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Examining the Consequences of Skin Color, Discrimination, and Religious Coping on the Mental Health of Black Americans

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in

Sociology

by

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Abstract

This thesis explores the effects that skin color, discrimination, and religious coping have on Black Americans' mental health. Using colorism as a theoretical framework I ask two research questions, How does everyday discrimination and skin color influence the mental health of young Black Americans? How do gender and religion mediate the impact of discrimination and skin color on mental health? This thesis utilizes data from the National Longitudinal Study of Adolescent to Adult Health (Add Health), 1994-2008. The dependent variables used in this thesis are the mental health measures depression diagnosis and feeling disliked. The primary independent variable in this thesis is interviewer reported skin color. My findings indicate that there is skin color variation among mental health outcomes. I find that the two mental health outcomes depression diagnosis and feeling disliked showed different outcomes. Lighter skin respondents reported more experiences of depression diagnosis and darker skin respondents reported more experiences of feeling disliked. The findings in this thesis show how colorism can influence skin color differences in mental health. I also show how skin color variation can be influenced by the way that mental health is being measured for Black Americans.

Introduction

Colorism is a system of discrimination among individuals of color that gives advantages to individuals with lighter skin over individuals with darker skin (Hunter 2002; Hunter 2007). Colorism plays a major role in the lives of Black Americans, as it is deeply embedded in American history in much of the same ways that racism is. Hall (2010) claims that "racism, sexism, classism, colorism, and victim-group discrimination are included among the various American 'isms' brought about by Western racism and colonialism" (p. 35). The role of colorism in Black Americans' lives makes skin color an important predictor of various life outcomes and opportunities (Hargrove 2019; Keith and Herring 1991; Monk 2014), even shaping variation within the mental well-being of Black Americans (Louie 2020; Monk 2015).

Colorism is one experience that can impede mental health, but racial discrimination is another experience that can also negatively influence mental health. Contributing to the previous research on skin color and discrimination on mental health outcomes (Louie 2020; Monk 2015), I explore the effects that skin color, discrimination, and religious coping have on Black Americans' mental health with the National Longitudinal Study of Adolescent to Adult Health (Add Health). Previous research affirms that skin color and discrimination serve as an important predictor of mental health outcomes, and that darker skin color among African Americans is negatively associated with mental health. This study aims to investigate if these findings hold up amongst a different nationally represented data set (Add Health) with a sample of young people. I also consider coping resources that may work as a buffer from negative mental health. Religious importance may serve as a coping resource to explain the connection between skin color and mental health (Breland-Noble, Wong, Childers, Hankerson, and Sotomayor 2015; Louie 2020). In doing so I address the following two research questions: How does everyday discrimination and skin color influence the mental health of young Black Americans? How do gender and religion mediate the impact of discrimination and skin color on mental health?

I first discuss colorism as the theoretical framework that guides this study. Second, I discuss how skin color, discrimination and religious coping might negatively influence the mental health (well-being) among this sample of young Black Americans. Third, I explain and describe my measures and analytical strategy. Fourth, I present the results of the study. Lastly, I discuss the final implications of this study.

Literature Review

Implications of Colorism for Black Americans in the US

Colorism has been a permanent fixture in the lives of African Americans as it was birthed out of the institution of slavery. The racial hierarchy placed whites at the top and Blacks at the bottom and created an in-group hierarchy, which, accordingly, placed light skin at the top and darker skin at the bottom. Wilder (2015) defines colorism as "the

unequal treatment and discrimination of individuals *belonging to the same racial or ethnic minority group* (e.g., African Americans) based upon differences in physical features-most notably skin complexion (color), but also facial features and hair texture" (p. 6). The privileges and disadvantages of light and dark skin can be an important predictor of life outcomes.

Skin color serves as a major source of stratification among Black Americans, as lighter skinned Blacks have better life outcomes in terms of income, occupational attainment, and educational attainment (Keith and Herring 1991; Monk 2014). Similarly, skin color is also a major predictor of individual health. Taylor W. Hargrove (2019) investigated if skin color was also a source of stratification beyond SES with self-rated health and cumulative biological risk measures and found that skin color was also a predictor of health outcomes among African Americans.

Colorism is an important factor in the lives of African Americans because it works similarly to the way that racism works. In the same way that the racial hierarchy in the United States stratifies individuals based on their race, skin color is another dimension of that stratification. Skin color is the main indicator of racial membership. Within racial groups there is a racial hierarchy in place that ranks individuals for their closeness to the larger racial hierarchy. Skin color rankings are put in place to rank people for their closeness to whiteness, Hall (2018) states that "the term *light* as in skin color is a racial descriptor constructed for purposes of designating proximity to 'superior' race Caucasian populations" (p. 2140). In much of the same ways that we think about how race matters in almost all social outcomes and experiences skin color should be considered in the same way.

The Impact of Racial and Skin Color Discrimination on the Mental Health of Black Americans

Although skin color can predict different life outcomes for Black Americans it doesn't take away from the fact that as a whole Black Americans can be subjected to unfair treatment on the basis of race alone. According to Hunter (2007) "regardless of physical appearance, African Americans of all skin tones are subject to certain kind of discrimination, denigration, and second-class citizenship, simply because they are African American" (p. 238). Everyday racial discrimination among African Americans are commonplace experiences. Broman, Mavaddat, and Hsu (2000) reported that 60 percent of African Americans perceived that they were victims of personalized acts of discrimination in the past three years. One of the first meta-analysis on the connections between discrimination and mental health for African Americans found that perceived racism is strongly associated with worse mental health (Pieterse et al. 2012). Racial discrimination among Africans Americans is connected to negative mental health outcomes including depression and anxiety (Banks et al. 2006; Monk 2015). Individuals that experience perceived discrimination also experience lower levels of mastery and psychological distress, as a result of feeling a lack of control over one's life (Broman et al. 2000).

Discrimination is an inescapable reality for many African Americans as it operates through race membership and through skin color (Hunter 2007). Skin color discrimination or colorism influence African Americans both interracially, across racial groups and intraracially, within racial groups (Monk 2015; Uzogara et al. 2014; Uzogara and Jackson 2016). Individuals with lighter skin perceive less discrimination from whites (out-group) than darker-skinned individuals and darker skinned individuals experience worse discrimination (in-group) while medium skin serves as a protected status (Uzogara et al. 2014; Uzogara and Jackson 2016).

There are a number of studies that focus on skin color, mental health and discrimination (Borell et al. 2006; Louie 2020; Monk 2015). These studies show that skin color and discrimination are common predictors of adverse mental health outcomes. Amongst African Americans dark skin was a common predictor of worse mental health. Borrell et al. (2006) found that perceived racial discrimination was associated with poor mental and physical health among African American men and women. Ellis P. Monk (2015) found that skin color was a major predictor of interracial and intraracial discrimination which predicted depression, self-rated mental and physical health. Patricia Louie (2020) replicates this study with a youth sample to capture the developmental period of adolescence when mental health issues may begin to arise, and found that Black adolescents with darker skin had higher levels of depressive symptoms than lighter-skinned adolescents. Darker skin tone is a source of added discrimination among Black adults, who are "11 times more likely" to face discrimination than lighter-skinned Black adults (Klonoff and Landrine 2000: 336). Considering the aforementioned research, I argue that skin color and discrimination will also be a predictor of depression and negative feelings, such as feeling disliked. I hypothesize the following:

Hypothesis 1: Darker-skinned Black Americans will report higher levels of depression and feeling disliked than their lighter-skinned counterparts.

Hypothesis 2: Darker-skinned Black Americans will report more encounters with discrimination, which will result in worse mental health (well-being) than their lighter-skinned counterparts.

Variation within the Impact of Racial and Skin Color Discrimination on the Mental Health of Black Americans

Colorism might not impact all Black Americans equally. My work will also explore potential mediators and moderators within the relationship between colorism, discrimination, and mental health. First, skin color can work differently for men and women, as lighter skin works to privilege men and women differently. Skin color has more of an influence on physical attractiveness for women than men, demonstrating the desirability for light skin for women being connected to physical appearance (Hill 2002). The dominant form of colorism among African American women is dark skin disadvantage (Moore et al. 2020). Light skin works as a form of social capital for women. A lighter skin tone can be interpreted as beauty, and beauty operates as social capital for

women. Women who possess this form of capital (beauty) are able to convert it into economic capital, educational capital, or another form of social capital" (Hunter 2002).

In the same way that lighter skin serves as a form of privilege among Black Americans, being a man can also serve as a form of privilege among other Black men and women. This privilege creates a gendered and color hierarchy system that rewards lighter-skinned men and affords them an economic advantage for their privileged status within their gendered and racialized status (Reece 2020). Men in this position benefit from the skin color and gender privilege that is not afforded to darker-skinned men and all Black women. Considering the gendered differences in skin color variations. For example, in Hargrove's analysis she found that darker skinned African American women had worse health compared to lighter skinned women but not men, and thus indicating that the influence of skin color on Black American can also be gendered. Therefore, I hypothesize the following:

Hypothesis 3: The impact of discrimination and darker skin tone on depression and feeling disliked will be larger among Black women compared to men.

Second, religion may be used as way to cope with life experiences of discrimination and racism. Religion serves as an important factor in African American lives (Chatters et al. 2009) and there is a reason to believe that it can serve as an important coping strategy, for life stressors and issues (Chatters et al. 2008). Louie (2020) claimed that it is important to investigate different coping resources such as religion, that could explain skin color variation in mental health. Religiosity works as a coping strategy by giving individuals a sense of relief over situations that they cannot control. Having a relationship with a higher power or God, gives individuals a sense of peace knowing that their life stressors are in the hands of a higher power, and they are not alone in their struggles (Koenig et al. 1998). Therefore, I hypothesize the following:

Hypothesis 4: Religious importance will mediate the relationship between colorism, discrimination, and mental health (well-being).

Data and Methods

The data in this study is the National Longitudinal Study of Adolescent to Adult Health (Add Health), 1994-2008 (Harris & Udry 2018). Add Health was created as a response to a mandate by the United States Congress to fund a study on adolescent health. Add health is a longitudinal nationally representative sample of American adolescents in the 7th grade through the 12th grade starting in the 1994-1995 school year. The sample consisted of five waves. The study followed adolescents from adolescence into early adulthood in 2008, with four in-home interviews. This study utilized Waves III and IV. Two different waves were used because the variable skin color was only collected in Wave III. Wave III consisted of 15,000 of the Wave I respondents that could be located. Wave IV consisted of interviews of 80.3% of the Wave I in-home respondents. This study focused on Wave III and Wave IV. Wave III was collected from

August 2001 to April 2002, and Wave IV was collected in 2008 and 2009. The Add health sample included 1,013 young Black Americans aged 25-34.

Measures

Dependent Variables: Mental Health Measures

This study uses wave 4 depression diagnosis and feeling disliked to measure mental health. In wave 4. *Depression diagnosis* was measured with the question "Has a doctor, nurse or other health care provider ever told you that you have had or had: depression?" Responses were dummy coded (0) no and (1) yes. The variable *Feeling disliked* is a item from the Center of Epidemiological Studies-Depression (CES-D) measure of depression symptoms (Radloff 1977). It was utilized in order to examine one symptom of depression indirectly without asking questions that overtly ask about mental status, given the way mental illnesses are under or mis-diagnosed among Black populations, when health care professionals don't recognize or look for nontraditional signs of depression in their Black patients (Baker 2001). With Black populations depression symptoms can present themselves in alternative ways such as anger, irritability and distracting themselves with tasks (Baker 2001). *Feeling Disliked* was measured with the prompt "During the past seven days: You felt that people disliked you, during the past seven days." Respondents answered (0) never (1) sometimes (2) a lot of the time (3) most of the time or all of the time.

Independent Variables

The primary variable of interest is wave 3 interviewer reported skin color. Skin color studies have utilized self-reported skin color in order to account for phenotypic distinctions among Blacks that may not be observed by non-Black interviewers (Hill 2002; Monk 2015; Louie 2019). However, Add Heath only measures interviewer reported skin color in wave 3. *Skin color* was measured with the question "What is the respondent's skin color?" Skin color is captured as (1) White (2) Light Brown (3) Medium Brown (4) Dark Brown (5) Black. Skin color was recoded (1) Light (2) Medium (3) Dark (4) Darkest. It was also reverse coded to assign greater value as skin color gets darker.

Discrimination was inspired by the widely accepted everyday discrimination scale (Williams et al. 1997). Add health only had one of the measures in wave 4 with question "In your day-to-day life, how often do you feel you have been treated with less respect or courtesy than other people?" Respondents answered (0) Never, (1) Rarely, (2) Sometimes, and (3) Often. This variable was recoded to (0) Never, (1) Rarely, (2) Sometimes. The categories sometimes and often were combined due to the small number of responses in the often category.

Religious importance was measured in wave 4 with the question "How important (if at all) is your religious faith to you?" Respondents answered (1) not important (2)

somewhat important (3) very important (4) more important than anything else. Religious importance was recoded as (1) not important (2) somewhat important (3) very important. The category more important than anything else and very important were combined in order to account for small number of observations.

This study uses four control variables from wave 4, household income, education, sex, age, and health insurance. Monk (2015) and Louie (2019) influenced the selection of these variables. *Household income* was measured with the question "Thinking about your income and the income of everybody who lives in your household and contributes to the household budget, what was the total household income before taxes in {2000/2007}? Include all sources of income, received by these household members." If the response was "don't know" the respondent was asked, "What is your best guess of the total household income before taxes?" Respondents answered (1) less than $10,000; (2) $10,000 to $14,999; (3) $15,000 to $19,000; (4) $20,00 to $29,000; (5) $30,000 to $39,000; (6) $40,000 to $49,000; (7) $50,00 to $74,000; (8) $75,000 or more. *Education* was measured with the question "What is the highest grade or year of regular school you have completed?" Respondents answered (1) 6^{th} grade, (2) 7^{th} grade, (3) 8^{th} grade, (4) 9^{th} grade, (5) 10^{th} grade, (6) 11^{th} grade, (7) 12^{th} grade, (8) 1 year of college, (9) 2 years of college, (10) 3 years of college, (11) 4 years of college, (12) 5 or more years of college, (13) 1 year of graduate school, (14) 2 years of graduate school, (15) 3 years of graduate school, (15) 4 years of graduate school, and (16) 5 or more years of graduate school. Interviewer reported *sex* was measured by asking "Respondent's gender", the interviewer answered (1) male and (2) female. Sex was dummy coded (0) male and (1) female. *Age* was reported as the "Calculated age at time of the interview". Respondent's age was measured by year of birth 1974-1983. Age was recoded to number of years 25-34. *Health Insurance* was measured with the question "Which of the following best describes your current health insurance situation" and recoded (0) no (1) yes.

Analytic Approach

I first conducted an examination of the descriptive characteristics. Next, I conducted a logistic regression predicting depression diagnosis and feeling disliked by including skin color. I then ran the same regression adding in control variables. Then I ran the same regression adding in discrimination. I then repeated the same regression adding in religious importance. This process is repeated for men and women separately.

Findings

Univariate Findings

Table 1 displays the descriptive statistics of all the variables in the study. The tables are comprised of three panels that describe the full sample, sample of women, and the sample of men. The full sample consisted of 1,013 respondents. Over half (59%) of the sample consisted of women. The average age of respondents was about 29 years old. Most of the respondents were medium skin (31%), followed by the darkest skin color

(28%), then dark skin (26%), and the smallest number of respondents were light skin (15%). Most (76%) of all respondents had health insurance converge. The women's sample consisted of 599 respondents, and the average age was about 29 years old. For the women's sample most of the women were categorized as medium skin (34%), while dark and the darkest skin each make up 24% of the sample, and women categorized as light skin made up the smallest part of the sample. The majority (81%) of women in the sample had health insurance converge. The men's sample consisted of 414 respondents, and the average age was about 29 years old. In the men's sample most of the men were darkest skin color (31%), followed by dark skin (30%), medium skin (27%), and the light skin (12%) men made up the smallest part of the sample. Most (69%) of men had health insurance converge.

Table 1. Descriptive Statistics of Variables in Study

	Full Sample	Women	Men	P value	Min-Max
Depression Diagnosis	0.10 (0.306)	0.15 (0.355)	0.04* (0.199)	0.000	0-1
Feeling disliked	0.26 (0.440)	0.24 (0.426)	0.30* (0.457)	0.041	0-1
Skin color				0.000	
light skin color	0.15 (0.356)	0.18 (0.381)	0.12* (0.323)		0-1
medium skin color	0.31 (0.463)	0.34 (0.475)	0.27 (0.444)		0-1
dark skin color	0.26 (0.441)	0.24 (0.428)	0.30 (0.460)		0-1
darkest skin color	0.28 (0.448)	0.24 (0.428)	0.31 (0.464)		0-1
Discrimination				0.791	
never	0.33 (0.471)	0.34 (0.474)	0.32 (0.467)		0-1
rarely	0.39 (0.488)	0.39 (0.487)	0.40 (0.490)		0-1
sometimes	0.28 (0.448)	0.27 (0.447)	0.28 (0.451)		0-1
Religious Importance				0.106	
not important	0.04 (0.204)	0.04 (0.192)	0.05 (0.220)		0-1
somewhat important	0.15 (0.355)	0.13 (0.338)	0.17 (0.378)		0-1
very important	0.81 (0.394)	0.83 (0.376)	0.78 (0.417)		0-1
Years of schooling	5.67 (2.202)	5.96 (2.150)	5.25* (2.212)	0.000	1-13
Household income	7.16 (3.017)	6.82 (3.004)	7.66* (2.970)	0.004	1-12
Health Insurance	0.76 (0.429)	0.81 (0.397)	0.69* (0.464)	0.000	0-1
Age	28.91 (1.795)	28.81 (1.752)	29.07* (1.846)	0.022	25-34
Women	59% (0.492)			—	0-1

Note. Standard deviation in parentheses.
* $p < .05$, Significant differences between men and women samples shown.

Multivariate Findings

Table 2 shows the odd ratios from four sets of logistic regression models. In model 1, depression diagnosis was regressed on skin color. In model 2, depression diagnosis was regressed on skin color with covariates. In model 3, depression diagnosis was regressed on skin color and discrimination with covariates. In model 4, depression diagnosis was regressed on skin color, discrimination, and religious coping with covariates.

In model 1, I find that Black respondents with the medium, dark and the darkest skin color had lower odds of being diagnosed with depression than Black respondents with light skin. Skin tone differences between Black respondents were found as well. Black respondents with the darkest skin had the lowest odds of being diagnosed with depression. The odds of being diagnosed with depression is 55% lower for the darkest skin Black respondents as opposed to light skin Black respondents. In model 2, I add in the control variables sex, education, income, age, and health insurance. I find that adding in the covariates reduces the odds between skin color and depression diagnosis. Black respondents with medium, dark, and the darkest skin have even lower odds of being diagnosed with depression than Black respondents with light skin. Skin color differences show that Black respondents with the darkest skin continue to have the lowest odds of a depression diagnosis. The odds of being diagnosed with depression for the darkest skin Black respondents is 61% lower than lighter skin Black respondents.

In model 3, I add in discrimination. I find that discrimination was positively associated with depression diagnosis. Accounting for discrimination slightly decreases the odds between medium, dark, and darkest skin tone with depression diagnosis, holding all else constant. Black respondents with medium, dark and the darkest skin have lower odds of being diagnosed with depression than light skin Black respondents. Again, I find the same skin color differences between are medium, dark, and the darkest skin. The darkest skin tone people had the lowest odds of a depression diagnosis. The odds of being diagnosed with depression for the darkest skin respondents is 63% lower than Black respondents with light skin. In model 4, I add in religious coping. I find that religious coping had a positive association with depression diagnosis. Accounting for religious coping slightly increased the odds between skin color and depression diagnosis. Medium, dark, and darkest skin Black respondents still have lower odds of diagnosed than light skin Black respondents. Skin color differences remain the same as, with the darkest skin tone black have the lowest odds of a depression diagnosis. The odds of a depression diagnosis for those with the darkest skin is 57% lower than those with lighter skin, after accounting for all control variables.

Table 2. Depression diagnosis regressed on skin color, discrimination, and religious coping (Add Health) 1994-2008. (N=1013).

	Model 1	Model 2	Model 3	Model 4
Skin color [A]				
medium skin color	0.620^{+} (0.176)	0.485 * (0.149)	0.456* (0.142)	0.481* (0.153)
dark skin color	0.505* (0.155)	0.461* (0.150)	0.438* (0.144)	0.505* (0.170)
darkest skin color	0.452* (0.141)	0.391** (0.132)	0.369** (0.126)	0.433* (0.151)
Women		3.395*** (0.981)	3.514*** (1.019)	4.012*** (1.199)
Years of schooling		0.966 (0.056)	0.961 (0.056)	0.966 (0.058)
Household income		0.895** (0.036)	0.912* (0.038)	0.909* (0.038)
Age		1.156* (0.073)	1.164* (0.074)	1.167* (0.075)
Health insurance		0.839 (0.225)	0.839 (0.228)	0.871 (0.242)
Discrimination [B]				
rarely			1.895* (0.568)	2.002* (0.608)
sometimes			2.768** (0.831)	2.880** (0.879)
Religious coping [C]				
somewhat important				0.353* (0.169)
very important				0.204*** (0.086)
N	1013	927	927	925

Note. Standard errors in parentheses
[A] The omitted skin color category is light.
[B] The omitted discrimination category is never, and the category often was combined with the category sometimes.
[C] The omitted religious importance category is not important.
$^{+}p < .10$, $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$

Table 3 shows the odd ratios of men and women separately. In model 1, depression diagnosis was regressed on skin color. In model 2, depression diagnosis was regressed on skin color with covariates. In model 3, depression diagnosis was regressed

on skin color and discrimination with covariates. In model 4, depression diagnosis was regressed on skin color, discrimination, and religious coping with covariates.

In the women's model l, I find that Black women with medium, dark, and the darkest skin color have less odds of diagnosed with depression than light skin Black women. Skin color differences show that, the odds of being diagnosed with depression is 49% lower for women with dark and the darkest skin compared to lighter skin women. In women's model 2, I add in the control variables sex, education, income, age, and health insurance. I find that the controls decreased the odds between skin color and depression diagnosis. The dark and darkest skin Black women have lower odds of diagnosed with depression than lighter skin women. The odds of being diagnosed with depression for the darkest skin Black women are 62% lower than light skin Black women. In women's model 3, I add in discrimination. I find that discrimination was positively associated with depression diagnosis. Discrimination slightly reduces the odds between skin color and depression diagnosis, holding all control variables constant. The odds of a depression diagnosis for darker skin Black women is 65% lower than light skin Black women. In women's model 4, I add in religious coping. I find that very important religion had a negative association on depression diagnosis. Black women with darkest skin have 61% lower odds of being diagnosed with depression than light skin women, after accounting for all control variables.

In the men's panel, I find that skin color had no significance on the depression diagnosis of Black men across all the models. The addition of covariates, discrimination, or religious coping did not create a significant association.

Table 3. Depression diagnosis regressed on skin color, discrimination, and religious coping by gender (Add Health) 1994-2008.

	Women				Men			
	Model 1	Model 2	Model 3	Model 4	Model 1	Model 2	Model 3	Model 4
Skin color [A]								
medium skin color	0.584^{+} (0.181)	0.443* (0.147)	0.410** (0.139)	0.416* (0.145)	1.108 (0.948)	0.953 (0.835)	0.810 (.720)	0.908 (.820)
dark skin color	0.509^{+} (0.176)	0.398* (0.144)	0.371** (0.137)	0.416* (0.156)	1.185 (0.989)	0.970 (0.831)	0.958 (.836)	1.218 (1.099)
darkest skin color	0.509^{+} (0.176)	0.385* (0.142)	0.349** (0.131)	0.390* (0.149)	0.752 (0.664)	0.556 (0.513)	0.537 (0.508)	0.712 (.684)
Years of schooling		0.928 (0.062)	0.920 (0.062)	0.923 (0.064)		1.088 (0.131)	1.106 (0.138)	1.115 (.141)
Household income		0.917^{+} (0.042)	0.931 (0.044)	0.925 (0.045)		0.830* (0.073)	0.840^{+} (0.075)	0.842^{+} (.078)
Age		1.133^{+} (0.080)	1.146^{+} (0.082)	1.156* (0.084)		1.253 (0.175)	1.310^{+} (0.186)	1.293^{+} (.188)
Health Insurance		0.898 (0.279)	0.906 (0.286)	0.929 (0.300)		0.677 (0.369)	0.612 (0.337)	0.672 (0.379)
Discrimination [B]								
rarely			2.398** (.797)	2.616** (0.887)			0.540 (0.427)	0.481 (.391)
sometimes			2.643** (.905)	2.715** (.950)			3.139^{+} (1.976)	3.233^{+} (2.063)
Religious importance [C]								
somewhat important				0.325^{+} (0.194)				0.258 (.232)
very important				0.186** (0.097)				0.169* (0.132)
N	599	551	551	550	414	376	376	375

Note. Standard errors in parentheses
[A] The omitted skin color category is light.
[B] The omitted discrimination category is never, and the category often was combined with the category

sometimes.
[C] The omitted religious importance category is not important.
$^{+}p < .10, ^{*} p < .05, ^{**} p < .01, ^{***} p < .001$

Table 4 mimics table 2 and shows the odd ratios from four sets of logistic regression models with feeling disliked as the dependent variable. In model 1, I find people with medium, dark, and the darkest skin color have higher odds of feeling disliked than light skin people. Skin tone differences between skin colors were also found. Black respondents with dark skin had the highest odds off feeing disliked. The odds of feeling disliked for dark skin Black respondents is 2.5 times higher than with light skin Black respondents. In model 2, I add in the control variables sex, education, income, age, and health insurance. I find that adding in the covariates reduces the odds between medium skin and dark skin with feeling disliked. The darkest skin color no longer had an association with feeling disliked. Black respondents with dark skin had the highest odds off feeing disliked. The odds of feeling disliked for dark skin black is 90% higher than light skin Blacks. In model 3, I add in discrimination. I find that discrimination has a positive association on dark skin color, only dark skin had an association with feeling disliked. The odds of feeling disliked for dark skin Black respondents is 92% higher than light skin Blacks, holding all control variables constant. In model 4, I add in religious coping. I find that religious coping did not have an association with feeling disliked. Again, only dark skin had an association with feeling disliked. The odds of feeling disliked for dark skin Black respondents is 96% higher than light skin Black respondents, after accounting for all control variables.

Table 4. Feeling disliked regressed on skin color, discrimination, and religious coping (Add Health) 1994-2008. (N=1013).

	Model 1	Model 2	Model 3	Model 4
Skin color [A]				
medium skin color	1.836* (.472)	1.607+ (.428)	1.529 (0.429)	1.554 (0.440)
dark skin color	2.502*** (.646)	1.899* (0.509)	1.918* (0.543)	1.955* (0.562)
darkest skin color	2.052** (.534)	1.399 (0.385)	1.400 (0.406)	1.410 (0.415)
Women		0.758+ (0.126)	0.771 (0.136)	0.768 (0.136)
Years of schooling		0.941 (0.038)	0.926+ (0.039)	0.936 (0.040)
Household income		0.878*** (0.025)	0.899*** (0.027)	0.897*** (0.027)
Age		1.057 (0.045)	1.077 (0.049)	1.072 (0.049)
Health Insurance		0.999 (.187)	1.021 (.205)	0.999 (0.201)
Discrimination [B]				
rarely			3.506*** (0.845)	3.535*** (0.855)
sometimes			9.048*** (2.199)	9.330*** (2.279)
Religious coping [C]				
somewhat important				1.972 (0.987)
very important				1.585 (0.736)
N	1012	927	927	925

Note. Standard errors in parentheses
[A] The omitted skin color category is light.
[B] The omitted discrimination category is never, and the category often was combined with the category sometimes.
[C] The omitted religious importance category is not important.
$^{+}p < .10$, $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$

Table 5 shows the odd ratios of logistic regression for men and women separately. Darkest skin had no significance with feeling disliked. Skin tone differences show that the dark skin women had the highest odds of feeling disliked. For dark skin women the

odds of feeling disliked are 79.5% higher than light skin Black women. In model 2, I add in the covariates and find that the dark and medium skin color no longer had an association with feeling disliked. In model 3, I add in discrimination I find that discrimination has a positive association on feeling disliked. Skin still had no association with feeling disliked. In model 4, I add in religious coping and find that it had no association with feeling disliked and skin color still had no association with feeling disliked.

In the men's model 1, Black men with dark skin had the highest odds of feeling disliked. The odds of feeling disliked for dark skin men is 4.2 times higher than men with light skin. In men's model 2, I add in the covariates, and find the that the odds between skin color and feeling disliked decreased slightly. Dark skin Black men were still most likely to feel disliked. The odds of dark skin black men feeling disliked is 3.3 times higher than light skin men. In men's model 3, I add in discrimination. After controlling for discrimination medium skin color lost its association with feeling disliked. Dark skin Black men were still most likely to feel disliked. The odds of feeling disliked for dark skin black men is 3.3 times higher than light skin men, holding all else constant. In the men's model 4, I added in religious coping. I find that religious coping had no association with feeling disliked. Dark skin Black men were still most likely to feel disliked. The odds of feeling disliked for dark skin black men is 3.4 times higher than light skin men, after accounting for all control variables.

Table 5. Feeling disliked regressed on skin color, discrimination, and religious coping by gender (Add Health) 1994-2008.

	Women				Men			
	Model 1	Model 2	Model 3	Model 4	Model 1	Model 2	Model 3	Model 4
Skin color [A]								
medium skin color	1.674^{+} (0.509)	1.383 (0.443)	1.356 (0.461)	1.400 (0.481)	2.331^{+} (1.140)	2.308^{+} (1.144)	2.072 (1.070)	2.078 (1.086)
dark skin color	1.795^{+} (0.574)	1.420 (0.474)	1.425 (0.504)	1.456 (0.522)	4.173** (1.976)	3.251* (1.573)	3.319* (1.673)	3.415* (1.760)
darkest skin color	1.381 (0.452)	1.040 (.359)	0.973 (0.355)	1.006 (0.371)	3.583** (1.699)	2.499^{+} (1.229)	2.669^{+} (1.375)	2.609^{+} (1.371)
Years of schooling		0.916 (0.052)	0.905 (0.053)	0.919 (0.055)		0.976 (0.057)	0.954 (0.059)	0.960 (0.060)
Household income		0.874*** (0.034)	0.904 (0.037)	0.901* (0.037)		0.889** (0.039)	0.898* (0.041)	0.896* (0.042)
Age		1.089 (0.064)	1.096 (0.069)	1.093 (0.069)		1.013 (0.065)	1.050 (0.072)	1.045 (0.072)
Health Insurance		0.986 (0.259)	1.043 (0.295)	1.024 (0.290)		1.005 (0.273)	1.039 (0.303)	1.004 (0.294)
Discrimination [B]								
rarely			3.616*** (1.172)	3.699** (1.210)			3.436** (1.244)	3.465** (1.258)
sometimes			8.958*** (2.884)	9.397** (3.057)			9.446*** (3.552)	9.686*** (3.655)
Religious coping [C]								
somewhat important				1.787 (1.233)				2.281 (1.715)
very Important				1.275 (0.805)				1.992 (1.408)
N	599	551	551	550	413	376	376	375

Note. Standard errors in parentheses

[A] The omitted skin color category is light.
[B] The omitted discrimination category is never, and the category often was combined with the category sometimes.
[C] The omitted religious importance category is not important.
$^{+}p < .10, ^{*}p < .05, ^{**}p < .01, ^{***}p < .001$

Discussion & Conclusion

In this paper I make multiple contributions to the skin color and mental health literature. I contribute by using the nationally representative Add Health data, which to my knowledge has not been commonly utilized in skin color and mental health studies. I also contribute to the literature by exploring religious involvement as a useful coping strategy. I asked the two research questions: How does everyday discrimination and skin color influence the mental health of young Black Americans? How does gender and religion mediate the impact of discrimination and skin color on mental health? Overall, I found, skin color variation among mental health (well-being), lighter skin respondents reported more experiences of depression diagnosis and darker skin respondents reported more experiences of feeling disliked. In the full sample, darker skin Black respondents reported less depression diagnosis's than their lighter skinned counterparts. While individuals with darker skin feel less liked than lighter skinned counterparts. In my gendered samples, I find that the darkest skin women were more likely to be diagnosed with depression than lighter skinned women while skin color was not significant for Black men. I find that darker skin men feel less liked than lighter skinned men while skin color was not significant like it was for men.

I expected to find that darker skin was a predictor of *feeling disliked* because it is in line with colorism studies that point to darker skin as a disadvantage. Colorism as a system of discrimination, that gives advantage to lighter skin over darker skin color (Hunter 2002; Hunter 2007; Monk 2014). For darker skin individuals reporting more instances of *feelings disliked* could be a consequence of colorism.

An unexpected find was that the two mental health outcomes showed conflicting outcomes. Contrary to what I expected darker skin Blacks reported less depression diagnosis than their lighter skinned counterparts. Monk (2015) and Louie (2020) reported that depressive symptoms are more prevalent among individuals with darker skin. My findings contradict these findings, as depression diagnosis was more prevalent among lighter skin individuals. This contradiction could be the result of a mental health paradox amongst Black Americans. The Black-White mental health points to the contradictory findings that Blacks report better mental health outcomes than their White counterparts, consistently across gender, age, sociodemographic factors, and mental health disorders (Erving, Thomas, and Frazier 2019; Thomas-Tobin, Erving, Hargrove, and Satcher 2020). Therefore, my findings could be indicating a paradox by skin color-- that could be considered a "dark-light skin color mental health paradox" or a "skin color paradox".

There are a few potential reasons for the "skin color paradox" that I could have found in this study. A major reason for this could be the way that the mental health questions were asked. The mental health outcomes were asked in different ways in order to get at an individual's mental health status. For instance, *feeling disliked* does not directly ask about mental health status but is a question in the widely recognized Center of Epidemiological Studies-Depression (CES-D) scale (Radloff 1977). While the *depression diagnosis* question more directly asks about mental health. There could be something about the way that directly asking about mental health status is asked that dissuades or excludes individuals from reporting their status. Standardized measurements of mental health are created by the dominant white racial group for the dominant racial group, and do not consider how racial stratification and racism among racially marginalized groups can influence their psychological status (Brown 2003). The lack of consideration of racial stratification and racism misses' indicators of psychological distress related to racial marginalization. Therefore, nontraditional, or non-standardized ways of recognizing mental health distress is crucial to avoid misdiagnosis or non-diagnosis in individuals suffering from a mental disorder like depression (Baker 2001). There is also the possibility that receiving a depression diagnosis may have influenced the reporting. The question asked, "has a doctor, nurse or other health care provider ever told you that you have had or had: depression?" This would mean that an individual would have either sought out mental health services or revealed depressive symptoms to a mental health professional they were seeing. The possible stigma surrounding mental health in the Black community could have deterred some individuals from seeking mental health services even if they were experiencing depressive symptoms. Snowden (2001) states that some African Americans avoid their mental health problems due to a long history of distrust of mental health professionals and self-reliance to solve problems.

Another reason for this paradox, could be something going on with the way skin color works with relation to resilience among darker skinned individuals. The Black-white health paradox affirms that a reason that Blacks may fair better when it comes to mental health and overall health is due to resiliency to racial discrimination and inequality (Keyes 2009). This may be very similar to what I am finding here as darker skin individuals have a sense of resiliency. Resiliency may be attributed to certain things like racial socialization that would allow for a sense of racial pride that could be a shield against the consequences of racial discrimination and inequality (Keyes 2009). This sense of pride in darker skin tones may work as a shield against worse mental health. This resilience could be attributed to racial pride movements with pro-Black slogans such as "Black is Beautiful" and more recently "Black Girls Rock" and "Black Boy Joy" for instilling a sense of pride in individuals darker skin color and other Afrocentric features that are often demonized in a Eurocentric society. For darker skinned individuals this sense of racial and skin color pride may be more necessary to protect from possible psychological distress surrounding racial discrimination.

I proposed that the findings would be gendered and that mental health outcomes would be worse for women than men. I find that this was true for *depression diagnosis* and not *feeling disliked*. Women were actually the ones that were worse off when it

comes to *feeling disliked*. Why does asking different questions about mental health influence men and women differently? Skin color not being a predictor for *depression diagnosis* for Black men, an explanation for this could be related to the usage of mental health outcome *depression diagnosis.* This measure implies that in order to actually be diagnosed with depression an individual would seek out mental health services. What I could be finding is that Black men may not be seeking mental health services. Black men who may have experienced trauma and mental distress are unlikely to seek out mental health services (Motley and Banks 2018), therefore making a diagnosis for something like depression unlikely. This could also be a result of misdiagnosis. If Black men are going to seek mental health services, they may not be diagnosed if they do exhibit symptoms of depression or are not forthcoming with actual symptoms.

This study also aimed to consider religious coping as a possible coping resource for the mental health stressors such as depression. Louie (2020) claimed that coping resources were important to consider in order to understand what causes differences in mental health by skin color. I find that for the full sample individuals reported religious importance, but it didn't mediate the relationship between skin color and discrimination on mental health outcomes. Similarly, Dawne M. Mouzon (2017) investigated if religious involvement as a coping strategy could explain the Black-White mental health paradox. She rationalized that the greater amount of differential religious involvement and importance of Black Americans compared to Whites may serve as a buffer that protects from negative mental health. She found that although African Americans report more religious involvement than Whites it did not explain the paradox. Which she explains could be attributed to the lack of diversity in religiosity measurements within NSAL data and the lack of incorporation of important sociodemographic factors like gender that often intersect with race (Mouzon 2017). Likewise, I found that religious importance did not explain the paradox in skin color.

There are several limitations of this study. First, there was no control for interviewer's race. This study used interview reported skin color, and interviewer reported skin color can be influenced by the race of the interviewer. Interviewers may inaccurately judge variations in skin color when they don't have personal understanding of variations in skin color among Blacks. Future researchers should consider controlling for interviewer's race and utilizing self-reported skin color measures.

Second, this study is also limited by the use of public use data over restricted data. It will be useful to gain access to the restricted data set to be able to use more variables. The study would benefit from having access to a better variety of mental health variables. Future researchers should also consider this study from a qualitative perspective. This would allow for a more in depth understanding of the skin color mental health paradox. A qualitative approach may be able get at some of the measurement issues with a mental health diagnosis. For example, possible interviews could be designed to ask more culturally relevant indicators of mental health status.

In conclusion, this study not only demonstrates the ways that colorism influences skin color differences in mental health among Black Americans but also brings insight into skin color variation in mental health can be dependent on how mental health outcomes are measured. My findings show that color variations work differently depending on what and how mental health questions are being asked. This is important for future mental health researchers too. Future research should continue to consider other possible coping resources or strategies that could help explain skin color variation in mental health. Identifying the possible coping resources that could buffer the individuals from the trauma and stressors are helpful to explain the connection between skin color and mental health.

Notes

1. The terms Black American and African American interchangeably throughout this paper.
2. The CES-D informed depression scale was originally included as a measure of mental health but was removed because it was not found to be statistically significant in any of the models.
3. The anxiety diagnosis variable was also originally included as a mental health measure but was removed because it was not statistically significant in any of the models.

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