Title: In-vivo praying and catastrophizing mediate the race differences in experimental pain sensitivity

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Running Head: Praying, catastrophizing, race, and pain

Declaration:
We confirm that there has been no previous presentation of the data used in this paper, neither are there any closely related manuscripts that have been submitted for simultaneous consideration to the same or another journal. The research reported herein was supported by a grant from the Department of Psychology at Indiana University-Purdue University Indianapolis. There are no conflicts of interest that might be seen as influencing or prejudicing the research.

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Abstract

Black individuals have a lower tolerance for experimental pain than White individuals. Black and White individuals also differ in their use of pain coping strategies, which may explain the race differences in pain sensitivity. We examined the extent to which situation-specific pain coping mediated Black-White differences in pain sensitivity. We hypothesized that: (1) Black participants would demonstrate lower pain tolerance than White participants, (2) Black participants would use different pain coping strategies than White participants, and (3) the differential use of these strategies would mediate the relationship between race and pain tolerance. Healthy college undergraduates (N=190) participated in a cold pressor task and then completed the CSQ-R to assess their situation-specific pain coping. Compared to White participants, Black participants demonstrated lower pain tolerance, engaged in more situation-specific catastrophizing and praying, and ignored pain less frequently. Catastrophizing and praying were inversely related to pain tolerance and were significant mediators of the relationship between race and pain tolerance. The indirect effect of praying was stronger than that of catastrophizing. Race differences in pain sensitivity may be due, in part, to differences in the use of catastrophizing and praying as coping strategies. These results may help guide treatments addressing maladaptive pain coping.

Perspective:
This study suggests that race differences in pain sensitivity may be due, in part, to the differential use of catastrophizing and praying strategies. Psychosocial treatments for pain should encourage patients to take an active role in their pain management.

Keywords: Race; Catastrophizing; Praying; Experimental Pain; Coping
Introduction

Chronic pain affects approximately 100 million Americans and is associated with $635 billion in annual medical treatment and lost productivity. Although ubiquitous, the experience of pain differs based on race and ethnicity. Compared to non-Hispanic Whites, Black individuals have a heightened sensitivity to both clinical and experimental pain. Not only are Black individuals more sensitive to pain, but they report more pain-related interference and disability than non-Hispanic Whites. Given the personal and public health burden of chronic pain, it is important to better understand these racial differences in order to optimize pain care for all patients.

Coping is one of the most widely studied psychosocial constructs in pain, and may help explain race differences in pain sensitivity. Racial groups differ in their use of pain coping strategies. Black individuals engage in pain-related praying and catastrophizing more than non-Hispanic Whites, while non-Hispanic Whites more often use ignoring strategies. These differences may be particularly important to understanding racial differences in pain sensitivity, as previous studies have found that catastrophizing and praying are associated with increased pain sensitivity, while ignoring strategies are associated with less pain.

Most of the coping literature has focused on the strategies individuals use when they experience pain (i.e., general pain coping). More recently, several studies have examined situation-specific (i.e., in-vivo) pain coping. Unlike general pain coping, situation-specific pain coping refers to the techniques used to manage pain during a specific task, such as an experimental cold pressor task (CPT). For example, several studies found the association between situation-specific catastrophizing, a cognitive-affective response to pain, and experimental pain sensitivity was stronger than that between general coping strategies and pain sensitivity. Moreover, Fabian and colleagues found that Blacks reported greater situation-specific catastrophizing, but not general catastrophizing, than Whites and that situational-specific catastrophizing mediated the relationship between race and tolerance for experimental cold pain. Although the relationship between pain, race, and situation-specific catastrophizing has been examined, to our knowledge, no studies have examined other situation-specific coping strategies in the context of race differences in pain sensitivity. Such studies will enhance understanding of racial differences in pain and may eventually lead to individualized clinical approaches targeting these strategies.

The goal of the current study was to examine situation-specific coping strategies as potential mediators of the relationship between race and experimental pain sensitivity. We hypothesized that (1) Black participants would engage in praying and catastrophizing strategies more and ignoring strategies less than White participants, and (2) the differential use of situation-specific coping strategies would mediate the relationship between race and pain sensitivity.
Methods

Participants

Participants were 190 healthy undergraduates from Indiana University-Purdue University Indianapolis (IUPUI). Potential participants were excluded if they met any of the following exclusion criteria: chronic pain, circulatory problems, hypertension, diabetes, heart or vascular disease, a history of fainting spells, a seizure disorder, Raynaud’s Disease, Sick Cell Anemia, a recently sprained or fractured wrist or hand, pregnancy, or previous participation in a cold pressor pain task (CPT).

Procedures

All procedures were approved by the University's Institutional Review Board. Students interested in participating in the study were contacted via telephone to answer a number of health-related questions and determine study eligibility. Eligible participants scheduled a time to complete the study individually in a laboratory at IUPUI.

Upon arrival, all participants provided informed consent to participate. Next, they completed a questionnaire to rule out use of analgesic medications within the past 24 hours and consumption of caffeine and alcohol within the last two hours. Participants who had used analgesic medications or consumed caffeine or alcohol were rescheduled. Prior to the CPT, participants completed a computerized demographic questionnaire. During the CPT, participants were asked to submerge their non-dominant hand up to their wrist into a circulating bath of 2°C Celsius water (Thermo Scientific Arctic Series Refrigerated Bath Circulator). They were instructed to leave their hand in the water until they could no longer tolerate the sensation. Participants were asked to say ‘pain’ as soon as they experienced any painful sensations. While their hand was submerged in the water, participants rated the intensity of their pain every 10 seconds using written visual analog scales (VAS). When the participants were no longer able to tolerate the sensation, they were asked to say ‘pain limit’ and complete one last VAS rating upon removing their hand from the water. Participants who had not reached pain tolerance after three minutes were asked to remove their hand from the water and make a final VAS rating. After completing the CPT, participants completed a modified version of the Coping Strategies Questionnaire-Revised (CSQ-R) measuring situation-specific (“in-vivo”) coping strategy use during the CPT. They were then debriefed and compensated with either class credit or a $10 Amazon gift card.

COLD PAIN THRESHOLD AND TOLERANCE

Pain threshold was determined by measuring the amount of time in seconds each participant’s hand remained in the water before saying ‘pain.’ Pain tolerance was the total number of seconds elapsed at the time of withdrawal from the cold pressor.

PAIN INTENSITY
During the CPT, participants were prompted every 10 seconds to rate their pain intensity on a VAS (0-100) with anchors of ‘no pain’ and ‘worst pain imaginable.’

PAIN COPING

The Coping Strategies Questionnaire-Revised (CSQ-R) is a 27-item self-report measure of pain-related coping\textsuperscript{35}. The CSQ-R consists of six cognitive strategies (diverting attention, reinterpreting pain sensations, coping self-statements, ignoring pain sensations, praying/hoping, and catastrophizing) that were retained from the original CSQ. Participants rated how often they use each strategy to cope with pain from 0 (never do that) to 6 (always do that). Consistent with previous studies, the instructions for the CSQ-R were revised to measure situation-specific coping, such that participants were asked to rate how often they used each strategy to cope with the pain they experienced during the CPT\textsuperscript{7,12,20,24}. The CSQ-R has a more refined factor structure than the original CSQ, with subscale reliability ranging from 0.72 to 0.86\textsuperscript{35,36}. The 6-factor structure reported by Hastie, Riley & Fillingim\textsuperscript{22} was retained in this sample with good overall ($\alpha = 0.85$) and subscale (range of $\alpha = 0.83$-0.91) reliability.

Data Analysis

Independent samples $t$-tests were used to identify race differences in pain sensitivity and coping variables. Pearson’s correlations were used to evaluate the bivariate associations among coping variables and measures of pain sensitivity.

A multiple mediation analysis was conducted to test our hypotheses that coping strategy use would mediate the association between race and pain tolerance. In a multiple mediation model, one can test both the overall mediation effect for all mediators included in the model (i.e., total indirect effect) and the effects of each mediator independently (i.e., specific indirect effects). Specific indirect effects are interpreted as the indirect (i.e., mediation) effect of the independent variable (race) on the dependent variable (pain tolerance) through a given mediator (coping strategy), controlling for all other mediators in the model\textsuperscript{33}. The total indirect effect is interpreted as the indirect effect of the independent variable on the dependent variable through all of the mediators in the model. This multiple mediation analysis was conducted using Preacher and Hayes’ bootstrapping procedures and SPSS Macros\textsuperscript{32,33}. The bootstrapping procedure, unlike the Sobel test, is a nonparametric procedure that does not assume that the indirect effects (path $a \times b$) of the independent variable on the dependent variable are normally distributed. The bootstrapped mediation analysis indicates whether the total effect (path $c$) of race on pain tolerance is composed of a significant direct effect of race on tolerance (path $c'$) and a significant indirect effect of race on tolerance through one or more mediators (coping strategies). Path $a$ denotes the effect of race on the mediator(s), whereas path $b$ is the effect of the mediator(s) on pain tolerance. Tests of mediation were based on 3,000 bootstrap resamples to produce the 95% confidence intervals for each candidate mediator and were used to test the significance of both total and specific indirect effects.
Mediation models are considered significant if zero is not contained within the 95% confidence intervals\textsuperscript{32,33}.

\section*{Results}
\subsection*{Participant Characteristics}
Participant demographic characteristics can be found in Table 1. The sample consisted of 190 Black and non-Hispanic White participants. The sample was primarily female (73.7%) and non-Hispanic White (56.8%). The gender distribution between Black and White participants did not significantly differ ($X^2 (1) = .02, p = .89, \nu = .01$). The mean age for Black [23.15 years (7.64)] and White [21.81 years (6.11)] participants did not significantly differ ($t_{(188)} = 1.30, p = .19, d = .20$).

\subsection*{Race Differences in Pain Sensitivity and Psychological Variables}
The results of independent samples $t$-tests (see Table 2) indicated that Black participants exhibited a lower pain tolerance ($t_{(186)} = 4.85, p < .01; d = 0.69$) and reported less pain at tolerance ($t_{(186)} = -2.18, p < .05; d = 0.38$) than did White participants. There were no significant race differences in pain threshold ($t_{(188)} = -0.44, p = .66, d = 0.07$). Black participants engaged in situation-specific catastrophizing ($t_{(188)} = -0.38, p < .01, d = 0.56$) and praying ($t_{(188)} = -8.13, p < .01, d = 1.25$) more than White participants, while White participants ignored pain more frequently than Blacks ($t_{(188)} = 3.25, p < .01, d = .48$). There were no significant race differences in the use of distraction, distancing, or coping self-statements (all $p$ values > .05).

\subsection*{Bivariate Associations Between Pain and Psychological Variables}
Pearson correlations among pain and psychological variables are shown in Table 3. Situation-specific catastrophizing ($r = -0.34, p < .01$) and praying ($r = -0.40, p < .05$) were negatively related to pain tolerance, while situation-specific ignoring ($r = 0.29, p < .01$) and distancing ($r = 0.15, p < .05$) were positively associated with pain tolerance. Pain intensity at tolerance was not significantly associated with any of the coping strategies (all $p$ values > .05).

\subsection*{Mediation}
The potential mediating role of coping strategy use in the association between race and pain tolerance was examined using a bias-corrected (BC) bootstrapped multiple mediation analysis with 3000 bootstrap re-samples. Results of the multiple mediation analysis indicated that in-vivo coping accounted for 29% of the variance in pain tolerance and significantly mediated the relationship between race and pain tolerance (see Table 4). Results also indicated significant effects of race on catastrophizing, praying, and ignoring ($t = 3.78, p < .01; t = 8.51, p < .01; t = -3.25, p < .01; t = -3.18, p < .01; t = -4.40, p < .01$; respectively) and significant direct effects of catastrophizing and praying on pain tolerance ($t = -3.18, p < .01; t = -4.40, p < .01$; respectively). The indirect effects of both
catastrophizing and praying were significant, as the 95% CI did not include zero. Thus, both catastrophizing and praying individually mediated the association between race and pain tolerance. Finally, the 95% CI was examined for the contrast between the indirect effects of catastrophizing and praying to determine whether the indirect effects of catastrophizing and praying were significantly different from each other. The 95% CI did not include zero, indicating that the indirect effect of praying was statistically different than the indirect effect of catastrophizing (see Table 4). Although this analysis does not identify which effect is larger, an ocular inspection of the point estimates of each indirect effect indicates that the indirect effect of praying is stronger than the indirect effect of catastrophizing. These findings indicated that the effect of race on pain tolerance was mediated by overall coping strategy use but more specifically by the use of catastrophizing and praying, with the strongest indirect effect through praying.

**Discussion**

There are well-documented race differences in experimental pain sensitivity, with Black individuals having a lower tolerance than White individuals for heat, cold, and ischemic pain. Various psychosocial factors may account for these differences. We examined situation-specific (i.e., in-vivo) pain coping strategies as potential mediators of the association between race and experimental pain sensitivity. We found that, compared to Whites, Blacks demonstrated a lower tolerance to experimental cold pain, and this difference was mediated by race differences in situation-specific coping. More specifically, race differences in pain tolerance were mediated by race differences in situation-specific catastrophizing and praying. Black participants catastrophized and prayed more than White participants during the CPT, and these differences were associated with a lower pain tolerance demonstrated by Black participants. When compared directly, the relationship between race and pain tolerance was more strongly associated with the use of praying than catastrophizing.

Consistent with our hypotheses, there were several race differences in the use of situation-specific pain coping strategies. Compared to Whites, Black participants engaged in more catastrophizing and praying but less ignoring strategies. This is consistent with previous literature examining general (i.e., dispositional) pain coping. The current study provides novel information about race differences in situation-specific coping strategies, which, to date, have only been reported for catastrophizing.

Results of our multiple mediation analysis indicate that Black participants not only prayed and catastrophized more than Whites in response to pain, but that these differences may help explain why Blacks had a lower pain tolerance than Whites. This is consistent with a previous investigation identifying general catastrophizing as a mediator of the race differences in pain sensitivity. Pain catastrophizing, as measured by the CSQ, is a passive, cognitive coping strategy involving perceptions of helplessness (e.g., “It’s terrible and I think it’s never going to
get any better.”)37. Pain catastrophizing is suggested to increase pain sensitivity through enhanced attention to painful stimuli as well as heightened emotional responses to pain. Indeed, catastrophizing has been associated with increased activity in brain areas related to anticipation of pain, attention to pain, and emotional aspects of pain and motor control21,38. Those who catastrophize about pain preferentially process pain-related information and interpret even ambiguous sensations as painful41. Taken together with previous findings, our results suggest that one reason Blacks are more sensitive to pain than Whites may be their tendency to catastrophize more.

It is interesting to note, however, that the mediation effect of praying was more robust than that of catastrophizing. The church plays a central role within the Black community. Compared to Whites, Blacks attend church more, read religious materials more, listen to religious programs more, request prayer from others more, self identify as more religious, and place higher importance on religion9. Thus, Blacks might be expected to pray more than Whites in general and in response to situational stressors such as illness, discrimination, and socioeconomic hardship that affect Blacks at higher rates than Whites3, 19,23,27,28, 40. Our finding that Black participants prayed more in response to pain is consistent with this body of literature.

Although the race differences in prayer and religion are well defined, the mechanism of how praying impacts pain sensitivity is less clear. Perhaps it is an effect driven by our measurement of prayer as a coping strategy. Prayer, as measured by the CSQ, is a passive coping strategy associated with avoidance1,30. Previous research suggests that passive coping and avoidance are related to worse pain and functioning and increased rates of disability4,5,30,31,44. Thus, Blacks’ more frequent engagement in a passive type of prayer (i.e., praying for pain to stop) may reduce their ability to tolerate pain. Whether such an effect is driven by prayer, per se, or the fact that this type of prayer is passive in nature remains to be known. Future studies should consider alternative measures of prayer, such as the Prayer Functions Scale2 or the Multidimensional Prayer Inventory29, that more broadly conceptualize prayer beyond passive strategies; such work would facilitate better understanding of its relationship to pain, and more specifically as a putative mechanism of race differences in pain sensitivity. Furthermore, because there are racial differences in religious affiliation9, future investigations should examine religious affiliation as a potential moderator of the relationship between race, praying, and pain.

These results have potentially important clinical implications. Geisser and colleagues provide evidence to suggest that maladaptive coping is a more important determinant in pain sensitivity than is adaptive coping18. One implication is that psychosocial treatments for chronic pain may need to focus more on reducing maladaptive coping; increasing adaptive coping should be a secondary goal. Indeed, reducing catastrophic cognitions is already a primary focus of some psychological treatments for pain42,43. Our results support this clinical emphasis.
Although praying has also been linked to greater pain sensitivity, we do not recommend that clinicians attempt to dissuade patients from praying. Not only is there insufficient scientific support for such an attempt, but it would also likely backfire, alienate the patient, and harm the clinical relationship. Rather, it seems reasonable and consistent with the evidence to encourage patients to take a more active role in their treatment, which may include adopting a more active type of prayer in the context of pain. Instead of using prayer to passively seek pain reduction or elimination, patients could be encouraged to achieve greater empowerment from their higher power, such as praying for the strength to overcome their pain and/or persist in valued life activities in the midst of pain. Such an emphasis is consistent with current evidence and the spirit of patient-centered care.

Several limitations should be considered when interpreting these findings. Because the study sample was comprised of healthy college-aged adults, generalizing these results to chronic pain patients may be limited. Relatedly, the relationship between race and coping with acute experimentally-induced pain may differ from that of chronic pain. Future research should examine race differences in situation-specific coping use within a chronic pain population, perhaps during a pain flare. We examined only one method of experimental pain – the cold pressor task; thus, future studies should attempt to replicate these findings in other experimental modalities (e.g., heat, pressure). Additionally, because we did not measure general (i.e., trait level) pain coping, these results do not speak to its relationships to race and pain sensitivity. Finally, it is possible that differences in pain sensitivity actually drove the racial differences in coping strategies. Future studies could experimentally manipulate the use of coping strategies to elucidate the causal nature of the relationship between race, pain, and coping.

Despite these limitations, our study provides new insights into the putative mechanisms that underlie the associations between race and pain sensitivity. We found that compared to White individuals, Black individuals demonstrated a lower tolerance for experimental cold pain, which may be related to their increased use of praying and catastrophizing as pain coping strategies. Our results suggest that in addition to focusing on reducing catastrophic cognitions, psychosocial treatments for chronic pain should encourage patients to take a more active role in their treatment rather than passively praying for relief. Further, the present findings support the need to examine a broader conceptualization of prayer in order to elucidate the aspects of prayer that influence pain sensitivity.
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   predicts experimental pain sensitivity in African Americans and Hispanics. *Pain* 
**Figure Legend**

*Figure 1.* The mediating effect of coping strategies in the association between race and pain tolerance.

**Table 1:** Participant demographic characteristics

**Table 2:** Race differences in pain sensitivity and psychological variables

**Table 3:** Pearson's correlations among pain sensitivity and situation-specific coping

**Table 4:** Bootstrapped multiple mediation analysis testing indirect effects of race on pain tolerance through pain coping
Figure 1. The mediating effect of coping strategies in the association between race and pain tolerance.

B = -31.03**

B = unstandardized regression coefficients

*p < .05
**p < .01
<table>
<thead>
<tr>
<th>Variable</th>
<th>Black (N = 82)</th>
<th>White (N = 108)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>23.15 ± 7.64</td>
<td>21.81 ± 6.11</td>
<td>0.19</td>
</tr>
<tr>
<td>Female (%)</td>
<td>60 (73.2)</td>
<td>80 (74.1)</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Table 2. Race Differences in Pain Sensitivity and Psychological Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Black (N = 82)</th>
<th>White (N = 108)</th>
<th>t-value</th>
<th>Cohen's d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Threshold (seconds)</td>
<td>18.45 ± 16.53</td>
<td>17.27 ± 19.06</td>
<td>-0.44</td>
<td>0.07</td>
</tr>
<tr>
<td>Pain Tolerance (seconds)</td>
<td>48.99 ± 37.89</td>
<td>80.03 ± 50.36</td>
<td>4.85**</td>
<td>0.69</td>
</tr>
<tr>
<td>Distraction</td>
<td>3.10 ± 1.60</td>
<td>2.85 ± 1.43</td>
<td>-1.16</td>
<td>0.17</td>
</tr>
<tr>
<td>Catastrophizing</td>
<td>3.24 ± 1.27</td>
<td>2.56 ± 1.19</td>
<td>-3.78**</td>
<td>0.56</td>
</tr>
<tr>
<td>Ignoring</td>
<td>3.34 ± 1.36</td>
<td>3.98 ± 1.35</td>
<td>3.25**</td>
<td>0.48</td>
</tr>
<tr>
<td>Distancing</td>
<td>2.54 ± 1.60</td>
<td>2.59 ± 1.47</td>
<td>0.21</td>
<td>0.03</td>
</tr>
<tr>
<td>Self-statements</td>
<td>5.08 ± 1.40</td>
<td>5.11 ± 1.14</td>
<td>0.14</td>
<td>0.02</td>
</tr>
<tr>
<td>Praying</td>
<td>4.59 ± 2.09</td>
<td>2.39 ± 1.48</td>
<td>-8.13**</td>
<td>1.25</td>
</tr>
<tr>
<td>Pain Rating at Tolerance</td>
<td>72.94 ± 25.58</td>
<td>80.24 ± 18.26</td>
<td>2.18*</td>
<td>0.33</td>
</tr>
</tbody>
</table>

* p < 0.05  
** p < 0.01
Table 3. Pearson's Correlations Among Pain Sensitivity and Situation-Specific Coping

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pain Threshold</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Pain Tolerance</td>
<td>0.280**</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Distraction</td>
<td>0.109</td>
<td>0.031</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4 Catastrophizing</td>
<td>-0.103</td>
<td>-0.341**</td>
<td>0.057</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Ignoring</td>
<td>0.036</td>
<td>0.288**</td>
<td>0.305**</td>
<td>-0.268**</td>
<td>---</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6 Distancing</td>
<td>-0.012</td>
<td>0.145*</td>
<td>0.331**</td>
<td>0.164*</td>
<td>0.464**</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Coping Self-statements</td>
<td>0.055</td>
<td>0.117</td>
<td>0.152*</td>
<td>-0.057</td>
<td>0.421**</td>
<td>0.183*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Praying</td>
<td>-0.05</td>
<td>-0.402**</td>
<td>0.342**</td>
<td>0.293**</td>
<td>-0.043</td>
<td>0.125</td>
<td>0.078</td>
<td>---</td>
</tr>
<tr>
<td>9 Pain at Tolerance</td>
<td>-0.005</td>
<td>-0.061</td>
<td>-0.098</td>
<td>0.098</td>
<td>0.001</td>
<td>-0.030</td>
<td>0.009</td>
<td>-0.105</td>
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</table>

* p < .05
** p < .01
Table 4. Bootstrapped Multiple Mediation Analysis Testing Indirect Effects of Race on Pain Tolerance through Pain Coping

<table>
<thead>
<tr>
<th>Indirect Effects</th>
<th>Point Estimate</th>
<th>Bootstrapping BC 95% CI</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>Total</td>
<td>-24.96</td>
<td>-36.16</td>
</tr>
<tr>
<td>Catastrophizing</td>
<td>-5.80</td>
<td>-11.16</td>
</tr>
<tr>
<td>Praying</td>
<td>-17.87</td>
<td>-27.35</td>
</tr>
<tr>
<td>Ignoring</td>
<td>-1.72</td>
<td>-7.18</td>
</tr>
<tr>
<td>Distraction</td>
<td>0.71</td>
<td>-0.37</td>
</tr>
<tr>
<td>Distancing</td>
<td>-0.22</td>
<td>-3.50</td>
</tr>
<tr>
<td>Coping Self-statements</td>
<td>-0.06</td>
<td>-1.97</td>
</tr>
</tbody>
</table>

Contrast

Catastrophizing vs. Praying 12.07  3.49  22.01