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The Impact of Undermining Coparenting on the Mental and Physical Health Outcomes of Black Fathers: The Role of Depression and Restrictive Emotionality

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ABSTRACT

The parenting literature has established the coparenting relationship as central to the parenting behaviors and outcomes of men. The construct of coparenting encompasses supportive efforts among individuals that facilitate the rearing of children and unsupportive actions that can undermine parenting efforts (Merrifield & Gamble, 2013). Few studies have examined undermining coparenting as an experience that shapes Black men's health outcomes. In this study, we apply the social determinants of health framework to examine the impact of Black fathers' perceptions of undermining coparenting on their self-reported ratings of mental and physical health. Using a nationally representative sample of Black men ($n = 255$), correlational analyses revealed perceptions of undermining coparenting to be a significant predictor of higher levels of anger and poorer perceptions of physical health. These relationships were found to be mediated by depressive symptoms and moderated by restrictive emotionality. It is recommended that the negative impact of undermining coparenting on health be considered as a potential comorbidity contributing to negative health outcomes for Black men. This study adds to the literature on coparenting, Black men's health, and Black fatherhood more generally and urges policymakers and practitioners to consider undermining as an often overlooked, but significant, social determinant of health impacting the well-being of Black men. We also offer recommendations for promoting Black men's health by educating families on the effects of undermining and offering the supports necessary for achieving positive coparenting dynamics.

KEYWORDS

Coparenting; social determinants of health; Black fathers; mental health; physical health

Introduction

Resoundingly, father involvement is critical for positive child outcomes, and coparenting is one of the most promotive factors of father involvement (Doyle et al., 2014; D. Roberts et al., 2014). However, the literature has neglected to provide an adequate knowledge base regarding how coparenting impacts fathers' physical and mental health outcomes. Black fathers are at an increased risk for health disparities, compared to women and other racial/ethnic groups of men (Shikany et al., 2018) and an

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abundance of studies have explored the etiologies of these disparities (Thorpe et al., 2015) based on the social determinants of health conceptual framework (SDoH) (World Health Organization [WHO], 2010). However, to our knowledge, the present study is the first to call attention to the need to consider coparenting dynamics as a SDoH among Black fathers. We draw on the SDoH framework to understand how such determinants, particularly coparenting dynamics, influence the mental and physical health of Black fathers. In this paper, we use the term "Black fathers" to represent the considerable amount of ethnic heterogeneity and phenotypic expressions that characterize African diasporic groups in the United States, including African Americans, Caribbean Blacks, Blacks from Latin America, and Blacks from the continent of Africa (Griffith, Metzl, et al., 2011; Volpe et al., 2022).

SDoH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks (United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d.; WHO, 2010). These social determinants – which include socioeconomics, policies, racism, sexism, and lifestyle behaviors, among others – can significantly increase one's risk for developing a mental and/or physical health condition such as depression, anxiety, toxic stress, decreased life expectancy, and cancer (Alon et al., 2024; Compton & Shim, 2015; Silva et al., 2016, World Health Organization [WHO], 2024. There are four major categories of social determinants that have a greater impact on mental health, in comparison to physical health (American Psychological Association [APA], 2022). These include: (1) societal problems (e.g., adverse childhood experiences, discrimination or social exclusion, violence, criminal justice involvement), (2) socioeconomic status (e.g., low education attainment, un/under employment, poverty, income inequality), (3) physical/built environment (e.g., neighborhood conditions), and (4) basic needs (e.g., housing instability, food insecurity, poor access to healthcare). This study addresses gaps in the literature by examining the relationship between Black father's perceptions of undermining coparenting and their mental and physical health outcomes. We further explore if these relationships are mediated by depression and moderated by restrictive emotionality, which is defined as "having difficulty and fears about expressing one's feelings and difficulty finding words to express basic emotions" (O'Neil et al., 1995, p. 176).

The impact of coparenting dynamics on black fathers' mental and physical health

Coparenting has been broadly defined as shared parental duties between mothers and fathers (Arendall, 1996; Feinberg, 2003). Feinberg's (2003) model places coparenting at the center of the family and includes four components: agreement/disagreement on childrearing, division of labor, support/undermining, and joint management of family interactions. Despite this uniform definition, the experience of coparenting can vary across cultures. For example, due largely to historical trauma, policy inequities, and structural racism, Black men have disproportionately higher rates of imprisonment (Ulmer et al., 2016), detachment from their households (Lemmons & Johnson, 2019), and scarcity of positive paternal role models (Lemay et al., 2010).

These SDoH adversely impact men's mental and physical well-being, their ability to seek help, and as a result, their parenting and coparenting dynamics (Affleck et al., 2018). Despite these barriers, research has shown that Black fathers are more likely to engage in child-rearing tasks, in comparison to other racial/ethnic groups of men (Fagan, 2024; Jones & Mosher, 2013). Given the significant role that Black fathers play in the lives of their children and families, it is important to understand the coparenting system and its impacts on their health as adverse impacts on paternal health can influence child well-being (Kotelchuck, 2022). Family processes, specifically coparenting dynamics, is an important factor to consider when examining mental health risk among Black fathers.

For example, in one longitudinal study, Black fathers who reported lower levels of relationship support from their partners at baseline experienced a significant increase in depressive symptoms over time (Fagan, 2009). Among nonresidential Black fathers, interpersonal stress related to family dynamics has been found to be the strongest predictor of depressive symptoms, after accounting for other factors (i.e., financial strain and perceived neighborhood characteristics; Tsuchiya et al., 2018).

Thus, investigating the mechanisms through which coparenting affects the mental health of Black fathers is imperative for informing targeted interventions and support systems. Depression in men is complex and often manifests differently than it does in women. Research suggests that anger/aggression may be a symptom of depression among men (Martin et al., 2013).

The overwhelming majority of studies suggest that anger precedes depression in men (Galambos et al., 2018; Jakubowska et al., 2023, Martin et al., 2013; Simon & Lively, 2010), with the exception of a few studies which suggest that depression is a precursor to anger (Brownhill et al., 2005; Winkler et al., 2006). Anger as expressed by Black men is not well understood and is often only discussed within the context of child maltreatment and/or interpersonal violence (Hampton et al., 2003). To address research gaps and add nuance to the research on Black fathers' health, the present study explores whether depression mediates the relationship between negative coparenting (i.e., undermining coparenting) and anger among Black fathers. Given that the pathway from depression to anger has been understudied, this study makes a significant contribution to the literature.

Family and home dynamics are also important social determinants of physical health for Black men. The "home," where Black men physically live, and the social structures that are part of that home, play a pivotal role in their health outcomes. The institution of family as a key contributor in the promotion of physical health among Black men is critical to consider given its role in facilitating the survival of Black Americans and the welfare of the Black community (Gordon et al., 1994). Yet, the explicit role of family as a social determinant of physical health has been largely omitted from literature (Booysen et al., 2021). Because family dynamics impact health, the lack of focus on the family has been noted as a critical theoretical shortcoming (Russell et al., 2018). In qualitative studies, Black men define health as the ability to provide for and enjoy time with their families (Griffith et al., 2015). Thus, family dynamics are a potentially powerful influencer of Black men's perceptions of their own physical health. Despite the prominence of fatherhood and family in Black men's conceptualization of physical health, few studies have examined the impact of these factors on their physical health outcomes (Torche & Rauf, 2021). We address this gap by investigating the intersections between fatherhood, coparenting dynamics, and physical health outcomes among Black fathers.

Coparenting and undermining

The research on undermining coparenting is scant, which hinders our ability to understand its impact on the mental and physical health outcomes of Black fathers. Feinberg's (2003) seminal research posits that coparenting can involve either support or undermining. Support refers to each parent's supportiveness of the other, affirmations of the other's competency as a parent, acknowledging and respecting the other's contributions, and upholding the other's parenting decisions and authority. On the other hand, undermining is expressed through criticism, disparagement, and blame. Tan et al. (2021) found that fathers who have an undermining coparent may practice more harsh parenting and exhibit lower levels of self-efficacy. Consequently, these fathers may experience increased stress, struggle to take on challenges, persevere, and mobilize resources to achieve their parenting goals, which may impact their health and wellbeing (Merrifield & Gamble, 2013). Like much of the broader research on coparenting in Black families, the extant literature focuses primarily on the impact of undermining on fathers' parenting outcomes, but not specifically on fathers' health outcomes. This study addresses this important gap.

Traditional masculine norms and black men's mental and physical health

Men consistently exhibit poorer health outcomes compared to women, including higher mortality rates (Crimmins et al., 2019) and lower healthcare utilization (Addis & Mahalik, 2003; Courtenay, 2000; Griffith, Ober Allen, et al., 2011; Pinkhasov et al., 2010; Staples, 1995). Researchers have explored adherence to traditional forms of masculinity as one of the factors contributing to men's health disparities. Traditional masculinity is defined as a set of beliefs and behaviors associated with achievement, help-seeking avoidance, rejection of the appearance of weakness or femininity, and

risk taking. Research suggests that adherence to traditional masculinity is related to an array of negative health consequences. For example, traditional masculinity emphasizes emotional stoicism, leading men to suppress or restrict emotions they perceive as negative (Hammond, 2012).

Emotional restrictiveness can exacerbate stress and contribute to depression and anxiety. The inability to express emotions can also hinder healthy coping mechanisms and social support (e.g., Gerdes & Levant, 2018). A 2016 meta-analysis (Wong et al., 2017) revealed that certain aspects of traditional masculinity are particularly important for understanding adverse mental health outcomes. Across 78 samples and over 19,000 participants, traditional masculine norms related to self-reliance and sexist attitudes were found to be more robust predictors of poor mental health, in comparison to norms related to deriving a sense of identity and purpose from one's work (Wong et al., 2017). We extend this literature to a focus on the restrictive emotionality component of masculinity as this is an understudied area that may be particularly important for understanding men's mental and physical health outcomes.

The current study

Conceptual models (i.e., Feinberg, 2003) and empirical research underscores the importance of coparenting and suggests a significant relationship between coparenting dynamics and depression among men (e.g. Fagan, 2009; Macdonald et al., 2020). Additionally, it is widely known that depression has physical health consequences and is related to anger in men (Galambos et al., 2018; Jakubowska et al., 2023; Martin et al., 2013). It has also been found that men who exhibit traits of traditional masculinity, such as restrictive emotionality, tend to also experience negative health consequences (Darabos & Hoyt, 2017). In the present study, we draw upon the existing literature and the social determinants of health conceptual framework (WHO, 2010) to explore the direct effect of undermining coparenting on the mental and physical health outcomes of Black fathers and the indirect effects of depression and restrictive emotionality on this relationship (see Figure 1). To our knowledge, no study to date has examined the impact of undermining coparenting on physical health nor have any studies focused on how undermining coparenting relates to anger specifically. Although it has important implications for mental health, anger is a variable that is often understudied in the literature, particularly among Black men. Given the exploratory nature of this study, an a priori hypothesis was not specified. However, this study seeks to answer the following research questions:

RQ1: Does restrictive emotionality **moderate** the relationship between undermining coparenting and mental health outcomes (as measured by anger) among Black fathers?

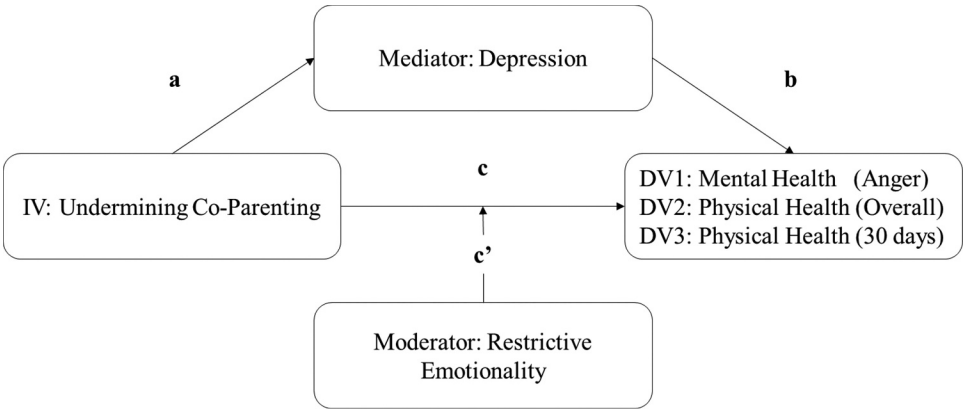

Figure 1. Study Conceptual Model. Mediation with moderated direct path

RQ2: Does depression **mediate** the relationship between undermining coparenting and mental health outcomes (as measured by anger) among Black fathers?

RQ3: Does restrictive emotionality **moderate** the relationship between undermining coparenting and overall physical health outcomes among Black fathers?

RQ4: Does depression **mediate** the relationship between undermining coparenting and overall physical health outcomes among Black fathers?

RQ5: Does restrictive emotionality **moderate** the relationship between undermining coparenting and short-term physical health outcomes among Black fathers?

RQ6: Does depression **mediate** the relationship between undermining coparenting and short-term physical health outcomes among Black fathers?

Method

Participants

Study participants comprise a subsample ($n = 255$) of a larger nationally representative quantitative study that explores the impacts of fathering on a wide range of health outcomes among a diverse group of fathers across the United States ($N = 529$). An oversampling of Black fathers was obtained. Specifically, Black fathers comprised nearly 50% of the sample. All other groups of fathers were sampled based on their representation in the United States Census. To be included in this study, participants had to: 1) identify as male, 2) be 18 years of age, and 3) have at least 1 biological child. This sample was achieved using Qualtrics Panels – a company that assists academic researchers with obtaining nationally representative samples via an online survey platform. Most Qualtrics' samples are obtained from traditional, actively managed, double-opt-in market survey research panels. Through use of panel aggregators (i.e., third party companies that offer access to a large pool of diverse participants across multiple platforms), survey market research panels attract millions of individuals per year, which enables studies that would be otherwise difficult to conduct on smaller platforms possible (Moss et al., 2023). By leveraging the power of market research panels, researchers can easily gather large samples with multiple quotas matched to the U.S. census, sample people in more than 100 countries, target participants within specific U.S. cities and zip codes, and recruit individuals from hard-to-reach groups (Moss et al., 2023).

The socio-demographic characteristics of the subsample of Black men were captured. In terms of ethnicity, 95.5% ($n = 246$) of the sample identified as non-Hispanic/Latino and 3.5% ($n = 9$) identified as Hispanic/Latino. Respondents' ages ranged from 21–70 years, with an average age of 37 years ($SD = 9.5$). Respondents were asked to report their total number of children (i.e., biological, adoptive, and stepchildren), which ranged from 1–17. On average, the total number of biological children reported was 2 ($SD = 1.77$). Nearly half (45.9%; $n = 117$) of the sample reported being single/never-married and nearly half reported being married (41.6%; $n = 106$), followed by divorced or separated (9.8%; $n = 25$), widowed (.4%; $n = 1$), and other (2.0%; $n = 5$). Over one-third (40.0%; $n = 102$) of the sample reported experiencing food insecurity within the last 12 months. A little over one-third (37.3%; $n = 95$) of respondents reported having been to jail or prison since the age of 18, while 59.6% ($n = 152$) reported no such history of incarceration.

In terms of health insurance, 69.0% ($n = 176$) of the sample indicated having healthcare coverage, while 26.7% ($n = 68$) reported having no healthcare coverage, being unsure (3.1%, $n = 8$), or preferring not to answer the question (1.2%, $n = 3$). As it relates to employment, nearly 74.2% ($n = 181$) of the sample reported being employed full-time and 7.8% ($n = 19$) part-time, while 0.8% ($n = 2$) reported

being students, 2.9% (n = 7) temporarily laid off, 9.4% (n = *23*) unemployed, 2.0% (n = 5) retired, 2.0% (n = 5) disabled, and 0.8% (n = 2) preferred to not answer. In terms of education, 1.2% (n = 3) of the sample did not finish high school, 50.4% (n = 124) reported a high school diploma or a GED as their highest degree, 8.9% (n = 22) reported completing technical or vocational school, 8.1% (n = 20) indicated completing an Associate's Degree, 15.9% (n=39) reported completing a Bachelor's degree, 14.6% (n = 36) indicated completing a Graduate or Professional degree, and 0.8% (n = 2) preferred to not answer. Finally, as it relates to annual household income, 16.7% (n = 41) of participants reported earning less than $20,000 annually, 25.2% ($n$=62) between $20,000–$39,999, 22.4% (n = 55) between $40,000 - $59,999, 9.4% ($n$ = 23) of between $60,000 - $79,999, 7.4% ($n$ = 18) between $80,000 - $99,999, 18.3% ($n$ = 45) $100,000 or more, and 0.8% (n = 2) preferred to not respond.

Procedures

Qualtrics' panel partners maintain a wide variety of psycho-demographic personal profiles on potential respondents. To ensure profiles are consistently updated, panel partners request updates from potential respondents at varying cadences. Respondents are invited to take part in surveys in various ways. Often, they are sent an e-mail invitation informing them that the survey is for research purposes only, how long the survey is expected to take, and what incentives are available. Other times, respondents may see surveys they are likely to qualify for upon signing into a panel portal. Other common invitation methods include in-app notifications and SMS notifications. To avoid self-selection bias, survey invitations do not include specific details about the contents of the survey and are instead kept very general.

Respondents receive incentives based on the length of the survey, their specific panelist profile, and target acquisition difficulty, among other factors. The specific rewards vary and can include cash, airline miles, gift cards, redeemable points, charitable donations, sweepstakes entrance, and vouchers. The incidence rate (i.e., the rate of qualified responses) for this survey was 66%. Although response rates are traditionally reported in survey research, they are only calculable when surveys are administered by e-mail or on paper. In addition, given qualtrics' use of modern fielding methods (i.e., leveraging apps or dashboards wherein potential participants might see a large number of surveys for which they are eligible and only opt into some), calculating the response rate was not possible. The survey was administered online via Qualtrics. To address complexities of fertility and family structure, the survey asked respondents to indicate the age, gender, and race/ethnicity of their youngest child. Respondents were then asked to focus on the youngest child and that child's mother in replying to all survey items. Survey duration was approximately 25–30 minutes. IRB approval was obtained from the first author's institution. Informed consent procedures were also undertaken as a part of survey administration.

Measures

Dependent variables

Anger. Anger was operationalized using the Dimensions of Anger Reaction-5 (DAR-5) Scale as a Brief Measure of Anger (Forbes et al., 2014). The DAR-5 is a 5-item self-report measure. Each item on the DAR-5 is answered using a 5-point Likert scale ranging from "5 = all or almost all of the time" to "1 = none or almost none of the time." Participants were given the following prompt: "Thinking over the past 4 weeks, circle the number under the option that best describes the amount of time you felt that way." Sample items include: "I found myself getting angry at people or situations," "When I got angry, I got really mad," "My anger prevented me from getting along with people as well as I'd have liked to." ($\alpha = 0.89$)

Physical health. Physical Health was operationalized using the Centers for Disease Control's Health Days Core Module (CDC HRQOL-4). The HRQOL-4 is a 4 item self-report measure. For the purposes of this study, we only used 2 of the 4 items. For the first item, participants are given the following

prompt: "Would you say that in general your health is," which is answered on a 5-point Likert scale ranging from "5=Poor" to "1=Excellent." For the second item, participants are asked the following question: "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"

Independent variable

Undermining coparenting

Undermining coparenting was operationalized using The Coparenting Relationship Scale (CRS) (Feinberg et al., 2012). The CRS is a 35-item self-report measure. To tap undermining, we used the Undermining Subscale. Each item on the CRS is answered using a 6-point Likert scale ranging from "6=very true of us" to "0=not true of us." Participants were given the following prompt: "For each item, select the response that best describes the way you and your partner work together as parents." Sample items include the following: "My partner does not trust my abilities as a parent," "My partner undermines my parenting," "My partner sometimes makes jokes or sarcastic comments about the way I am as a parent." ($\alpha = 0.91$)

Mediating and moderating variables

Depression

Depression was operationalized using the Short Form of the Center for Epidemiological Studies Depression Scale (CES-D) (Andresen et al., 1994). The CES-D Short Form is a 20-item self-report measure. Each item on the CESD is answered using a 4-point Likert Scale ranging from "3=Most of the Time (5–7 days)" to "0=Rarely or None of the Time (less than 1 day)." Participants were given the following prompt: Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week by using the rating scale provided. Sample items include the following: "I was bothered by things that usually don't bother me," "I had trouble keeping my mind on what I was doing," I felt that everything I did was an effort." ($\alpha = 0.80$)

Restrictive emotionality

Gender role investment was operationalized using the Gender Role Conflict Scale-Short Form (GRCS-SF). The GRCS-SF is a 16-item self-report measure. The instrument is comprised of four subscales (i.e., Success, Power, Competition; Restrictive Emotionality; Restrictive Affectionate Behavior Between Men; and Conflict Between Work and Family Relations). Each item on the GRCS-SF is answered using a 6-point Likert scale, ranging from "6=strongly agree" to "1=strongly disagree." A higher subscale score indicates more gender role conflict in that dimension. Based on previous research related to the adverse consequences of emotion suppression for mental (Hammond, 2012) and physical health (Wade, 2009) among Black men, we focused on the restrictive emotionality subscale. Sample items include the following: "I do not like to show my emotions to other people," and "I have difficulty expressing my emotional needs to my partner" ($\alpha = 0.86$)

Socio-demographics variables

The socio-demographics characteristics of the sample were captured using several single-item indicators. The characteristics that were of particular interest are those known to influence physical and mental health outcomes, such as race, ethnicity, age, marital status, number of children, level of education, income, employment status, criminal history, healthcare coverage, and food insecurity.

Data analytic strategy

Preliminary analyses were conducted to prepare the data for the main study analyses. First, men that identified with any racial/ethnic group other than Black, White, and Hispanic/Latino were excluded from analyses as the sample sizes for these groups (n = <20) were too small to provide the statistical power necessary for meaningful comparisons. This resulted in a reduced overall sample size (n = 494). Second, relevant scale items were reverse coded and summary statistics for all scales and subscales were calculated, along with Cronbach's alpha reliability scores. For the main study analyses, we employed PROCESS model 5 to test the fit of a moderated mediation model. PROCESS is a macro tool for conducting mediation analysis in SPSS version 27 (Hayes, 2018).

The model examined the indirect effect of undermining coparenting on mental (i.e., anger) and physical health, mediated by depression, with race and restrictive emotionality as potential moderators. We used the significance of the interaction terms between the amount of undermining and the race and restrictive emotionality moderators to test for moderation. We used the confidence interval of the test of "indirect effects of x on y" to test for mediation (confidence interval ranges that excluded 0 were deemed significant). An initial test of a moderated mediation model explored whether greater undermining led to poorer physical health and higher levels of anger, as moderated by race and mediated by higher depressive symptoms. The moderation interactions were not significant (all p's > .11). However, the 3 mediation CI's did not include 0, thus the mediation effect was significant. This suggests that the impact of undermining coparenting on mental and physical health is relevant to all men. However, for the purposes of this study, we report the results obtained with Black male participants only (n = 246).

Prior to conducting the tests of moderated mediation, several assumptions of multiple regression were tested. Specifically, these assumptions included ensuring the independence of observations, linearity of relationships among variables, that error values were homoscedastic, that multicollinearity did not exist among the IVs, and that error values were normally distributed. To test the independence of observations, we obtained the Durbin-Watson statistic of the model for each of the three DVs, which tests for the presence of autocorrelation in error terms. The Durbin-Watson statistic can vary between 0 and 4, with values in the range of 1.5 – 2.5 indicating that the assumption of independence is met. In this case, the Durbin-Watson statistics ranged from 1.69–1.84, indicating that this assumption was not violated. To verify the assumption of linearity with the IVs collectively and each DV, we generated a scatter plot using the studentized residual and unstandardized predicted values.

Through visual inspection of each scatterplot, the data appeared to be horizontal in nature, without curvature, indicating that this assumption was not violated. Through visual inspection of those same scatterplots, the data appeared to be scattered equally across different values of the DV, indicating that the assumption of homoscedasticity was met. To test whether multicollinearity existed, we verified the values of the variance inflation factor (VIF) between IVs in each model. VIF values above 5 indicate multicollinearity and warrant corrective measures. All VIF statistics ranged from 1.16–1.35, suggesting that multicollinearity did not exist in the proposed models. Finally, to test for the normality of error values, standardized residual plots were visually inspected. The anger and overall physical health measures appeared normally distributed, while the short-term physical health measure showed a minor positive skew. Visual inspection of the p-P plot of regression standardized residuals also suggested a slight lack of normality in the variable's distribution. However, regression is robust against non-severe violations of normality (Hayes, 2018), thus all analyses were performed using the original data.

Results

Bivariate results

As shown in Table 1, we first tested for bivariate correlations between our independent, mediating, moderating, and dependent variables, using listwise deletion to address missing values. The independent variable, undermining coparenting, was found to be significantly

Table 1. Correlations and Descriptive Statistics for Measures ($n = 227$).

Variable	1	2	3	4	5	6
1. Anger	1.00					
2. Physical Health (Overall)	−0.049	1.00				
3. Physical Health (30 days)	0.348***	−0.04	1.00			
4. Undermining Co-Parenting	0.401***	−0.224***	0.350***	1.00		
5. Depression	0.514***	0.12	0.367***	0.435***	1.00	
6. Restrictive Emotionality	0.381***	−0.009	0.196**	0.241***	0.406***	1.00
M	2.19	2.36	7.87	3.57	10.83	3.15
SD	1.05	1.13	8.93	1.99	6.55	1.46

** = $p < .01$., *** = $p < .001$.

associated with the potential mediating variable, depression (path a) ($r = .44$, $p < .01$). Depression was not found to be significantly associated with overall physical health (in general, how would you rate your physical health?) ($r = .12$, $p > .05$) (path b). However, depression was found to be significantly associated with short-term physical health (how many days during the past 30 days was your physical health not good?) ($r = .367$, $p < .01$) (path b) and anger ($r = .51$, $p < .01$) (path b). Undermining coparenting was also significantly associated with all outcome variables – overall physical health ($r = -.22 <$ p .01) (path c), short=term physical health ($r = .35$, $p < .01$) (path c), and anger ($r = .40$, $p < .01$) (path c). Undermining coparenting was also significantly associated with the potential moderating variable, restrictive emotionality ($r = .24$, $p < .01$) (path c).

Multivariate results

Next, we tested a moderated mediation model to determine the extent to which depressive symptoms mediates the relationship between mental (as measured by anger) and physical health outcomes among Black fathers. The model further tested whether potential mediation effects would be moderated by restrictive emotionality. With *anger as the dependent variable*, the overall moderation interaction was not significant ($p = .57$). However, the test of conditional direct and indirect effects suggests that the moderation interaction was only significant for those who exhibited moderate ($p = .01$) to high ($p < .02$) levels of restrictive emotionality. The mediation CI (.06–.15) was also significant, suggesting that depression mediated the effect of undermining coparenting on anger. Taken together, these results suggest that not only did depression mediate the association between undermining coparenting and anger, but the effect was also strongest among those who expressed moderate or high levels of restrictive emotionality.

With overall physical health as the dependent variable, the overall moderation interaction was significant ($p = < .01$). However, the test of conditional direct and indirect effects suggests that this interaction effect was only significant for those fathers who reported moderate (p = .01) or high (p = .01) levels of restrictive emotionality. The mediation CI (.04–.12) was also significant. These results suggest that not only did depression mediate the effect of undermining coparenting on overall physical health outcomes, but the effect was strongest for those expressing higher levels of restrictive emotionality.

With *short-term physical health as the dependent variable*, the overall moderation interaction was not significant ($p = .37$). However, the test of conditional direct and indirect effects suggests that this interaction effect was significant for those fathers who reported moderate ($p < .01$) or high ($p < .01$) levels of restrictive emotionality. The mediation CI (.18–.83) was also significant. These results suggest that not only did depression mediate the effect of undermining coparenting on short-term health, but the effect was strongest for those who exhibited higher levels or restrictive emotionality. These results are displayed in Table 2.

Table 2. The role of undermining coparenting on black fathers' mediator-adjusted anger, physical health (overall) and physical health (30 days) as a function of restrictive emotionality and depression ($n = 237$).

	Depression (*M*)			Anger *Model 1*			Physical Health (Overall) *Model 2*			Physical Health (30 days) *Model 3*		
Variable	Coeff	*SE*	*p*	Coeff	*SE*	*p*	Coeff	*SE*	*p*	Coeff	*SE*	*p*
Total Effects on Physical and Mental Health Outcomes												
Constant	5.89	0.81	***	1.05	0.26	***	1.88	0.31	***	2.53	2.43	.30
Undermining Coparenting (*X*)	1.43	0.20	***	0.06	0.07	.36	0.02	0.08	.74	0.24	0.62	.69
Restrictive Emotionality (*W*)				0.02	0.08	.84	0.20	0.10	*	−0.74	0.78	.14
X x *W*				0.01	0.02	.57	−0.07	0.02	**	0.27	0.19	.35
Depression (*M*)				0.07	0.01	***	0.05	0.01	***	0.33	0.10	***
R		0.43			0.56			0.36			0.43	
Direct Effect				Effect	*SE*	*p*	Effect	*SE*	*p*	Effect	*SE*	*p*
Conditional Direct and Indirect Effects on Physical and Mental Health Outcomes												
Restrictive Emotionality (*W*)												
Low				.07	.05	.11	−.06	.05	.27	.65	.40	.11
Moderate				.10	.03	**	−.19	.04	***	1.13	.31	***
High				.11	.05	*	−.29	.06	***	1.53	.45	***
Indirect Effect				**Effect**	**LLCI**	**ULCI**	**Effect**	**LLCI**	**ULCI**	**Effect**	**LLCI**	**ULCI**
Depression (*M*)				.10	.06	.15	.08	.04	.12	.47	.18	.83

Note: Coeff. = coefficient; *M* = mediator; W = moderator; X = independent variable; LLCI = lower limit of confidence interval; ULCI = upper limit of confidence interval.
* = $p < .05$., ** = $p < .01$., *** = $p < .001$.

Discussion

In this study, we applied the social determinants of health framework to examine the impact of Black fathers' perceptions of undermining coparenting on their self-reported ratings of mental and physical health and whether these relationships were mediated by depressive symptoms and moderated by restrictive emotionality. For *research question 1* (does restrictive emotionality **moderate** the relationship between undermining coparenting and *mental health outcomes*, as measured by anger, among Black fathers?), a significant positive association was found between undermining coparenting and anger. This relationship was moderated by restrictive emotionality. In other words, higher levels of undermining were associated with higher levels of anger, specifically among fathers who reported moderate or high levels of restrictive emotionality.

Previous research has shown coparenting and characteristics of traditional forms masculinity to be related to men's mental health, primarily anxiety and depression (Fagan, 2009; Tsuchiya et al., 2018; Wong et al., 2017). Our study is one of the first to establish the relationship between undermining coparenting, restrictive emotionality, and anger among Black men. Our results suggest that men who tend to suppress their emotions may exhibit anger when their co-parent undermines their fathering. Thus, men who endorse forms of traditional masculinity, such as restrictive emotionality, may be at particular risk of negative mental health outcomes as a result of undermining coparenting.

As it relates to *research question 2* (does depression **mediate** the relationship between undermining coparenting and *mental health outcomes*, as measured by anger, among Black fathers?), this relationship was found to be mediated by depression, which underscores the impact of coparenting on mental health outcomes among Black fathers. The vast majority of studies to date have explored the direct association between paternal mental health and coparenting (Price-Robertson et al., 2017; Tissot et al., 2017; Turney & Hardie, 2021; Williams, 2018). This study adds to this literature base by demonstrating a key mechanism that underlies the relationship between coparenting and fathers' negative mental health outcomes. Furthermore, these findings provide support for prior work establishing depression as a precursor to anger (e.g., Brownhill et al., 2005; Winkler et al., 2006). Thus, it is important to consider anger among Black men outside of the stereotypical pejorative context as a precursor to child abuse and other forms of violence (e.g.,

Hampton et al., 2003). Taken together, not only does this data suggest that depression mediates the relationship between undermining coparenting and anger, but this relationship should be of particular concern among men who demonstrate higher levels of restrictive emotionality as the negative mental health impact tends to be strongest among this group.

For *research question 3* (does restrictive emotionality **moderate** the relationship between undermining coparenting and *overall physical health* outcomes among Black fathers?), a significant negative association was found between undermining coparenting and Black fathers' ratings of their overall physical health; in other words, higher levels of undermining were associated with lower ratings of overall physical health. This relationship was moderated by restrictive emotionality, particularly for those fathers who reported moderate or high levels. This relationship was also mediated by depression. (*research question 4*: does depression **mediate** the relationship between undermining coparenting and *overall physical health* outcomes among Black fathers?). Thus, not only did depression influence the relationship between undermining coparenting and overall physical health, but the relationship was stronger for those who expressed higher levels of restrictive emotionality.

As it relates to *research question 5* (does restrictive emotionality **moderate** the relationship between undermining coparenting and *short-term physical health* outcomes among Black fathers?), a significant positive association was found between undermining coparenting and Black fathers' perceptions of their physical health in the short term (i.e., last 30 days); in other words higher levels of undermining coparenting were correlated with a greater number of days that Black fathers perceived their physical health as "not good." This relationship was moderated by restrictive emotionality, particularly for those fathers who reported moderate or high levels.

This relationship was mediated by depression (*research question 6*: does depression **mediate** the relationship between undermining coparenting and *short-term physical health* outcomes among Black fathers?). Taken together, not only did depression influence the association between undermining coparenting and short-term physical health, the strength and direction of this relationship was also impacted by restrictive emotionality. Given findings from previous research (e.g. Almeida, 2021; Darabos & Hoyt, 2017), it is not surprising that depression and restrictive emotionality were related to worse health outcomes among our sample of Black fathers. However, our results highlight specific mediating and moderating mechanisms by which undermining coparenting leads to negative health outcomes for Black fathers, and how these mechanisms may differentially impact fathers in the short and long-term. Overall, these findings point to undermining coparenting as an important social determinant of health among Black fathers that should be taken into consideration by social work practitioners, educators, and researchers, as well as policymakers and members of the Black community.

Strengths and limitations

This study contributes to the social work and public health literature by advancing our understanding of a key social determinant of Black men's mental and physical health that is often understudied – coparenting dynamics. In addition, in this study, we examined the association between depression and anger (instead of the association between anger and depression), which helped to uncover the significance of this pathway for Black fathers, warranting further and more in-depth study that can inform the development of mental health interventions. This study also illuminated the levels (i.e., moderate and high) at which restrictive emotionality interacts with undermining coparenting to influence Black fathers' mental and physical health outcomes, which provides helpful insight and guidance for practitioners in working with this population. On the whole, the findings from this study encourage new directions in both research and practice that draw greater attention to the effects of adverse coparenting experiences on fathers' physical and psychological well-being. Aside from these strengths, some limitations should also be noted.

First, this study is cross-sectional and correlational in nature. As such, causality cannot be inferred. Second, this study relied solely on self-reports from respondents, introducing the issue of social desirability bias. However, given men's lower tendency to seek help for mental or physical health generally and underreporting of depressive symptoms specifically (W. Courtenay, 2000; Galdas et al., 2005), this bias would likely play out as men underreporting the severity of undermining coparenting on their health. We also gathered data related to participant's subjective perceptions of their own physical and mental health, rather than physiological measures captured by healthcare professionals.

Third, we only obtained father reports of undermining coparenting, which is only one perspective. Future studies should employ data triangulation strategies that allow for obtaining multiple types (i.e., surveys, interviews, observations) and sources (i.e., mothers, fathers, and significant others) of data regarding coparenting dynamics. Fourth, due to the use of an opt-in method by Qualtrics panels (i.e., participants can opt into the surveys they want to take part in), random sampling methods were not employed, which heightens the risk of self-selection bias. However, Qualtrics does attempt to minimize this bias by limiting the details about the contents of surveys in invitations sent to participants.

Directions for future research

This study provides new evidence in response to questions regarding the impact of undermining coparenting on men's health and the role of depression and restrictive emotionality in this relationship. Yet, there are still many questions that remain unanswered. To fully understand and improve the health of Black men, it is imperative to take a comprehensive and holistic approach (Gilbert et al., 2016). The social determinants of health framework does not account for certain psychological, social, historical, and cultural factors that reflect the environment and context in which Black fathers live (Bush, 2013). The findings of this study suggest that the social determinants of health framework should be broadened to include these factors. Specifically, future researchers should pursue in-depth exploration of family-related variables in relation to Black fathers' health outcomes. In this study, we considered the extent to which depression mediated the association between undermining coparenting and mental (i.e., anger) and physical health outcomes.

To further elucidate the underlying mechanisms by which coparenting dynamics influence the health of Black fathers, future researchers might investigate undermining coparenting as a predictor of other health-related outcomes known to be disproportionately high in Black communities such as stress. In addition, the present data suggests the importance of examining the causes and correlates of undermining as it can shed light on precursors to negative health outcomes. Furthermore, one might also consider exploring how depression (independent variable) may influence perceptions of coparenting dynamics (dependent variable) among Black men as previous studies have pointed to the impact of parental mental health on coparenting (Turney & Hardie, 2021; Williams, 2018). Given the adverse impact of anger on health (Shimbo et al., 2023), there is also a need for additional studies that explore the manifestations of anger, in the context of coparenting, among Black men.

Additional qualitative research is also needed to explore the experience of undermining coparenting and its impact on health, from the perspective of Black fathers, as well as ways to improve coparenting dynamics. Additionally, to avoid the assumption of homogeneity and acknowledge the diversity of Black people across the African diaspora, future researchers should seek to employ within-group designs to determine any additional within-group differences (Volpe et al., 2022) that may have be important for understanding the relationships examined beyond restrictive emotionality as explored in this study. Doing so can help to explore this topic among Black men with varying characteristics and lived experiences. Since this study is cross-sectional in nature, future scholars should also study undermining coparenting longitudinally as coparenting dynamics can change over time.

Longitudinal studies should also further examine the pathway from depression to anger among Black men to solidify the temporal ordering of these variables as this relationship is understudied and may have significant implications for clinical practice and mental health intervention development. Finally, to ensure that future research is relevant to the experiences of Black fathers, researchers should

employ a community-based participatory research (CBPR) approach where possible, which would include directly involving them in the planning and implementation of the research process, as well as the dissemination of study outcomes. Among the advantages of CBPR are improved relevance of research questions, enhanced research recruitment and data collection, collective dissemination, and shared benefits among stakeholders (Akintobi et al., 2018).

Implications and recommendations for practice and policy

The social work profession maintains a commitment to closing the health gap (Spencer et al., 2016) and social workers have an important role to play in health promotion and eliminating racial/ethnic and gender disparities in health, particularly as it relates to mental health (Bowen & Walton, 2015). However, the profession has been largely absent in the discourse on how to improve the health of Black men specifically (Watkins et al., 2015). Nevertheless, social work professionals are uniquely positioned to promote the health and well-being of Black men (Watkins et al., 2015) and lead in the development and implementation of multi-level, contextually and community-based strategies to address health disparities among this group (Spencer et al., 2016; Sprague-Martinez et al., 2018). While context plays an important role in disentangling health disparities (Griffith et al., 2010; Sprague-Martinez et al., 2018), men's health research has traditionally been decontextualized (Rieker & Bird, 2005).

To enhance the development of clinical interventions, and mitigate health disparities, it is important that social work practitioners understand the complex interplay between the multiple contextual factors that underlie Black men's health outcomes. Though gender, racial, and ethnic disparities in health have been well documented in the United States, it remains unclear how these factors intersect to influence the mental and physical well-being of Black men (Griffith, Ober Allen, et al., 2011; Watkins et al., 2011). However, studies have suggested that the causes of adverse health among men are primarily social and behavioral in nature (Featherstone et al., 2007) and that men's health cannot be fully understood without consideration for the underlying relational and social processes that are embedded within the context of fathering (Griffith et al., 2010; Rieker & Bird, 2005). Family ties have wide-ranging consequences for health, both negative and positive (Umberson & Thomeer, 2020).

Studies of Black men specifically underscore the salience of family and extended kin (Sarkisian, 2007) and the ways that family structure and dynamics can influence their health and well-being (Watkins et al., 2011). This is consistent with the seminal works of Black family scholars that describe the Black family as an instrument of culture (Nobles, 2007) and emphasize the importance of collectivism and kinship ties for the survival of Black people in America (Billingsley, 1992). The results of this study provide practitioners with an understanding of the role coparents play in influencing the health of Black fathers. Given study results, practitioners should consider exploring coparenting dynamics as a part of routine assessment of the mental and physical health of Black men. Practitioners should also be intentional about working with Black fathers to develop the coping skills needed for navigating challenging coparenting interactions. It is also recommended that practitioners seek to provide culturally relevant psycho-educational interventions for Black families, especially mothers, focused on understanding the impact of undermining coparenting on Black fathers' health outcomes. It is also important for social worker practitioners to understand the role of traditional masculine norms in shaping the health of men. Social and relational contexts influence the type of masculinity that men construct, which has implications for health risk (Griffith, Metzl, et al., 2011).

In addition, men from diverse cultural backgrounds construct masculine ideologies in ways that are important to understand for effective social work practice (Griffith, Metzl, et al., 2011). In particular, constraining aspects of male gender norms can negatively influence men's health (Fleming et al., 2014). Restrictive emotionality is one form of masculinity that Black men employ, often in reaction to stressful life events (i.e., racism and oppression) (Jackson, 2018), that can intersect with coparenting dynamics in ways that have a detrimental impact to health. There is a need for deeper understanding of the emotion management and regulation

strategies (N. A. Roberts et al., 2008) that Black men sometimes employ in response to perceived stress in their social environment (Jackson, 2018). Such insight can assist social work practitioners in their efforts to help Black men find acceptable and healthy ways to address the challenging emotions (i.e., anger) that often coincide with feelings of being undermined in the coparenting relationship. Incorporating messaging into public health interventions that is designed to educate about the more harmful aspects of masculinity (i.e., restrictive emotionality) and impacts on health can potentially improve Black men's health outcomes (Fleming et al., 2014).

Furthermore, Gilbert et al. (2016) states "creating solutions to improve the poor health of Black men may come only when we collectively recognize how to undo and ameliorate policies that have unwittingly produced the health profile of Black men we see today" (pp. 307–308). Historically, public policies, such as paternity establishment, welfare reform policies, child support, and work policies, have tended to fuel undermining coparenting, especially among Black fathers that are part of non-traditional family structures (i.e., nonresident fathers), as these policies were originally constructed to support the traditional nuclear family configuration (Cabrera & Peters, 2014). My Brother's Keeper was initiated by the Obama Administration to promote the health and well-being of young men and boys, but has now moved out of the realm of federal responsibility. In support of the U.S. Department of Health and Human Services' Healthy People 2030 initiative, creating a federal Office of Men's Health, in the Department of Health and Human Services (similar to the Office of Women's Health), may provide a space to focus on the unique social determinants of health that impact Black fathers (Enyia et al., 2016).

Conclusion

Although much progress has been made in ameliorating health disparities, ongoing work is needed by public health social work professionals, researchers, and policymakers (Keefe, 2010). This study contributes significantly to the literature by raising awareness related to the impact of coparenting dynamics on Black men's health, which is an area of research that has been largely overlooked. It also bridges a notable gap between two historically divergent areas of scholarship – fatherhood and men's health. Specifically, it calls attention to the need to study fatherhood alongside men's health and the need for a more in-depth understanding of the ways the context and environment of fathering can impact the health of men. The results of this study also invite social work practitioners to see the experience of fathering, and in turn coparenting, as a unique window into understanding men's health and development (Kotelchuck, 2022).

These findings also provide important guidance for practitioners pertaining to potential avenues for the development of clinical interventions that focus on fostering more positive and supportive coparenting dynamics, thereby enhancing the health of Black men and alleviating health disparities. Finally, study findings offer valuable insights for policymakers that can result in more critical examination of the ways current social welfare policies may activate undermining. Fathers' health has important implications for the health of children and families (Kotelchuck, 2022). Thus, attending to the health of fathers in social work practice, education, research, and policy is beneficial for individual fathers, children, families, and communities.

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Dedication

This paper is dedicated to the first author's father, George H. Lemmons, Jr., who experienced many struggles with coparenting, yet remained steadfast in his commitment to fathering.

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