental, is highly correlated with overall life satisfaction (American Psychological Association 2016; Freitas, Franco, and Teasdall 2021). Traditional mental health care is considered to be an amalgamation of therapy and medical treatment (Wang, Berglund, and Kessler 2000; U.S. Department of Health and Human Services 2001). Research finds that formal mental health service utilization varies across racial and ethnic groups. Specifically, black Americans are the group least likely to use traditional mental health services the least compared to other races and ethnicities, especially whites (Holden and Xanthos 2009; American Psychological Association 2016; Williams 2018; Freitas et al. 2021).

A major aspect of mental health is how people cope with life events and stressors. These behaviors can be individual or social (Department of Health and Human Services 2001; American Psychological Association 2016). Traditional formal coping strategies that are promoted by various organizations such as the American Psychological Association (2016) consist of a combination of therapy and medicine. Most formal coping mechanisms are geared toward a Eurocentric mindset and lifestyle in the fact that caring for one's mental health in appropriate ways typically involves medicalization (U.S. Department of Health and Human Services 2001; American Psychological Association 2016). Mental health professionals promote formal coping mechanisms that are foreign to many black cultures, especially without the guide of a mental health professional (Folkman and Lazarus 1988). Many traditional coping mechanisms do not consider differences in culture and how culture can affect individual social behavior, which includes coping mechanisms (Utsey, Adams, and Bolden 2000; Constantine, Donnelly and Myers 2002).

Over the past 50 years, the literature dedicated to individuals' use of personal coping mechanisms as an alternative to therapy and medicine has grown (Berjot and Gillet 2011; Folkman 1984; Folkman and Lazarus 1984; Lazarus and Folkman 1988; Utsey et al. 2000; Constantine et al. 2002; Dill 2017). Evidence shows that black people utilize certain personal coping mechanisms at a greater rate than traditional mechanisms, including social networks and religious services (Utsey, Adams and Bolden 2000; Schnittker et al. 2000; Constantine et al. 2002). Coping mechanisms are recognized as an important part of maintaining stable mental health (Schnittker et al. 2000; U.S. Department of Health and Human Services 2001). Because traditional mental health services promote learning coping strategies from a mental health professional, which is inherently medicalized, this use of informal coping mechanisms may help explain differences in black mental health service utilization.

Black mental health is paradoxical (Williams 2018). Arguably, black individuals on average deal with more frequent negative emotions and stressful situations than their white counterparts. Black communities are afflicted with stress-related diseases in higher rates as well (Utsey et al. 2000). Despite this, black people are consistently diagnosed with psychiatric disorders at a lower rate and have lower suicide rates (U.S. Department of Health and Human Services 2001; Brown 2003; Harris et al. 2005; Williams 2018; Freitas et al. 2021). Black people possibly partaking in coping strategies on their own rather than using traditional mental health services and receiving regulated coping strategies from a mental health professional can assist in explaining the black-white inequality in mental health service utilization rates. It is necessary to understand differential groups of black people's specific coping mechanisms to ensure that they are dealing with their emotions in a way that

promotes mental health stability. Understanding how black individuals use personal coping mechanisms can provide a more complete understanding of black mental health.

This study attempts to address two questions related to personal coping mechanism use and blacks' use of traditional mental health services: 1) How are personal coping mechanisms used by different races/ethnicities? and 2) Among blacks, what are the within-group differences in usage of personal coping strategies in the black community by gender, education, and income? The literature has established a conceptual difference between traditional and informal coping mechanisms, but research is lacking on which coping mechanisms are utilized by different racial groups (Folkman and Lazarus 1988; U.S. Department of Health and Human Services 2001; Utsey et al. 2000; Schnittker et al. 2002). Understanding different racial groups' willingness to utilize certain coping strategies (both formal and personal) can have implications for why previous work has shown differences in mental health access and outcomes. This proposal will outline a study that will use different coping strategies to understand both within-group black mental health coping mechanisms by gender, income, and education as well as cross-racial differences by analyzing survey data from a 2022 telephone survey of Harris County residents in Houston, Texas.

LITERATURE REVIEW

General Mental Health

The mental health literature has grown over the past 50 years and has come to be regarded as important as physical health (Wang et al. 2000; U.S. Department of Health and Human Services 2001; World Health Organization 2010; Williams 2018). Mental health is defined as "a state of well-being" in which people can deal with the normal stresses of life and can effectively contribute to society (World Health Organization 2010:1). According to mental

health professionals, formal mental health services consist of a combination of therapy and medication (U.S. Department of Health and Human Services 2001; World Health Organization 2010; American Psychological Association 2016). The American Psychological Association (2016) and other mental health professional organizations promote the use of mental health services to cope with life's events, stressful or otherwise (Wang et al. 2000; Constantine et al. 2002; World Health Organization 2010; Williams 2018; Freitas et al. 2021).

While it is important for everyone to access mental health services, black Americans have been systematically underserved in this regard, despite often facing a number of life circumstances that could increase their need for such services (Utsey et al. 2000; Constantine et al. 2002; Brown 2003; Mouzon 2013; Williams 2018; Freitas et al. 2021). Black people persistently have a lower socioeconomic standing than whites and are afflicted by discriminatory practices in every sector of life (Holden and Xanthos 2009; American Psychological Association 2016; Williams 2018; Freitas et al. 2021). Stress-related diseases like hypertension and cancer, as well as post-traumatic stress disorder (PTSD), have been found in high levels among the black population (U.S. Department of Health and Human Services 2001). It would be unsurprising if black people's mental health is notably worse than whites, but that has not been found in the literature, at least in terms of formal diagnoses. In fact, black people are diagnosed with psychiatric disorders at a lower rate than their white counterparts and exhibit higher levels of good self-rated mental health, convincing many scholars that the black community overall have better mental health than their white counterparts (Holden and Xanthos 2009; Mouzon 2013; Williams 2018).

This paradox concerning black mental health has been a major topic in the mental

health literature (Mouzon 2013; Williams 2018). Black people are less likely to be diagnosed with mental health disorders than whites, but some research calls into question whether or not this truly means that blacks have psychiatric disorders at a lower rate. A possible explanation for this paradox is that black people are not visiting medical professionals in order to be diagnosed with psychiatric disorders (Brown 2003; Breslau et al. 2005; Holden and Xanthos 2009; Mouzon 2013). Many black Americans are distrustful of modern medicine, stemming from unethical practices like the Tuskegee Institute study (U.S. Department of Health and Human Services 2001; Brown 2003). Discrimination against blacks in terms of being prescribed medicine and being diagnosed with disorders is also rampant in the mental health community. On average, antidepressants with fewer side effects are prescribed more often to whites than blacks (Holden and Xanthos 2009). Blacks are also more likely to be misdiagnosed or not given a diagnosis at all (U.S. Department of Health and Human Services, Brown 2003; Holden and Xanthos 2009; American Psychological Association 2016 Williams 2018). Some scholars argue that the black mental health paradox stems from a myriad of problems, including lack of cultural competency among mental health professionals concerning black peoples' experiences and mental processes (Holden and Xanthos 2009; Williams 2018; Freitas et al. 2021).

According to Freitas et al. (2021), it is likely that the criteria for diagnosing mental health disorders neglect to recognize the personal cultural experiences of blacks face when they attempt to be diagnosed. This can directly affect the paradoxical situation of black mental health (Brown 2003; Holden and Xanthos 2009; Mouzon 2013; Freitas et al. 2021). Black people are not diagnosed with psychiatric disorders at a higher rate than the rest of the population, but blacks are forced to cope with situations that are unique to their race and

culture, which can be mentally detrimental (Williams 2018). Blacks' lived experiences have been affected by the historical events of slavery and Jim Crow racism that contribute to contemporary discrimination in social, political and economic arenas (Brown 2003; Williams 2018; Freitas et al. 2021). Interactions and events that are marred with discriminatory practices, whether they are unconscious or conscious, can cause psychological distress (Brown 2003; American Psychological Association 2016). It is necessary for psychological distress related to cultural or racial discrimination be
addressed in ways that promote stability in mental health in the Black community (Sellers et al. 2003; Williams 2012; Williams 2018; Williams and Sternthal 2010).

It can be argued that the mental health services Blacks receive needs to be tailored to their racial and cultural experiences (Utsey et al 2000; Wang et al. 2000; Department of Health and Human Services 2001; American Psychiatric Association 2016; Freitas et al. 2021). However, not much is known about the mental processes of blacks, such as how mental illnesses can be manifested or recognized differently according to race (U.S. Department of Health and Human Services 2001; American Psychological Association 2016). There is also the persistent problem of a lack of diversity in mental health careers with only 2% of mental health professionals being black (U.S. Department of Health and Human Services 2001; Brown 2003; American Psychological Association 2016; Williams 2018; Freitas et al. 2021). These barriers can assist in explaining the racial differences in coping strategies (formal versus personal).

Informal Coping Strategies in Response to Formal Mental Health Services

A major aspect of mental health treatment is coping mechanisms. According to Lazarus and Folkman (1984), coping is defined as cerebral and behavioral efforts to maintain homeostasis

during taxing internal and external demands. They can be both unconscious and conscious behaviors that assist in reducing negative emotions. Coping mechanisms can be individual or social behaviors. Formal coping strategies that involve mental health professionals include therapy and pharmaceutical intervention. Through therapy, individuals learn ways to cope that are promoted by mental health professionals. These strategies can include breathwork, journaling, and group therapy (World Health Organization 2010; American Psychological Association 2016). Coping strategies may assist with everyday stressors but are supposed to be combined with therapy and medication when dealing with extreme stress or psychiatric disorders.

Over the past few decades, the literature concerning personal coping strategies has become more popular, especially coping strategies used in minority communities. Mental health care is often medicalized, meaning that mental health care is often framed in such a way that the only "appropriate" measures to stabilize mental health are provided through a mental health professional (Constantine et al. 2002). Because minority communities are weighted with inequalities in the health field, some have found measures more suited to their individual cultures to supplement traditional mental health services and stabilize their mental health (Utsey et al. 2000). This is especially true for the black community (Constantine et al. 2002). These measures can include informal coping mechanisms, which are strategies that individuals utilize to deal with negative emotions or negative mental health episodes without the help of a mental health professional.

For example, Utsey et al. (2000) created the Africultural Coping Systems Inventory (ACSI). This consists of a set of Africultural coping mechanisms, which are personal coping strategies in response to formal mental health services utilized by blacks. It

is a 30-item measure that is divided into four main groups: problem focused; detachment; wishful thinking; seeking social support; and focusing on the positive. It is rooted in coping behaviors blacks utilize that stem from collective coping, spiritual coping, and ritual-centered coping. Some African belief systems are represented in current black American coping through religion and rituals. The ACSI provides coping strategies from an African worldview in contemporary black American communities. Various African cultures stress collective orientation and spiritual guidance. Therefore, specific items in the ACSI include seeking support from friends and family, utilizing religious services, and finding other structural, scheduled things to keep oneself occupied (rituals). Utsey et al. (2000) acknowledge that coping strategies can be more closely related to the cultural-social worldview of the individual instead of the standardized measures of modern medicine, which are more focused on Western culture.

Furthermore, the literature focused on coping strategies in the black community have generally been concentrated on negative mechanisms such as substance use or alcoholism (Joon Jang and Johnson 2003; Brown et al. 2006; Sutherland 2010). While it is important to acknowledge the impact that negative coping mechanism may have for blacks, it is also important to focus on the positive coping mechanisms that black people utilize (Constantine et al. 2002; Buchanan, Settles, and Langhout 2007; Stanton and Low 2012). This paper will address this significant gap by investigating positive coping mechanisms used by black Americans, including social networks, religion, and exercise. These have been established in literature as some of the most common coping mechanisms among blacks (Utsey et al. 2000; Constantine et al. 2002).

Factors Affecting Black Mental Health Service Utilization

The American Psychological Association (2016) recommends learning coping strategies with the assistance of a mental health professional. This can be difficult for people of color, especially blacks, for a variety of reasons such as: stigma in both the medical field and in black communities concerning black mental health disorders; cultural incompetency within the medical field; and financial barriers like health insurance inequality. These factors will not be measured in this paper, but they need to be explained to fully understand black-white and within-group black coping mechanism utilization.

People of all races and ethnicities face stigma when seeking mental health services (Okazaki 2009). Seeking mental health services has been historically stigmatized in the United States (Okazaki 2009), and this may be worse for the black population (U.S. Department of Health and Human Services 2001; Brown 2003; Okazaki 2009; World Health Organization 2010). Blacks can feel stigmatized by many mental health professionals because of their race due to issues like cultural incompetency and racism (Brown 2003; Holden and Xanthos 2009).

There is also stigma from within the black community to receive medicalized Treatment for psychiatric disorders or general stress (Holden and Xanthos 2009; Freitas et al. 2021). Mental health disorders are sometimes seen as a “white” problem or the result of religious malfeasance, effectively stigmatizing anyone dealing with mental health disturbances (Dill 2017). A qualitative study conducted by Cruz et al. (2008) found that shame, which stems from stigmatization, is a significant barrier in blacks effectively seeking traditional mental health treatment.

Cultural incompetency from mental health professionals toward problems that are

specific to the black community is another major problem that affects black mental health service utilization. It is challenging to discuss mental health issues, especially with a mental health professional that does not share the same cultural background and personal experiences (Brown 2003). Different cultures cause an issue of cultural distrust and cultural incompetency that can diminish black people's ability to seek mental health services (Freitas et al. 2021). More black doctors could assuage cultural incompetency in mental health, but according to the American Psychological Association (2016), only 2% of mental health professionals are black, despite making up 13.1% of the US population (U.S. Census Bureau 2022).

Misconceptions created by mental health professionals during interactions with blacks can lead to impairments in the clinical decision-making process (Holden and Xanthos 2009; Freitas et al. 2021). For instance, the American Psychological Association (2016) found that blacks are prescribed medicine with worse side effects than their White counterparts. In 2018, only 30% of black people diagnosed with a mental health disorder received any type of treatment for it (Freitas et al. 2021). Subconscious biases of non-black doctors can negatively modify the dynamic of the patient-provider relationship (Holden and Xanthos 2009).

Financial barriers such as insurance and ability to pay can also be detrimental to black mental health service utilization, which can be an explanation for blacks' use of coping mechanisms outside of mental health services. In 2019, 12% of blacks were uninsured versus 9% of whites (Artiga et al. 2021). Even in the case of middle-class black individuals with insurance, their insurance is less likely to cover adequate mental health services (Moodley 2000; U.S. Department of Health and Human Services 2001; Holden and Xanthos 2009;

World Health Organization 2010). Black individuals are more likely than their white counterparts to delay mental health treatment until their symptoms are detrimental (Breslau et al. 2005; Williams 2018). Black people have also been found to leave treatment prematurely (Holden and Xanthos 2009). Lack of ability to pay can be a major contribution to blacks alternating their treatment timeline (Holden and Xanthos 2009). Limited or no insurance can force blacks to take other avenues like finding coping mechanisms that are not related to the medical field.

Research on black mental health largely treats black minds as uniform across the board, when in reality different groups within the black community deal with their problems in different ways. Coping mechanisms are closely related to behavior, which is closely related to other social factors such as income, education, and gender (Constantine et al. 2002). The ACSI created by Utsey et al. (2000) has been further used to describe how blacks cope in different situations like racism, academic institutions, and adolescence (Constantine et al. 2002; Dill 2017; Greer 2021). Constantine et al. (2002) found that black adolescents who exhibit higher self-esteem utilize religious services in stressful situations. Also, collective identity and social networks can play a major role in stabilizing black adolescents' mental health. Greer (2021) conducted a study following black college students' coping strategies while dealing with racism and discrimination in academia. She found that Africultural coping strategies like religion, rituals like cooking or exercising, and social networks were the most commonly used among black students. This proposal can further this research by understanding how the different social positions of blacks relate to the various coping mechanisms employed within the group.

Hypotheses

Studies show that blacks are diagnosed with mental health disorders at a lower rate than whites (U.S. Department of Health and Human Services 2001; Brown 2003; Holden and Xanthos 2009; Okazaki 2009; Freitas et al. 2021). Research has also found that blacks often use personal coping strategies rather than employ medicalized coping mechanisms (Schnittker et al. 2000). However, there is a gap in the literature regarding blacks' willingness to utilize both formal and personal coping strategies, as well as how that can be compared both across racial groups and within the black community. Based on previous literature, I have established two hypotheses related to black Americans' willingness to engage with informal coping mechanisms. Before delving into differences among blacks in terms of coping strategies, I aim to first establish whether or not in my sample, black respondents are more likely to use personal coping strategies compared to other groups, and how that may differ by type of strategy used.

Hypothesis 1: Black individuals will be more willing than whites to utilize informal coping strategies such as exercise, social networks, and religion over formal mental health care.

Utsey et al. (2000) established that blacks use coping mechanisms specific to the black community. Research implies that blacks utilize traditional coping mechanisms, like therapy and medicine, at a lower rate than other coping strategies such as social networks, exercise, and religion without a comprehensive examination of the coping strategies different groups of blacks are using (U.S Department of Health and Human Services 2001; Brown 2003; American Psychological Association 2016; Freitas et al. 2021). However, with this study, I also examine within group differences in the use of different kinds of coping mechanisms by factors such as gender, education, and socio-economic standing. Little is known about the

differences among blacks in the use of informal coping strategies, and what other socio-demographic factors relate to personal avenues to cope. I posit that income, education, and gender are three variables that may attribute to variation in actions. Coping strategies are a major part of the way individuals act (Constantine et al. 2002; World Health Organization 2010). Because of this, I hypothesize that coping mechanisms will be differentially used by blacks according to income, education, and gender.

Hypothesis 2a: Black people with higher incomes and levels of educational attainment will use a combination of personal coping strategies with formal mental health care.

Higher SES and education are correlated to having health insurance and being more knowledgeable about mental health awareness (World Health Organization 2010; American Psychological Association 2016). This can suggest that blacks with higher incomes and education levels will be more open to utilizing therapy and medicine.

Hypothesis 2b: Black individuals with lower incomes and levels of educational attainment will be more likely to strictly use informal coping mechanisms and not formal mental health care.

Hypothesis 2c: Black women will be more likely to use formal mental health care than Black men.

Overall, women are more likely to utilize health services than men, including mental health services (Hall et al. 2021). Due to women's higher level of mental health care utilization, this could lead to higher rates of formal coping mechanisms like seeing a mental health professional. The data and methods subsequently discussed attempt to investigate

these hypotheses concerning mental health strategies across different racial groups and within the black community.

DATA AND METHODS

Data

To investigate racial differences in coping strategies, I utilize the 2022 Community Perceptions of Flood Mitigation Survey, which is a survey of adults in Houston, Texas. The survey was conducted throughout March and April of 2022 in Harris County of adult residents through a random telephone survey. The survey was distributed by Customer Research International, a survey research company based in Texas. The survey is connected to a broader project on community perceptions of flooding and flood mitigation strategies in the Houston area. However, it also includes questions on mental health outcomes and coping. While geographically limited, Houston is an adequate case to answer these questions due to its large black population. In fact, the black population in Houston is larger than the country's overall black population (23% versus 13.6%) (U.S. Census Bureau 2022). This provides more opportunity to speak with black respondents while utilizing a random telephone survey design without having to oversample the population. However, the results can only be generalizable to the Houston area.

Measures

Dependent Variables

In this analysis, I use a series of dependent variables related to mental health coping strategies. The survey included two paired survey questions about mental health coping mechanisms to see what type of coping mechanisms different racial groups are willing to use, as well as differential willingness to use coping mechanisms among blacks. These are used as the dependent variables in my analysis. The two questions are worded slightly differently to

examine first whether an individual felt based on past experience that they should use a mental health professional, as well as what they would hypothetically do in a negative mental health situation. The first question reads, "At any time in your life did you think that you should talk to a medical doctor or other health professional about problems with your emotions, nerves, or mental health?" with simple yes/no response options, which I dichotomized 1=yes, 0=no. The second question asks, "If a serious emotional problem arose, what would you do for help? Would you…" The question is followed by the following options: talk to a friend or family member; talk to a mental health professional; visit your religion congregation; exercise; or something else that they should specify. These are asked as a series of non-mutually exclusive yes or no questions. As such, I recoded each of these as dichotomous variables where 1=yes, 0=no.

Since these were asked as non-mutually exclusive questions, I examine each of these in separate binary logistic regression models (as opposed to a multinomial model) to see if there are racial/ethnic differences in who is more likely to use a mental health professional, both in terms of past experience and willingness, and who is more likely to use personal positive coping strategies.

Table 1. Descriptive Statistics for All Race Statistical Models

Variable Name	Mean/Proportion	Standard Deviation	Description
Independent Variables			
Latino	.21	-	Race (Latino=1, Else=0)
White	.53	-	Race (Non-Hispanic White=1, Else=0
Non-Hispanic Black	.17	-	Race (Non-Hispanic Black=1, Else=0)

Other	.09	-	Race (Other=1, Else=0)
Age	53.87	17.64	Age in Years
Female	.56	-	Sex (Female=1, Else=0)
Married	.52	-	Marital Status (Married=1, Else=0)
Education	.53	-	College (Bachelor's degree=1, Else=0)
Income	82295.45	52778.85	Income in Dollars
Foreign Born	.14	-	Foreign Born (Yes=1, Else=0)
Poor Mental Health	2.17	1.01	Mental Health Status (1=Excellent, 5=Poor)
Health Insurance	.89	-	Health Insurance Status (Yes=1, Else=0)
Dependent Variables			
Visit Medical Professional (Past)	.42	-	Should Visit Medical Doctor (Yes=1, Else=0)
Coping Mechanisms			
Visit Mental Health Professional (Present)	.81	-	Would Visit Mental Health Professional (Yes=1, Else=0)
Talk to Friends/Family	.92	-	Would talk to friend/family (Yes=1, Else=0)
Visit Religious Congregation	.50	-	Would Visit Religious Congregation (Yes=1, Else=0)
Exercise	.82	-	Would Exercise (Yes=1, Else=0)

Notes: 2022 Community Perceptions of Flood Mitigation Survey. *N*=648

Coping strategies (both formal and personal) are examined both across racial groups, as well as within-group differences among black respondents.

Independent Variables

The independent variables that are most salient to addressing my hypotheses are race, gender, income, and education. These variables are addressed through a series of survey items. Because I am conducting two different analyses with respect to race, race is treated differently in the two sets of models. For the first set of analyses, race is measured

dichotomously with a set of dummy variables for each race, including non-Latino white (white=1, else=0), Latino (Latino=1, else=0), non-Latino black (black=1, else=0) and non-Latino other (other=1, else=1), with whites as the reference category. For the second set of analyses, in which I am only comparing black coping strategies, race is not measured in the models because only blacks were analyzed. Instead, I select on the binary coding above and limit the sample to only those respondents who identify as black.[1] Household annual income was generated from a series of categorical answer choices in 10,000 increments, which are then converted into numbers by taking the midpoint of the category in order to treat it as continuous in the model. Due to the large number of missing values (28%) for this variable, I also impute income for those who did not provide a response using employment status, education level, age, and an item asking about their strategy to pay an unexpected $400 bill. Lastly, education was originally measured categorically by highest level of education obtained and is re-coded into a dichotomous measure for this analysis where 1=bachelor's degree or higher, 0=else.

Table 2. Descriptive Statistics for Black Only Statistical Models

Variable Name	Mean/ Proportion	Standard Deviation	Description
Independent Variables			
Age	55.16	15.30	Age in Years
Female	.65	-	Sex (Female=1, Else=0)
Married	.41	-	Marital Status (Married=1, Else=0)
College	.48	.50	College (Yes=1, Else=0) Graduate Degree (Yes=1, Else=0)
Income	70416.67	51746.68	Income in Dollars
Foreign Born	.09	-	Foreign Born (Yes=1, Else=0)

[1] Within both samples, I also tried to include separate measures for multiracial. However, since only few respondents identified as multiracial, and these results were not significant, I did not include these variables in my final models presented here for the sake of parsimony. This was replicated with Latino respondents in the black only sample as well.

Mental Health	2.14	1.04	Mental Health Status (1=Excellent, 5=Poor)
Health Insurance	.88	-	Health Insurance Status (Yes=1, Else=0)
Dependent Variables			
Visit Medical Professional (Past)	.40	-	Should Visit Medical Doctor (Yes=1, Else=0)
Coping Mechanisms			
Visit Mental Health Professional (Present)	.85	-	Visit Mental Health Professional (Yes=1, Else=0)
Talk to Friends/Family	.64	-	Would Talk to Friend/Family (Yes=1, Else=0)
Visit Religious Congregation	.64	-	Would Visit Religious Congregation (Yes=1, Else=0)
Exercise	.84	-	Would Exercise (Yes=1, Else=0)

Notes: 2022 Community Perceptions of Flood Mitigation Survey. *N*=648

Control Variables

I also control for a number of other factors that may relate to coping mechanisms. An important variable that may be related to mental health care outcomes is how people feel about their mental health. The survey addresses this by asking respondents how they would rate their mental health in general on a scale of excellent, very good, good, fair, or poor. This is treated as continuous in all models, where higher values mean poorer self-rated mental health.

Health insurance is also an important aspect of mental health and can affect Black mental health service utilization. I use health insurance as a control variable as financial ability to see a professional may relate to willingness or strategies. Health insurance is addressed in the survey by asking respondents, "Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?" The question is coded as dichotomous where 1=yes and 0=no.

I also include a number of other socio-demographic control variables. Age is included and treated as continuous. Marital status is asked with categories of married, living with a partner, divorced, separated, widowed, or never married, which I re-coded dichotomously where 1=married and 0=else. I also control for immigration status, where 1=foreign born, 0=U.S. born. Descriptive statistics for all variables can be found in Table 1 for the full sample and Table 2 for the black only sample.

Methods

In order to test my hypotheses, I estimated a series of five binary logistic regression models pertaining to the two sets of mental health services questions. First, one binary logistic regression model is made for the yes/no question pertaining to past willingness to utilize a traditional coping strategy (visit a medical professional). Next, four models are included that represent each coping mechanism analyzed for willingness to use that mechanism, meaning that there is a model for each possible coping mechanism: mental health professional, friends/family, religious congregation, and exercise. The list of coping mechanisms is not mutually exclusive, were asked a series of yes/no questions, and will therefore be treated individually in separate models.

I also estimate two different sets of these five models. I first examine these outcomes for the full sample, comparing different coping strategy utilization across racial/ethnic groups. These results can be found in Table 3. Next, I include the same five outcomes with a subset of black respondents to see whether different characteristics of black respondents are related to different coping mechanism usage. These results can be found in Table 4.

RESULTS

Across Racial Groups

I will first discuss the results for the full sample for the five different mental health coping strategies. As stated previously, the survey measurements are asked in two ways. One asks whether a respondent felt they should visit a medical professional in the past for their mental health in order to measure past willingness to utilize traditional mental health services. The other measure captures willingness by asking respondents what they would do in the event of an emotional problem. Respondents are given several options, including 1) friends/family (social networks) 2) mental health professional 3) religious services and 4) exercise.

Several variables are significant for whether someone felt that in the past that they should have visited a medical doctor or other health professional about problems with their mental health, all of which can be seen in Table 3. These include Latino, age, gender, poor self-rated mental health, and college education. Being Latino is significant in past willingness to visit a medical doctor, decreasing the odds by 42%. Age also has an inverse relationship to the outcome. Specifically, for every additional year of age, the odds of visiting a medical professional decrease by 2%. This indicates that the older someone is, the less likely to feel that they should have visited a medical doctor for their mental health in the past. The results also imply that self-identified women, versus self-identified men, are more likely to feel as if they should have visited a medical doctor in the past for emotional problems, increasing the odds by 58%.

Mental health status is also related to whether someone felt that they should have visited a medical professional for their emotional problems. For every category increase in poor self-rated health (ranging from excellent to poor) the odds of needing to see a mental health professional increase by 99.8%. This result suggests that people with more stable mental health largely do not feel like they should consult with medical doctors about mental

health services. Possessing a college degree, another significant factor, increases the odds of past willingness by 46%. This indicates that gender, poor self-rated mental health, and education are substantial factors in different racial groups' past willingness to visit a medical professional regarding emotional problems.

As another coping strategy, participants were asked whether they would visit friends or family members. Being female and obtaining a college degree are significant factors in respondents' discussing emotional problems with social networks. Being female, as opposed to male, increases the odds by 86%, making gender a substantively significant factor in speaking with friends or family about mental health problems. Also, having a college degree also increases the odds by 122%, suggesting that college education is an important factor in deciding whether a person utilizes their social networks to discuss emotional problems. Also, of note, none of the race/ethnicity variables are significant here. Third, participants are asked whether they would visit a mental health professional

for their emotional problem, which captures a traditional mental health services measure, but this time framed in terms of a hypothetical emotional problem. Here, again, female, age, self-rated mental health, and having a bachelor's degree are all significantly related to this coping mechanism. Specifically, the largest coefficient in this model is for gender, where being female is related to an increase in the odds by 114%, suggesting that there is a gender difference in respondents' present willingness. Age and self-rated mental health are also significant factors regarding willingness to utilize traditional mental health services. Age negatively influences willingness, decreasing the odds by 2%. Each category increase in poor self-rated health (ranging from excellent to poor) increases the odds of present willingness to utilize traditional mental health services by 26%. Finally, having a college degree is related

to an increase in the odds of willingness to visit a mental health professional by 56%. This implies that educational is an important factor in deciding whether or not to utilize traditional mental health services. The lack of racial/ethnic differences in willingness to utilize traditional mental health services is important here. Unlike what the previous literature suggests, none of the variables for race/ethnicity were significant in the model, meaning that there were no differences by race/ethnicity in the willingness to see a medical professional for a mental health problem.

Visiting a religious congregation is another option that respondents could choose as a coping mechanism. Here, being black, as opposed to white, increases the odds of visiting a religious congregation by 122%. This is a sizable effect and also demonstrates that being black is the most substantive indicator for someone participating in religious services as a coping mechanism. In addition to the black coefficient, both age and female are also significant. Age has a minor positive effect on visiting a religious congregation for mental health services, increasing the odds by only 1.3%. Being female, as opposed to male, increases the odds of visiting religious services by 39%. Lastly, using exercise as a coping mechanism is significant for age, education level, and mental health status. However, once again, none of the race/ethnicity variables are significant, indicating that there are no racial differences in the willingness to engage in exercise to cope with emotional problems at least in this sample. Age is significant, though, with each additional year of age decreasing the odds of using exercise to cope by 1.8% According to this result, as people age, they are less likely to utilize exercise to cope with emotional problems. Moreover, for people with a college education, the odds increase by 58%, holding all else constant.

Table 3. Coefficients (Standard Errors) and Odds ratios for All Race Models

	Medical Professional (Past)		Family/Friends		Mental Health Professional (Present)		Religious Services		Exercise	
VARIABLES	Coeff	OR	Coeff	OR	Coeff	OR	Coeff	OR	Coeff	OR
Latino	-.538*	.584*	.226	1.254	-.190	.827	.207	1.230	.141	1.152
	(.266)		(.499)		(.307)		(.243)		(.324)	
Non-Hispanic Black	-.367	.692	-.725	.484	.247	1.280	.798***	2.220***	.322	1.379
	(.251)		(.375)		(.310)		(.235)		(.298)	
Other (Race)	-.161	.851	-.629	.533	-.056	.946	-.299	.741	.374	1.453
	(.330)		(.495)		(.385)		(.307)		(.423)	
Age	-.024	.976	-.015	.985	.013	.986	.013	1.013	-.017	.983
	(.006)		(.009)		(.007)		(.005)		(.007)	
Female	.457*	1.579*	.618*	1.855	.762***	2.143***	.332*	1.393*	.102	1.112
	(.189)		(.301)		(.210)		(.175)		(.213)	
Married	-.514	.599	-.014	.987	.089	1.093	.289	1.335	.302	1.352
	(.191)		(.325)		(.223)		(.175)		(.223)	
College	.380*	1.462	.796	2.22	.447	1.564	-.108	.897	.457	1.579
	(.191)		(.334)		(.223)		(.176)		(.223)	
Income	.023	1.000	.066	1.000	-.006	1.000	.003	1.000	.009	1.046
	(.023)		(.042)		(.027)		(.021)		(.028)	
Foreign Born	-.362	.697	-.367	.693	-.305	.737	.069	1.072	.537	1.711
	(.281)		(.461)		(.312)		(.257)		(.391)	
Mental Health	.691	1.99	-.140	.869	.233	1.261	-.104	.902	-.210	.811
	(.097)		(0.15)		(.112)		(.085)		(.106)	
Health Insurance	.261	1.298	-.366	.693	-.090	.914	.060	1.062	-.460	.631
	(.305)		(.537)		(.365)		(.280)		(.401)	
Constant	-.959		3.00		1.300		.492		2.652	
	.531		.908		.633		-1.021		.669	

Notes: 2022 Community Perceptions of Flood Mitigation Survey. *N*=648. The coefficients and standard errors for income are multiplied by 10,000 for the ease of presentation.
Standard errors in parentheses.
*** $p<0.001$, ** $p<0.01$, * $p<0.05$ (two-tailed)

This indicates that college education is the largest factor in respondents' decision to use exercise as a coping strategy. For every category increase in poor self-rated mental health (ranging from excellent to poor), the odds of exercising to cope decreases by 19%.

Within-Group (Black)

In order to better understand blacks' coping mechanisms, I limit my sample to only black respondents. These results can be found in Table 4. For willingness to visit a medical professional in the past, only age and poor self-rated mental health are significant. For each additional year of age, the odds of visiting a medical professional decrease by 7.8%, which is a fairly substantial effect given the scale of the variable. This implies that older blacks are less likely to talk to a medical professional than younger Blacks. Furthermore, for every category increase in poor self-rated health (ranging from excellent to poor), the odds of visiting a medical professional increase by 263%. This sizable effect suggests that among the Black population, those who evaluate their mental health as poor are more likely to have perceived a need in the past to see a medical professional.

In regard to using family and friends as a coping mechanism, educational attainment and foreign-born status plays a significant role. As in the full model, having a college education is significant and increase the odds by 355%. Education seems to be a prominent factor for whether Blacks utilize social networks for their emotional problems. For foreign born respondents, we also observe a decrease in the odds of using friends and family as a coping mechanism by 81%.

Willingness to use traditional mental health services in the form of a mental health professional for a hypothetical emotional problem is only significant with age in the black only sample. For every additional year of age, the odds of visiting a mental health

professional decrease by 2.1%. Surprisingly, in contrast to the full model, gender is not significant in deciding whether or not someone in the black community would access traditional mental health services. This could imply that there are greater gender differences regarding coping strategies across racial groups than within the black community. In the all-race models, I find that being black, versus being white, is significant in deciding to visit a religious congregation for emotional problems. However, the sample is reduced to only black respondents, I find that blacks' visiting religious services is not affected by any additional factor such as age, gender, college education, etc. Specifically, no variables are significant in this model specification. In the case of exercise, as with the full sample, few variables are significant. Exercise is a significant coping mechanism among married black respondents, with each additional year of marriage increasing the odds of using exercise to cope by 325%. Black respondents who are married are more likely to use exercise to cope than other demographics.

DISCUSSION AND CONCLUSION

The goal of this study is to understand mental health coping mechanisms, both across racial groups as well as within the black American community. A large portion of the literature pertaining to black mental health is simplistic. It only compares black-white disparities, or it focuses on negative coping mechanisms. This paper attempts to address that gap by comparing coping mechanisms across all major racial groups, not just black-white comparisons.

Table 4. Coefficients (Standard Errors) and Odds Ratios for Black Only Models

	Medical Professional (Past)		Family/Friends		Mental Health Professional (Present)		Religious Services		Exercise	
VARIABLES	Coeff	OR	Coeff	OR	Coeff	OR	Coeff	OR	Coeff	OR
Age	-.081*** (.019)	.922***	-.013 (.019)	.987	.000* (.017)	1.000*	.021 (.013)	1.021	-.012 (.017)	.988
Female	.029 (.524)	1.029	.642 (.574)	1.901	.918 (.519)	2.504	.456 (.408)	1.578	.556 (.524)	1.744
Married	-.192 (-.499)	.825	.669 (.658)	1.954	.669 (.579)	1.952	-.045 (.412)	.956	1.448* (.649)	4.255*
College	-.359 (.535)	.698	1.515* (.765)	4.549*	.548 (.625)	1.729	.643 (.446)	1.902	.659 (.601)	1.933
Income	.060 (.056)	1.000	-.009 (.072)	1.000	-.009 (.066)	1.000	-.035 (.048)	1.000	-0.082 (.061)	1.000
Foreign Born	-.048 (.802)	.953	-1.684 (.86)	.186	-.239 (.894)	.787	.798 (.827)	2.221	.263 (1.121)	1.589
Poor Mental Health	1.213*** (.265)	3.363***	.046 (.282)	1.048	.279 (.268)	1.322	.045 (.192)	1.046	-.247 (.253)	.782
Health Insurance	.008 (.753)	1.008	-1.618 (1.177)	1.198	-.072 (.761)	1.322	-1.082 (.712)	1.046	.154 (.755)	.782
Constant	1.068 1.176		3.095 1.752		.247 1.326		-.047 1.105		2.219 1.434	

Notes: 2022 Community Perceptions of Flood Mitigation Survey. *N*=129. The coefficients and standard errors for income are multiplied by 10,000 for the ease of presentation.
Standard errors in parentheses.
*** p<0.001, ** p<0.01, * p<0.05 (two-tailed)

This paper also focuses on positive coping mechanisms rather than negative strategies like drinking, drugs, or violence. I took coping strategies from the ACSI (Utsey et al. 2000) to survey participants in Houston, Texas to determine which coping mechanisms are most utilized in different racial groups. Because I am particularly interested in how different groups of black individuals cope, I also conduct a second analysis, in which I restrict my

sample to only black respondents and subsequently created another set of binary logistic regression models.

The findings reveal a possibility of several important patterns, both across and within racial groups. The main finding in this study is that the largest differences are seemingly not within the black community but across racial groups. This could be due to different cultures and structural constraints experienced by different racial groups, which can lead to differential willingness to engage with different types of coping mechanisms (Utsey et al. 2000). For example, the results suggest that Latinos are found to be less likely to be willing to visit a medical health professional in the past for their mental health than other races. This follows the literature that minority groups are more unlikely to utilize traditional mental health services compared to their white counterparts (U.S. Department of Health and Human Services 2001; Brown 2003; Cruz et al. 2008; Holden and Xanthos 2009; Williams 2018).

Another significant finding is that black people, more so than other racial groups, could be substantially more likely to utilize religious services to cope with emotional problems. This correlates with literature and partially confirms Hypothesis 1, being that blacks are more likely than other racial groups to access religious services for mental health (Brown 2003; Mouzon 2013; Williams 2018). When the sample was limited to only black respondents, the results imply that different demographics of black peoples' willingness to use religious services as a coping mechanism is not significant. Therefore, Hypothesis 2a, and 2b cannot be supported. This suggests that social categories of black individuals' use religious services as a coping strategy, suggesting the notion that institutional differences across racial groups are more of a deciding factor in coping strategy utilization than within-group differences.

Moreover, for coping strategies involving traditional mental health measures, there are few differences by race/ethnicity. The only significant coefficient here is for Latino respondents for past willingness to see a mental health professional, net of self-rated mental health. This relationship is negative, implying that people who are Latino are less likely to perceive a past need to see a mental health professional. However, for future willingness to see a mental health professional in the event of a hypothetical emotional problem, there are no differences by race/ethnicity, despite the literature suggesting the contrary (Holden and Xanthos 2009; American Psychological Association 2016).

Though there are larger differences across racial groups, there are also several black within-group differences regarding willingness to utilize both formal and personal coping strategies. Despite significance in several coping strategies in the all-race sample, female is not significant in any coping mechanism in the black-only sample. Therefore, Hypothesis 2c cannot be supported. While there are gender differences in the full sample, these findings suggest that there could be no gender differences in utilizations of different types of coping mechanisms in the black community. This contradicts substantial aspects of the literature regarding black women and mental health service utilization (Buchanan et al. 2007; Greer 2021; Hall et al. 2021). These findings deviating from the current literature regarding gender and mental health could have several origins. First, a substantial amount of research regarding mental health is concentrated in the majority population. Research typically does not compare women across racial groups, but rather women versus men, and typically white women versus white men (Lazarus and Folkman 1984; Simon 1995; Patel 2005). Empirical studies have failed to fully encapsulate different racial groups' willingness to use mental health services by gender, as these results show a possible deviation in the current literature.

In the within-group sample, foreign born black respondents are less likely to use social networks as a coping strategy, while college educated black people are more likely to use friends and family to cope with emotional problems. Moreover, among black respondents, only age is significantly related to willingness to use formal mental health care, with older respondents being generally less willing to use formal care options (both past and present). This implies that other factors measured here did not affect black respondents' willingness to utilize traditional mental health services. Also, in the black-only sample, marriage is a significant factor in using exercise to cope with emotional problems. This is not the case for the full sample.

Beyond the results for race, several results for other variables also produce notable possible associations with regard to the previous literature. For instance, these findings highlight that being female is a significant predictor for both past and present willingness to utilize traditional formal mental health services. This finding is consistent with literature, as women typically visit medical professionals in general, including mental health professionals, for their physical and mental health (Hall et al. 2021). Being female is also significant concerning using social networks and religious services as coping strategies. Emotional vulnerability is more socially acceptable among women, and across all religious traditions, women are more likely to participate in religious life, so the results follow the literature regarding women and coping mechanisms (Hall et al. 2021).

Age is also significant when it pertains to coping strategies. The results show that age decreases the likelihood of both past and present willingness to utilize traditional mental health services. In the models that include all races, age also is positively associated with

visiting religious services. These suggest that older individuals across racial groups are less willing to use formal mental health care and more willing visit their religious congregation.

Limitations

While these results provide important insights into mental health coping strategies by race, there are some limitations to the present study. First, the study can only be generalizable to the Houston area due to the sample being exclusively Houston residents. Another limitation is the small sample size of the black only respondents (N=129). Some results can either be minimized or exacerbated due to the small sample size. However, black Americans only make up a tiny percentage of the U.S. population (13.6%) (U.S. Census Bureau 2022). In the study, blacks account for 20% of the sample. It is also important to note that the study design is cross-sectional, so no causal implications can be made from this study.

Perhaps most importantly, the instruments utilized in this study only referred to willingness to use coping strategies (formal and personal). Therefore, structural barriers to being able to access differential coping strategies are not fully addressed here. Nonetheless, this study provides substantial implications for willingness to utilize different coping strategies both across racial groups and within the black community, which can provide a steppingstone for explicating differential traditional mental health utilization among racial groups.

Recommendations for Future Policy

Several recommendations can be made from this research for future policy regarding racial disparities in mental health. From my findings, there are inequalities between racial groups regarding what types of demographics seek traditional mental health services. More focus needs to be made to encourage older people to access formal mental health services, as my

findings imply that older people both across racial groups and within the black community would not visit a medical or mental health professional to discuss emotional problems. Also, more effort should be made to make mental health services more gender neutral. Seeking mental help is perceived as feminine, and results from this study in the all-race sample suggest women are more prone to accessing mental health services than men (Buchanan et al. 2007).

The results indicate that being Latino, more than other racial groups, negatively affects whether someone had past willingness to visit a medical professional regarding mental health (Brown 2003; Cruz et al. 2008; American Psychological Association 2016). Subsequent policy should focus on making traditional mental health services more inclusive for the Latino population.

A recommendation for future policy that can directly affect black mental health could be the integration of religious services and mental health services. The literature generally regards using religion to cope as negative (Brown 2003; Holden and Xanthos 2009; Mouzon 2013; Greer 2021). However, this study finds that blacks persistently use religion in order to cope with emotional problems, and that there are not social differences among Blacks in willingness to use religion as a coping mechanism. Instead of persuading blacks to use other coping strategies, mental health professionals should work with religious organizations and leaders to provide better services to the black community.

Recommendations for Future Research

Results from this study suggest that across racial groups, women seek formal mental health services (both by medical professional and mental health professional) at a greater rate than men. However, this was not true in the sample with only black respondents. Future research

should focus on how within group gender differences in the black community do not follow the overall population trends concerning mental health.

This paper also suggests that differences regarding coping strategies are greater across racial groups than within the black community. Cultural differences could also be a factor in blacks receiving accurate and plentiful mental health care (U.S. Department of Health and Human Services 2001; Brown 2003; Holden and Xanthos 2009; American Psychological Association 2016; Williams 2018), though this is not directly tested here. Future research should gather a deeper understanding of cultural differences across racial groups regarding mental health to implement effective policy change. This study can be a steppingstone to achieving equality across demographics in mental health.

Conclusion

The literature has suggested that, compared to whites, racial/ethnic minorities have lower rates of formal mental health services use (U.S. Department of Health and Human Services 2001; World Health Organization 2010; American Psychological Association 2016). The results of this study suggest that there are no differences between racial groups willingness to see a mental health professional.

Moreover, among black respondents, only age was significantly related to willingness to use formal mental health care, with older respondents being generally less willing to use formal care options. Other variables were not significant in blacks' willingness to utilize traditional mental health services (both past and present). Thus, if we observe differences in utilization patterns by group, this may be due to structural barriers, such as costs, lack of competent local providers, etc., rather than willingness to see a mental health professional. This analysis can provide a deeper understanding of different racial groups' coping

strategies, especially among blacks. It also postulates subsequent work for policy and research to promote inclusion and equity in mental health across racial groups.

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