Chapter 14
Gender and Mental Health

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Among the strongest and most consistent patterns of mental health problems are the differences between men and women.[1] Neither gender experiences worse mental health overall, but men and women experience substantially different types of problems (Avison & McAlpine, 1992; Gore, Aseltine, & Colten, 1993; Kessler, 2003; Turner & Lloyd, 1995; Rosenfield, Lennon, & White, 2005). Starting in early adolescence, women suffer more than men from internalizing disorders, which turn problematic feelings against the self in depression and anxiety. This difference means that women endure attributions of self-blame and self-reproach more often than men. Women struggle with a greater sense of loss, hopelessness, and feelings of helplessness to improve their conditions. They also live with more fears in the forms of phobias, panic attacks, and free-floating anxiety states. In contrast, men predominate in externalizing disorders that are problematic for others, including antisocial personality disorders and substance abuse or dependence. Men are more likely to have enduring personality traits that are aggressive and antisocial in character, with related problems in forming close, enduring relationships.[2] Men also are more often dependent on substances, suffer from physical problems, and experience trouble with work and family from drug or alcohol use.

The National Comorbidity Survey Replication provides the rates of these problems (Kessler, 2003). This large, nationally representative survey assesses the prevalence of mental health in the general population and is unbiased by gender differences in treatment or help-seeking. In internalizing problems, 46 million women (29%) suffer from depression over their lifetimes, compared to 28 million men (18%). In addition, 54 million women (34%) as opposed to 36 million men (23%) endure some form of anxiety during their lives (Kessler, 2003). In externalizing problems, 8 million men (5%)

[1] We primarily use the term "mental health problems" because it is more neutral than "mental illness," which involves complex questions and debates about disease.

[2] Some researchers think that females are as aggressive as males but express it differently: while males exceed females in direct aggression that confronts others and inflicts physical harm, females are higher than males in indirect or covert aggression that harms others' relationships, esteem, or reputation. However, a current meta-analysis shows that direct aggression is the only form in which significant gender differences occur (Card, Stucky, Sawalani, & Little, 2008).

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experience antisocial personality disorder versus 1.5 million women (1%).[3] Also, 54 million men (35%) versus 29 million women (18%) abuse substances sometime in their lives.

Eliminating these gender disparities would have an enormous impact. If we could reduce the excess of internalizing problems among women to the rates among men, 20 million fewer women would endure depression and anxiety in their lifetimes. Reducing the excess of externalizing problems among men to the rates among women would spare 21 million men from substance abuse or antisocial personality disorder.[4] These gender differences exist in numerous countries, which suggests that decreasing the disparities would improve mental health world-wide (World Health Organization, 2006).

Given the potential benefits, it is critical to understand the origins of gender differences in mental health, especially social sources that potentially can be modified. Sociological perspectives trace these disparities to our conceptions of gender and gender practices.[5] Research suggests that definitions of masculinity and femininity have psychological consequences for men and women by producing gender differences in major risk factors, which, according to stress process and other theories, include differences in the stressors men and women experience, their coping strategies, social relationships, and personal resources and vulnerabilities (Pearlin, 2010; Thoits, 2009, 2010; Turner, 2010). This chapter concentrates on the gender differences in these areas.

We pay attention to how social groups differ in gender conceptions and practices, as clues to the roots of these disparities. Because gender differences vary by race and, to some extent, social class, we first examine gender disparities in mental health across race and class groups.[6] We then discuss how these groups define gender. Finally, we examine the explanations for gender differences in mental health that are rooted in gender conceptions and practices.

Gender Differences in Mental Health by Race and Social Class

In the United States, the gender gap in internalizing problems is much smaller for African Americans than for whites, primarily due to the low rates for African American women (Breslau et al., 2005; McGuire & Miranda, 2008; Rosenfield, Phillips, & White, 2006; Schwartz & Meyer, 2010). Rates of depression and anxiety among African American women fall below or equal those of white women (Harris, Edlund, & Larson, 2005; Kohn & Hudson, 2002; Turner & Gil, 2002; Williams, Costa, & Leavell, 2009; Williams, Takeuchi, & Adair, 1992). For example, the National Comorbidity Survey shows that sometime in their lives, 23% of white women suffer from major depression or the milder form of dysthymia compared to 16% of African American women. Although results are somewhat mixed, the relative advantage of African American women appears especially marked in higher social classes (Jackson & Mustillo, 2001; Kronenfeld, 1999; Rosenfield, 2012).

In contrast, gender differences in externalizing problems are similar across race: rates among males exceed those among females for both African Americans and whites (Adrian, 2002; Rosenfield et al., 2006; Vega, Gil, & Zimmerman, 1993; Vega, Gil, Zimmerman, & Warheit, 1993; Warheit, Vega, Khoury, Gil, & Elfenbein, 1996; Warner, Kessler, Hughes, Anthony, & Nelson, 1995). Among African

[3] Rates of antisocial personality disorder are low in general.

[4] These numbers take into account the comorbidity of depression with anxiety, and of substance abuse/dependence with antisocial personality disorder.

[5] Gender practices refer to what men and women do, that is, how they enact masculinity and femininity.

[6] There are debates over the definition of class and related terms. Some distinguish social class from socioeconomic status as separate aspects of socioeconomic position (e.g., Muntaner, Eaton, Miech, & O'Campo, 2004; Schnittker & McLeod, 2005). Others view socioeconomic status as the hierarchical dimensions of education, income, and occupational status, while social class involves relations of production such as owner, manager, and worker (Muntaner et al., 2004). Still other conceptions of class center on authority and control in the workplace as the defining characteristics (Wright, 2000). In this chapter, we use socioeconomic status and social class interchangeably to refer to income, education, and occupational status.

Americans, 14% of men experience antisocial personality disorder or conduct disorder versus 8% of women; among whites, the corresponding rates are 19% for men and 6% for women (Rosenfield, 2012). Some research finds that African American males are somewhat higher on aggression and somewhat lower in delinquent behavior and alcohol problems than white males (Rosenfield et al., 2006). There is also evidence that race differences vary by social class (Brown, Eaton, & Sussman, 1990; Rosenfield, 2012; Williams et al., 1992). In higher classes, African American men resemble white men in rates of antisocial behavior, but in lower classes, they exceed white men's rates.

In sum, research suggests that African Americans experience fewer gender differences in internalizing problems, mainly due to low rates among women. Conceptions of gender and gender practices also differ substantially between African Americans and whites, suggesting their importance for explaining the gender differences in mental health.

Gender Conceptions and Practices

Conceptions of gender and gender practices generally include the division of labor, the power differences between men and women, and the character traits associated with males and females. In the United States, dominant conceptions of gender—those held by the groups in power (i.e., middle-class whites)—originated with the industrial revolution in the nineteenth century. Industrialization brought divisions between public and private spheres, that is, between the workplace and the home. Men began to leave home for employment, and women stayed to care for the children in the household (Connell, 1995; Flax, 1993). The productive work of the public sphere became primarily associated with males and masculinity, while the emotional work and domestic labor of the private sector became linked to females and femininity (Cohen & Huffman, 2003; Rosenfield & Smith, 2009).

Conceptions of gender and gender practices have changed since then, but the old contrasts continue to influence current conceptions and practices. This is partly because many social changes have slowed or stalled since the early or mid-1990s, including the increase in women's employment, the desegregation of occupations and fields of study in college, and the decreasing gender gap in wages (Cotter, Hermsen, & Vanneman, 2011; England, 2010). Overall, women have entered conventionally male domains such as employment and male-dominated occupations more than men have entered traditionally female domains like domestic labor and female-dominated occupations (England & Folbre, 2005).

Men retain primary responsibility for the economic support of the family, and women are still responsible for caretaking and domestic work, regardless of whether they are employed (Rosenfield & Smith, 2009). Women do two-thirds of the work at home even if they are employed for the same number of hours and earn the same salary as their husbands (Greenstein, 2000; Lennon & Rosenfield, 1995).[7] Women also have more jobs that are part-time, with lower security and wages. They are more concentrated in lower levels of management, with less direct decision-making power than men (Lennon & Limonic, 2009). Female-dominated occupations pay less than male-dominated occupations even when the same skills are required, which is a major contributor to the gender wage gap (England, 2010; England, Allison, & Wu, 2007). Women still earn 20% less than men for comparable jobs with identical requirements and qualifications (Hegewisch, Liepmann, Hayes, & Hartmann, 2010). This means that the same job in which men earn $50,000 a year pays $40,000 to women, adding up to $500,000 less for women over their lifetimes.

Dominant conceptions of gender still hold that males and females have qualitatively different characters (Connell, 1995; England, 2010). These conceptions have changed less over time than other aspects of gender such as the division of labor (Connell, 1995; England, 2010; Ridgeway, 2009). The dominant societal form of femininity—which Connell calls *emphasized femininity*—

[7] We note that sharing domestic work is associated with lower rates of divorce.

stresses personal traits of submissiveness, nurturance, and emotional sensitivity as ideals (Connell, 1995). In contrast, dominant conceptions of masculinity—termed *hegemonic masculinity*—associates men with assertiveness, competitiveness, and independence, traits needed for success in the labor market (Connell, 1995; De Coster & Heimer, 2006; Hagan, 1991; Heimer, 1995; Heimer & De Coster, 1999; Schippers, 2007; Simon, 2002).

African American definitions of gender, especially femininity, differ in several ways (Anderson, 1999; Billingsley, 1992; Carter, Corra, & Carter, 2009; Carter, Sellers, & Squires, 2002; Connell, 1995; Duneier, 1992; Harris, Torres, & Allender, 1994; Hunter & Davis, 1992; Patterson, 1998).[8] In African American gender culture, the private sphere of the family and the public sphere of the workplace are less divided by gender. For example, African American conceptions of motherhood encompass economic provision along with caretaking, with responsibilities for children's material as well as emotional well-being (Collins, 1994). African Americans conceptualize gender as more flexible and interchangeable, with greater gender role equality (Hill & Sprague, 1999).

African American women and men have more equal power relations than whites. Because African American men disproportionately live in poverty or are unemployed or discouraged workers, there is greater economic equality between African American women and men than between white women and men (Cotter et al., 2011; Shelton & John, 1993). African American women also attain higher levels of education than African American men, providing more power relative to black men than white women relative to white men (Patterson, 1998). African American daughters are often raised to take care of themselves, to get their education and a job to support themselves, and to carry responsibilities for themselves, their family, and their communities.

Partly as a result, male–female relationships have different meanings among African Americans than among whites. For instance, marriage is not the same economic safeguard for African American women as for white women, whose options for economic security are greater within marriage than outside of it. Whites' greater economic gender inequality intensifies the power differences between the genders, placing more relative power in white men's hands (Gerstel & Gross, 1989).

Consistent with these differences, the dimensions of the self associated with femininity differ for African Americans and for whites. Autonomy and connectedness are more equally valued in African American femininity (Collins, 1994). Raised in a cultural tradition that elevates cooperation, African American males and females are encouraged to be nurturing as well as to be independent and assertive. Spiritual values underscore caring and community as well as equality (Duneier, 1992). Given these egalitarian beliefs, African American parents socialize their daughters to be strong, self-reliant, and resourceful (Collins, 1994; Hill, 2002). In addition, the high regard for the uniqueness and expression of individuals among African Americans affirms the worth of both females and males. Furthermore, parents bolster self-esteem of both their daughters and sons in the face of racism (Billingsley, 1992; Collins, 1994). Racial socialization builds deflective coping strategies that neutralize to some degree the negative assessments from the external world (Miller, 1999). Income inequality is attributed to structural rather than personal characteristics, which helps preserve the worth of the individual. African Americans often view their own cultural values—including ethics of caring, sincerity, and civility—as superior to the more competitive and materialistic values of white culture and as grounds for personal pride.

In sum, African Americans and whites construct and enact femininity in different ways. As a result, African American women describe themselves in more androgynous terms, incorporating more conventionally masculine traits than white women. Like white women, African American women endorse expressiveness, warmth, and nurturance as part of their gender ideology, but they reject the passivity, dependency, and subordination that white women more often accept as part of the feminine role (Cole & Zucker, 2007; Settles, Pratt-Hyatt, & Buchanan, 2008).

[8] Although there are variations within race and class groups in conceptions of gender, we emphasize the differences between them in this chapter.

The differences between African American and white femininities appear to be even stronger when social class—especially education—is high. In addition to directly positive effects on mental health, greater education is associated with more egalitarian conceptions of gender, further increasing the differences in gender ideology based on race (Rosenfield, 2012). As evidence, African Americans with higher education hold more egalitarian beliefs about gender (Cotter et al., 2011). In addition, African American parents from middle-class backgrounds endorse and convey greater gender equality to their children than those with lower class backgrounds (Hill, 2002).

The more limited research suggests that masculinities also vary by race/ethnicity, but less than femininities do. As noted above, dominant conceptions associate masculinity with primary responsibilities in the public sphere, greater power in gendered relationships, and character traits of assertiveness, competitiveness, independence, and control (Coles, 2009; De Coster & Heimer, 2006). Connell refers to these hegemonic white middle-class conceptions as the culturally idealized form of masculine character (Connell, 1990, p. 83).

African American and white men share many conceptions of maleness (Harris, 1996; Hunter & Davis, 1992; Hunter & Sellers, 1998). Both define ambition, economic viability and responsibility, and an independent sense of self as core components of masculinity. In contrast to dominant masculinity, however, African American men are less conventional in gender roles than white men (Blee & Tickamyer, 1995; Hunter & Davis, 1992; Kane, 2000). Compared to white men, African American men describe themselves as more androgynous—combining masculine and feminine traits—as well as participating more often in childrearing and holding more egalitarian views of the family.

Masculinities also vary by social class (Blee & Tickamyer, 1995; Cooper, 2000; Shows & Gerstel, 2009). Oppressed groups are blocked from pathways to dominant masculine ideals of economic responsibility for the family and success in the workplace (De Coster & Heimer, 2006). "Protest masculinities" form in response to economic powerlessness as well as barriers to the jobs and education that underlie hegemonic masculinity (Connell, 1995; Connell & Messerschmidt, 2005; De Coster & Heimer, 2006). These protest masculinities often exaggerate claims to masculine position and emphasize physical power and prowess more than middle-class forms (Benson, Wooldredge, Thistlethwaite, & Fox, 2004; Levant & Richmond, 2007; Hunter & Davis, 1992; Schrock & Schwalbe, 2009). In addition, this form is particularly strong among African American males, given the additional obstacles they experience due to racism (Anderson, 1990, 1999; Connell, 1995; Majors & Billson, 1992; Morgan, 2004; Patterson, 1998).

We note that some research connects conceptions of gender to mental health problems. For example, traits associated with masculinity increase the risk of aggression, while femininity reduces the likelihood of committing aggressive acts (Reidy, Sloan, & Zeichner, 2009). As evidence, both men and women who are physically aggressive characterize themselves with masculine traits.

Gender and Stress

Given this background, we turn to explanations for the gender differences in mental health problems. As stated above, research suggests that conceptions of gender affect mental health problems through their impact on major risk factors. We focus on the gender disparities in these risk factors as explanations, including the differences between men and women in their exposure to stressors, coping strategies, social relationships, and personal resources and vulnerabilities.

Most studies on these factors compare all women to all men. Work on gender and race or gender and class is limited, and work on gender, race, and class together is nearly nonexistent. Past studies also concentrate much more on explaining women's predominance in internalizing problems than men's excess of externalizing problems. With these caveats in mind, we examine the gender differences in the exposure to stress.

Defined as a "relationship between the person and environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being," stress is a major predictor of mental health problems (Lazarus & Folkman, 1984, p. 19). Stressors are the events or situations that produce stress. Two main theories link gender to stress. The *differential exposure hypothesis* attributes gender differences in mental health to variations in the stressors men and women experience. The *differential vulnerability hypothesis* attributes mental health differences to discrepancies in men's and women's reactions to stressors (Day & Livingstone, 2003). This section concentrates on the exposure to stressors.

It is unclear whether women or men experience more stress overall because they experience different types of stressors that are difficult to equate (Hatch & Dohrenwend, 2007; Meyer, Schwartz, & Frost, 2008). Women face more recent life events than men, and, consistent with their greater responsibilities for caretaking and maintaining social ties, they suffer from more stressors involving significant others such as family events and the death of friends or relatives (Kessler & McLeod, 1984; Matud, 2004; Meyer et al., 2008; Turner & Lloyd, 2004; Turner, Wheaton, & Lloyd, 1995; Umberson, Chen, House, Hopkins, & Slaten, 1996). Women also view the events that happen to them as more negative and less controllable than men (Matud, 2004).

In contrast to women, men endure more traumatic or adverse events over the course of their lives. This excess is due largely to their involvement in more types of violence (Hatch & Dohrenwend, 2007; Kessler et al., 1995; Norris, 1992; Turner & Avison, 2003; Turner & Lloyd, 1995). Compared to women, men experience more physical assaults, injury traumas, and motor vehicle and other serious accidents. They are more often mugged, threatened with a weapon, shot or stabbed, or beaten badly—as well as witnessing someone else being injured or killed. They are more likely to be victims of property crimes, such as burglary, motor vehicle theft, and larceny. Finally, men more often experience illnesses, long-term disabilities, and hospitalizations. As opposed to these multiple forms of violence, women are exposed to more specific kinds of violent events. Consistent with women's greater fear for their safety where they live, they experience sexual abuse, sexual assault, and domestic violence much more often than men (Elliott, 2001; Hatch & Dohrenwend, 2007).

Some research links these differences in stressors to conceptions of gender and gender practices. In particular, women's positions of power and their social roles create stressors that produce internalizing problems (Elliott, 2001; Meyer et al., 2008). For example, women's lower earnings bring them greater financial strain, which generates anxiety and depression (Elliott). Women's dual role occupancy—combining employment and most of the work at home—results in an overload of demands that also produces greater depression and anxiety (Bird, 1999; Greenstein, 2000; Lennon & Rosenfield, 1992, 1995; Meyer et al., 2008; Mirowsky, 1996; Mirowsky & Ross, 2003; Rosenfield, 1992).

Even when household work is shared, women do the tasks over which there is less discretion and that have to be done repeatedly, such as preparing meals, shopping, cleaning, and laundry (Lennon & Limonic, 2009). These demands produce a stronger sense of time pressure among women than men, which raises anxious and depressive feelings (Roxburgh, 2004). Finally, the stress of managing child care arrangements, which often fall apart, takes a psychological toll. Women who have trouble with such arrangements suffer high levels of distress (Ross & Mirowsky, 1992). In contrast, when child care is secure and when husbands share more types of the work at home, the level of women's symptoms of depression and anxiety resemble the low levels in men.

Combining these studies, women's excess of internalizing problems partly results from the time pressure of household tasks and the overload of job and family demands. These patterns are consistent with role theory, which postulates that men's and women's mental health problems derive from destructive aspects of their gender roles (Meyer et al., 2008).

Gender also shapes the meaning of stressors for women and men, which has implications for their mental health. In general, stressors that are especially destructive to well-being challenge individuals' valued roles or cherished goals and ideals (Brown & Harris, 1978; Simon, 1997; Thoits, 1992). Girls' and women's greater orientation to maintaining social relations results in greater difficulty with interpersonal stressors. Research on adolescents links this difference to conceptions of gender. Adolescents—male

or female—with greater feminine traits evaluate peer-related stress as more important than those with more masculine traits (Compas, Orosan, & Grant, 1993). In addition, women are more distressed by events that happen to significant others than men, which researchers describe as the "costs of caring" (Kessler, McLeod, & Wethington, 1985).

Given their responsibility for caretaking and kinwork, strains in the family affect the well-being of women more than that of men (di Leonardo, 1987). For example, women react more strongly to marital conflict than do men (Pearlin & Lieberman, 1979; Turner, 1994). Problems with children are also particularly stressful in women; for example, women feel more distress than men when spending time away from their young children (Milkie & Peltola, 1999). Divorce increases mental health problems for both men and women, but for different reasons (Gerstel, Riessman, & Rosenfield, 1985). Men experience greater problems because they lose social support, while women suffer from greater problems because of the loss of economic support. These reasons are tied to the different advantages of marriage for men and women arising from conceptions of gender: men gain relatively more in social ties, women in economic sustenance.

Conceptions of gender underlie these differential meanings of stressors. For example, wives suffer greater depression than husbands after experiencing family events involving children, housing, or reproductive problems—but only when married couples endorse traditional conceptions of gender. It appears that women with conventional conceptions hold themselves responsible for such events, while men tend to distance themselves (Nazroo, Edwards, & Brown, 1997).

A few studies compare gender differences in stressors across racial or ethnic groups. Compared to African American women, white women report more physical assaults, emotional abuse, and violence at the hands of current partners as well as over their lifetimes (Coker, Smith, Mckeown, & King, 2000; Franko et al., 2004). African American women experience more loss events such as the illness of a relative or friend, problems in relationships with romantic partners, and financial hardships (Franko et al., 2004).

The meaning of combining work and parent roles also varies by gender and race. White women more often see paid work and being a parent as in conflict, which contributes to their higher distress relative to their husbands and to African American women (Simon, 1995). Similar to African American women, both African American and white men's conceptions of themselves as paid workers are consistent with their conceptions of being a good parent, in which breadwinning is part of their parental role. The costs and benefits of role meanings also differ by race and gender, particularly for the work role (Simon, 1997). For example, a central cost for women is that work outside the home detracts from time spent with family, which helps explain the greater internalizing problems among married mothers compared to married fathers, especially among whites (Simon).

In summary, gender as well as race shape the stressors individuals encounter and the meaning of these stressors, which contribute to the differential mental health problems among African American and white men and women. Although more often on whites, this research provides support for the differential exposure explanation of gender differences in mental health.[9] We turn to the differential vulnerability explanation below, starting with differences between men and women in how they cope under stress.

Gender and Coping

Described as the "cognitive and behavioral efforts made in response to a threat" (Tamres, Janicki, & Helgeson, 2002, p. 3), coping strategies vary by gender. Men are more stoic in their responses to stressors, women are more expressive (Matud, 2004; Milkie & Thoits, 1993). Men try to control, accept,

[9] There are overall race differences in stressors. For example, African Americans experience most stressors more often than whites, especially discrimination stressors (Sellers, Rowley, Chavous, Shelton, & Smith, 1997; Turner & Avison, 2003). However, these race differences are rarely differentiated by gender.

or not think about the problem; women seek social support, distract themselves, avoid the problem, and pray (Thoits, 1995). Men under stress participate more in physical activities; women more often console themselves and let their feelings out (Hänninen & Arob, 1996; Matud, 2004; Ptacek, Smith, & Dodge, 1994). Men try to reduce or divert stressors, while women involve themselves in social relationships and try to change the way they think about the situation (Copeland & Hess, 1995). Women more often cope with stressors by ruminating—focusing on internal feelings rather than on changing the situation—which helps account for women's higher rates of depression and depressive symptoms (Nolen-Hoeksema, Larson, & Grayson, 1999).

On the basis of these and other studies, many researchers conclude that men more often use problem-focused coping strategies, which change the stressor itself, while women use more emotion-focused coping, which change their perceptions about the stressor (Matud, 2004; Ptacek et al., 1994; Zwicker & DeLongis, 2010). There is some evidence that such differences originate in conceptions of masculinity and femininity. Whether male or female, adolescents who rate themselves high in masculinity employ more problem-focused strategies. Those who portray themselves as high in femininity engage more in emotion-focused coping strategies (Washburn-Ormachea, Hillman, & Sawilowsky, 2004).[10] Gender-linked coping strategies are also associated with mental health problems; for example, men who suppress emotions as a part of masculinity more often commit domestic violence (Umberson, Anderson, Williams, & Chen, 2003).

In contrast to these studies, a meta-analysis suggests that women exceed men in all types of coping strategies (Tamres et al., 2002). In this analysis of research from 1990 to 2000, women use more emotion-focused coping such as positively reappraising the stressor, wishful thinking, avoiding the problem, ruminating about the problem, positive self-talk, and seeking emotional support. In addition, women use more problem-focused coping strategies, including active attempts to change stressors, planning ways to change stressors, and seeking practical social support. Finally, women employ other strategies more often than men such as turning to religion. Of all these differences, the coping styles in which women most exceed men include emotion-focused strategies of positive self-talk, ruminating about problems, and seeking emotional support, which are consistent with the studies above and help reconcile the contrasting results to some extent (Tamres et al., 2002).

Women's greater coping efforts depend on their appraisal of stressors, however (Tamres et al., 2002). Women only exceed men in strategies such as positive reappraisal, active coping, self-blame, and avoidance when they perceive that stressors are severe. Women appraise stressors as serious more often than men, which contribute to their overall greater use of coping strategies. When women view stressors as less serious, gender differences in coping are minimal.

Gender differences in coping also depend on the type of stressor (Tamres et al., 2002). For example, under achievement stress, women use positive self-talk and seek emotional support more than men. Men and women are most similar in coping with stress in relationships, but there are still differences: women use more active coping, seeking support, and ruminating, while men more often avoid or withdraw from relationship problems.[11]

Two competing hypotheses explain differences in coping. A *situational hypothesis* claims that men and women differ in coping styles because they encounter different types of stressors. Also called *role restructuring,* this approach argues that men's and women's different positions and social roles lead them into different stressful situations that call for different coping strategies (Rosario, Shinn, Morch, & Huckabee, 1988). In contrast, a *dispositional hypothesis* holds that men and women cope differently regardless of the stressor, because of gender socialization and differences in dimensions of the self. Empirical evidence supports both of these explanations. Men and women differ in the types of

[10] We note that both men and women see problem-focused strategies as superior (Ptacek et al., 1994).

[11] Active coping works better for problems in relationships, while avoiding or withdrawing from relationship problems brings less satisfactory outcomes (Pearlin, 1989).

stressors they experience and vary in their coping strategies depending on the stressor, which supports a *situational hypothesis.* On the other hand, women use a particular cluster of coping strategies—seeking emotional support, rumination, and positive self-talk—across a variety of stressors, which supports a *dispositional perspective* (Tamres et al., 2002).

Although little research exists on gender and race in relation to coping, a recent study examines dispositional and situational coping among African Americans (Brown, Phillips, Abdullah, Vinson, & Robertson, 2011). This research finds strong overlaps in the dispositional coping mechanisms used by African American men and women; both employ strategies of acceptance and reframing of problems most frequently no matter what the stressor. African American women also use emotional support and self-distraction, but less often than African American men. In support of a *situational hypothesis,* African American women vary their coping strategies according to the particular stressor; they use religion, emotional support, and instrumental support for general stressors, while only emotional support for stressors that are racism-related. African American men, on the other hand, use the same strategies of acceptance and active coping under both types of stressors.

In summary, research primarily on white men and women suggests that there are differences in the amount and types of coping, particularly in the strategies they use most often, which is consistent with a differential vulnerability explanation of gender differences in mental health. Research on African Americans concurs with some of these differences. However, African American men and women overlap more in their coping strategies, which fit with their greater similarity in gendered conceptions of the self.

Gender and Social Relationships

Research on social support as a coping strategy points to the general importance of social relationships for gender differences in mental health. Overall, women and men are similar in the number of casual social relationships; however, women engage in more close social ties. Women report more people in their primary networks and more satisfaction with their close relationships than men (Fuhrer & Stansfeld, 2002). These positive social relationships benefit women's mental health more than men's (Elliott, 2001). In addition, support from family and friends help buffer or reduce the effects of stress for women more so than for men (Walen & Lachman, 2000).

Given that social support protects against problems like depression, we would expect women to have lower rates of internalizing problems than men. However, women's greater social support does not decrease their depression levels. Turner (1994) addressed this contradiction by examining the negative as well as the positive sides of relationships: women's closer social ties are sources of greater problematic interactions as well as support. Negative interactions increase mental health problems more than positive interactions reduce them (Newsom, Nishishiba, Morgan, & Rook, 2003). Thus, the closer social ties of women increase their stress, which raises symptoms of depression (Haines & Hurlbert, 1992; Turner & Marino, 1994; Umberson et al., 1996).

More generally, men and women offer and look for different kinds of social support (Cancian & Oliker, 2000). Men are more likely to hide problems and to give advice, even if it is unwanted. Men are also less likely to vent than women, and are more uncomfortable with their girlfriends' or wive's emotional expressiveness (Tannen, 1996).

Social support varies by race as well as gender. African American women are more likely than white women to engage in reciprocal exchanges of transportation, child care, and household help; white women are more likely than African American women to exchange emotional support (Sarkisian & Gerstel, 2004). These findings may reflect the fact that white women are more likely than African American women to be married and to report high marital quality, such as satisfaction with marriage and positive treatment by spouses (Broman, 2005; Goodwin, 2003). African American

men are less likely than white men to provide household assistance to family and non-family, and to receive household assistance from family (Roschelle, 1997). These findings suggest that, in the present time, African American families exchange similar or lower levels of support than white families. These patterns could also result from the lower marriage rates among African Americans in general (U.S. Census Bureau, 2004).

Some studies on gender and support look explicitly at African Americans. This includes research on fictive kin: individuals who are not related by blood or marriage but who are nevertheless regarded as kin members. These relationships are a hybrid of two commonly studied social relationships—family relationships and friendships—in terms of obligation, emotional rewards, and permanence. African American women have more fictive kin relationships than men (Chatters, Taylor, & Jayakody, 1994).

Other work with African Americans concerns the social support available to adolescents (Coates, 1987). Although here the size of male and female support networks does not differ. African American girls prefer a family member as a resource for both intangible and formal needs, whereas boys prefer their peers. In adulthood, African American men are also more likely than females to receive support from fellow church members when they are viewed more as friends than family (Taylor & Chatters, 1988).

Many researchers have assumed that African Americans' stronger social ties, especially in family relationships, explain their relatively good mental health. Thus far, few studies have asked whether networks and support help explain this paradox (Stack, 1974/1983). However, two recent large-scale studies test this assumption. Both find that neither friendships nor family relationships can account for the lower mental health problems among African Americans, contradicting this explanation (Kiecolt, Hughes, & Keith, 2008; Mouzon, 2010).

In sum, African American and white women tend to have more close relationships than African American and white men. These differences, however, do not account for variations in mental health patterns by race or gender. In the final discussion, we turn to differences in personal resources and vulnerabilities.

Gender and Personal Resources/Vulnerabilities

In theories of the stress process, personal resources are fundamental aspects of the self that are critical for well-being (Pearlin, 1989; Turner & Lloyd, 2004; Turner, Taylor, & Van Gundy, 2004). Stressors undermine mental health in part to the extent that they affect these self-conceptions (Brown et al., 1990; Mirowsky & Ross, 1996; Pearlin, 1989, 1999; Rosenberg, 1989). Personal resources also affect mental health by influencing individuals' interpretations of stressors (Pearlin, 1989; Thoits, 1995; Turner & Lloyd, 2004; Turner et al., 2004).

Self-esteem and mastery are considered primary personal resources. Self-esteem refers to the degree to which individuals see themselves as having worth or value; mastery involves the extent to which individuals perceive they have an impact on their social world. These aspects of the self have directly positive impacts on mental health as well as indirect effects by reducing the negative impact of stressors (Keith, 2004; Pearlin, Nguyen, Schieman, & Milkie, 2007; Pudrovska, Schieman, Pearlin, & Nguyen, 2005; Schieman, 2002; Turner & Lloyd, 2004; Turner & Roszell, 1994). For example, personal resources shape coping strategies; individuals with a greater sense of mastery and self-esteem are more persistent in problem-solving (Thoits, 2010).

Overall, women possess lower self-esteem than men (McMullin & Cairney, 2004; Robins & Trzesniewski, 2005; Thoits, 1995, 2010; Turner & Marino, 1994; Turner & Roszell, 1994). This difference emerges in early adolescence, as boys' sense of self-worth rises and girls' deteriorates. Self-esteem also has different sources for males and females (Harter, 1999). Women rely more on their connections with significant others and men more on their achievements to feel good about themselves (Banaji & Prentice, 1994; Josephs, Markus, & Tafarodi, 1992). Women also base their self-esteem on

their weight and physical attractiveness more than men. Consistent with their lower self-esteem, women rate their appearance more negatively (Banaji & Prentice, 1994).

Gender differences in mastery vary with socioeconomic status and job conditions. Women's deficits in mastery result in part from less education, income, and history of employment, as well as their lower job autonomy and more routinized jobs (Cassidy & Davies, 2003; Lennon & Limonic, 2009; Schieman, 2002). For these reasons, gender differences in mastery are more pronounced among older men and women. When education, employment, and income are more similar, as they are in younger cohorts, women resemble men in their sense of control (Ross & Mirowsky, 2002).

In race comparisons, gender differences in self-esteem and mastery are greater among whites than African Americans (Twenge & Crocker, 2002). The disparity is primarily due to white women's low self-evaluations, which fall below those of African American women and men of both races (Owens & King, 2001; McLeod & Owens, 2004). These differences help to explain the elevated rates of depression and anxiety of white women relative to all other race and gender groups (Nolen-Hoeksema et al., 1999).

Other personal characteristics and dispositions contribute to gender differences in mental health problems. For example, extreme emotional reliance on other people is more common in women and helps to explain their higher rate of internalizing problems (Turner & Turner, 1999, 2005). Mattering, defined as individuals' perceptions that other people care strongly about them, is also more frequent among women (Rosenberg, 1989; Taylor & Turner, 2001; Turner & Marino, 1994; Umberson et al., 1996). At the other end of the spectrum, extreme independence is more frequent in men than women and helps account for their higher rate of externalizing behaviors (Guisinger & Blatt, 1994; Hirschfeld, Klerman, Chodoff, Korchin, & Barrett, 1976; Norasakkunkit & Kalick, 2002; Rosenfield et al., 2005; Tremblay, Pipl, Vitaro, & Dobkin, 1994; Turner & Turner, 1999).

Certain cultural schemas help explain gender, race, and class differences in mental health (Rosenfield et al., 2005, 2006). Schemas of self-salience refer to beliefs about the relative importance of the self and others in social relations. Self-salience schemas that put others' needs above one's own increase the risk of internalizing problems, while those that put one's own interests first facilitate externalizing problems (Rosenfield et al., 2005). Self-salience varies by gender, race, and class (Rosenfield, 2012). Overall, women have lower self-salience than men, which helps explain women's excess of internalizing problems and men's predominance of externalizing problems (Rosenfield et al., 2005). Among women, African Americans possess greater self-salience than whites in higher classes especially, which contributes to African American women's particularly low rates of internalizing problems in higher class groups. Among men, African Americans exceed white men in self-salience in lower classes, while white men surpass African Americans in higher class groups. These differences also help explain patterns of externalizing problems, that is, the greater rates among African American men in lower class groups and the preponderance of white men in higher social classes (Rosenfield et al., 2005, 2006; Rosenfield, 2012).

Summarizing this research, African American and white men and women differ substantially in personal resources and vulnerabilities. These disparities contribute to the differences in mental health problems not only by gender but also by gender, race, and class.

Conclusion

Research on gender and mental health suggests that gender conceptions and practices push males and females to different forms of psychopathology by increasing multiple risk factors for internalizing and externalizing problems. The amount of these risk factors makes gender differences seem socially overdetermined—that is, resulting from more causes than are necessary to produce the outcome. Men and women in different races and classes are predisposed to varying problems through the stres-

sors they experience, the coping strategies they use, the social relationships they engage in, and the personal resources and vulnerabilities they possess. These differences also seem overdetermined insofar as the conceptions of gender underlying these risk factors are conveyed through socialization and major social institutions including schools, families, and workplaces.

The numerous sources of gender differences in mental health suggest multiple points for potential intervention, beginning with gender socialization in families and in schools from early childhood. The varying gender differences in mental health across racial/ethnic groups imply that these overall disparities can be changed. Differences by race include the smaller gender gap in psychological problems among African Americans and the apparent mental health advantage of African American women. Compared to whites, gender conceptions among African Americans reduce risk factors and, thus, the rates of gender-linked problems. To the extent that these variations result from social factors, they are amenable to and can be used as guides for change.

Different perspectives on stress help us understand the outcomes by gender and race. Both differential exposure and differential vulnerability approaches help account for the gender differences among whites. White men and women differ in stressors and their meanings as well as in coping efforts, relationships, and personal resources and vulnerabilities. However, differential vulnerability approaches account for variations by gender and race. African American men and women face more stressors than whites but respond with greater resilience from more effective coping strategies and personal resources (American Psychological Association, 2008).

The literature above also contradicts certain theories about gender and race differences in mental health. For example, the meta-analysis finding that women exceed men in most coping strategies challenges the long-standing assumption that women use more emotion-focused coping while men are more problem-focused (Matud, 2004; Ptacek et al., 1994; Zwicker & DeLongis, 2010). The failure of social relationships to explain gender and race differences in mental health contradicts the often proposed theory that African Americans' relatively good mental health is based in greater social connectedness (Mouzon, 2010; Rosenfield et al., 2006; Rudolph, 1997; Samaan, 2000).

The research examining gender by race and class underscores the importance of intersectionality for understanding the impact of gender on mental health (Kohn & Hudson, 2002). Intersectional approaches hold that different combinations of statuses have unique effects on outcomes (Jackson, 2005; Salazar & Abrams, 2005; Mullings & Schulz, 2006; Shields, 2008). Analyses of race, class, or gender separately cannot fully describe individuals' experiences (Choo & Ferree, 2010; Constantine, Alleyne, Wallace, & Franklin-Jackson, 2006; Salazar & Abrams, 2005; Shields, 2008; Syed, 2010). Since gender, race, and class operate simultaneously in all social situations, the impact of each depends on the value of the others (Constantine et al., 2006). This work fits within a growing body of research demonstrating the importance of these intersections for mental health (Anderson, 2006; Browne & Misra, 2003; Carter et al., 2002; Jackson, 2005).

Based on this work, we recommend further research. The field would benefit from more analyses of the interrelated nature of master status characteristics on mental health problems. As an example, we need work on gender and a wider range of racial/ethnic groups. Although the research is limited, some suggests that the effects of gender on mental health vary among Latinos and Asian Americans as well as African Americans and whites (Williams et al., 2009). For instance, along with white women, Asian American women and Latinas suffer from greater internalizing problems than African American women (Breslau et al., 2005, 2006; Harris et al., 2005; Kohn & Hudson, 2002; Lee, Lei, & Sue, 2001; Norasakkunkit & Kalick, 2002; Rosenfield et al., 2006). These differences are consistent with conceptions of gender across these groups. Compared to other racial and ethnic groups, Asian American women have less decision-making power in the family and less of a separate identity outside their roles in the family (Kibria, 1990; Pyke & Johnson, 2003). Girls tend to be devalued in families and feminine traits are regarded less highly than masculine characteristics. Latinos have a strongly gendered division of labor and more traditional attitudes toward gender roles than African Americans and whites (Harris & Firestone, 1998; Strong, McQuillen, & Hughey, 1994). Women characterize

themselves as possessing fewer masculine traits than African American women but more than white women (Vazquez-Nuttall, Romero-Garcia, & De Leon, 1987).

In line with these conceptions, some evidence suggests that Latinos and Asian Americans also differ in risk factors for psychiatric problems. Like white women, Latinas and Asian American women possess fewer personal resources than African American women, including lower self-esteem and self-salience (Rosenfield, 2012; Twenge & Crocker, 2002). Asian Americans exhibit greater passive coping strategies than whites (Bjorck, Cuthbertson, Thurman, & Lee, 2001), while African Americans engage in more active coping (i.e., John Henryism) than whites and Latinos (Kiecolt, Hughes, & Keith, 2009). Finally, Latinos have similar or lower levels of family support exchange than non-Hispanic whites (Roschelle, 1997; Sarkisian, Gerena, & Gerstel, 2007). Asian Americans seem to depend more on family than non-Hispanic whites, who are more likely to rely on non-family members (Kim & McKenry, 1998). These studies point to the need for further research on risk factors and gender conceptions among these and other racial/ethnic groups.

In summary, while the relationship between gender and mental health in terms of origins, predictors, and symptom presentation has been clarified over the past two decades, less work focuses on the intersection of gender with race/ethnicity in relation to mental health. Even less research addresses the intersection of gender, race/ethnicity, and class (Watkins, Walker, & Griffith, 2010). Scholars understand relatively little about how class, race/ethnicity, and gender interact to produce various differences in stressors. Likewise, more work is needed on the gender, race/ethnicity, and class differences in the use of coping strategies. While gender by race/ethnic differences in social relationships are fairly established—most notably in marriage and family relationships—the mechanisms by which they produce variations in mental health problems remain unclear. Finally, other status characteristics such as sexuality and disability need to be studied in conjunction with gender, race/ethnicity, and class (Meyer et al., 2008). More generally, the multiple sources of gender differences in mental health problems need to be investigated jointly. Given the complexity of gender differences in mental health and the excess of suffering that result from internalizing and externalizing problems, it is critical to continue work on these sources and interventions.

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Part IV
Social Antecedents