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Theories for race and gender differences in management of social identity-related stressors: A systematic review

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Abstract

Sociodemographic group-specific strategies for stress management may contribute to racial and gender disparities in health outcomes in the United States. We aimed to systematically review theoretical and empirical investigations of factors influencing variation in response to and management of identity-related stress among black and white Americans. OvidPsychInfo and PubMed databases were searched to identify eligible studies. Criteria were participant age of 18 years, conducted in the US sampling black or white participants, and published in English in a peer-reviewed journal. The final sample included 167 articles. Theories suggesting social status inequities as the primary contributor to disparate strategies employed by black and white women and men to manage social identity-related stress were most frequently tested and supported. Studies disproportionately focused on how women and black persons cope as targets of prejudice and discrimination rather than on how management strategies of men or white persons are affected as perpetrators. Finally, there was theoretical support for an interactive effect of race and gender on stress management, but empirical evidence was lacking, particularly among black men, white women, and white men. The literature could be strengthened through the use of prospective cohorts and nationally-representative samples, as well as study designs accounting for potential within-race and within-gender variation in the effects of social-identity related stressors on coping. With greater consistency in methodology, future empirical studies may yield additional information regarding group differences in stress management pertinent to clarifying mechanisms for the health consequences of exposure to social inequity among black and white women and men.

Keywords

Identity-based stress; coping; gender differences; race differences; intersectionality

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Introduction

In explaining persistent health disparities between black and white women and men in the United States, increasing attention has been dedicated to factors beyond clinical characteristics in predicting health outcomes. These include a number of social determinants, such as socioeconomic position and structural discrimination, which have been shown to exert a strong influence on both physical and mental health [1]. Establishing causal mechanisms for the relationship of these social factors with racial and gender inequities in disease outcomes has proved challenging, however, due in large part to theoretical and methodological inconsistencies, in addition to conflicting evidence, within the current literature. As an example of these conflicting findings, some studies find that racial discrimination is associated with hypertension among black Americans [2,3], while others have found no association [4,5]. Discrimination has also been linked to other cardiovascular disease risk factors such as sedentary behavior and obesity in black women [6,7], but findings among white persons remain inconclusive largely because few studies have ever examined how the experience or practice of discrimination affects cardiovascular health in this group [8]. Research also suggests gender differences in depression as stemming from women's subordinate social status [9]. Yet, among black persons, this gender disparity significantly attenuates when adjusting for socioeconomic status, while persisting among whites [10]. These varying results suggest additional intersectional effects of psychosocial exposures beyond the individual experiences associated with race or gender alone, complicating efforts to untangle the causal role of social adversity in explaining health disparities.

Group-specific strategies for managing psychosocial stressors may partially account for such disparate findings regarding the relationship between social inequity and health among black and white women and men. A number of interdependent demographic characteristics including race, gender, socioeconomic position, geographic location, and period of life likely contribute important variability to stress management strategies within these groups. While differences across race and gender in coping with stress have been well-documented [11], theoretical and empirical evidence for the factors driving variation in the management of social identity-based stressors among black and white women and men remains sparse and inconsistent. A comprehensive review of the current theories and empirical evidence for those theories may identify important gaps in the literature and in so doing identify areas for further research while also providing additional direction for interventions aimed at reducing racial and gender health disparities. As a method of narrowing the scope of such an endeavor to an informative proportion, the current review focuses only on the contribution of racial and gender identity to the methods individuals within these groups choose to cope with psychosocial stressors.

Racial and gender variation in stress exposure and management

Differential likelihood of resilience in the context of stress has been offered as one framework for interpreting variation in the relationship between social inequity and health across and within social groups [12]. These models point to differences in stress exposure and strategies for managing social stressors in explaining racial and gender disparities in

health outcomes. Additionally, group differences may not only be attributable to variation in magnitude of stress exposure but also to the nature of the stressors individuals experience as a result of group membership or social identity. As historically and presently disadvantaged groups, both women and black persons are exposed to psychosocial contexts which are thought to lend themselves to passive or emotion-focused coping, in contrast to a preference for problem-focused strategies likely resulting from the relative efficaciousness characteristic of dominant-status groups [13-15]. Such contexts include legalized discrimination against women and black persons which promoted state-supported segregation, denial of civil rights, and physical violence against these groups that to some degree persists today [16,17]. A lack of legal and social platforms from which to speak out against these pervasive inequities without fear of violent retribution may have contributed to the development of alternative strategies for managing the stress associated with racial and gender discrimination such as transference as well as avoidant and ruminative processes [14,15,17,72]. Despite an extensive history of research on the topic, conclusive evidence for the role of these social experiences in yielding distinct coping behaviors remains elusive.

A strong literature base suggests that women, tending toward self-blame and rumination, manage stress differently than men, who are more likely to confront or display aggression [14,15]. Among many other gendered health and social outcomes [19,20], these distinctive stress responses are reflected in gender discrepancies in self-violence under stress; evidence supports a stronger relationship between economic deprivation and suicide among men than women [21,22] as well as an increased susceptibility to post-traumatic stress disorder following traumatic exposure among women [23-25]. Group-specific stress management strategies have also been shown to vary in effectively reducing the negative consequences of stress [27-30]. The coping methods women are more likely to employ are thought to contribute to their increased risk for traditional conceptualizations of depression [30] and post-traumatic stress disorder [31], whereas men's management behaviors seem to reduce their risk for psychological distress but increase risk of physical harm and cardiovascular disease [30, 32]. Still, even given what is known about the distinct coping behaviors of women and men, the body of evidence for the factors driving such variation among black and white persons has yet to reach consensus.

It is also well-documented that racial and ethnic minorities in the U.S. rely more on social support, racial and ethnic identity formation [33], and John Henryism [34] in navigating stress than Americans of European descent. These strategies for coping with stress have been linked to improved emotional health and social attainment but increased risk of poor behavioral and physical health [35,36], including hypertension among black men [36], metabolic disorder among black women [37], and cardiovascular disease within both groups [38]. What remains to be clarified are the factors causing these distinctive coping behaviors.

Within-race gender differences in methods for coping with racial stressors have also been identified [39,40]. Black women have been shown to be more likely than black men to respond to gendered racism through increased intake of foods high in fat and sugar, stress management strategies that may partially explain higher rates of obesity within this group [41]. Likewise, studies have also noted within-gender racial differences in coping with gender discrimination with significant implications for mental health [42], lending credence

to the necessity of an intersectional approach to understanding and addressing psychosocial stress as a contributor to racial and gender inequities in health outcomes.

Further complicating efforts to clarify the role of stress in mediating the effects of social inequity on health, there is strong indication that individuals employ unique methods for managing different types of stressors [43]. Both women and men have been shown to respond differently to gender-identity threats than stressors unrelated to gender identity [44,45]. Black persons tend to manage race-based stress differently than generic life stressors, relying more on spirituality, racial identification, and behavioral reactivity in the former [16,17,28]. These discrepancies highlight the importance of not only considering stress management strategies but also stressor type in exploring variation in the impact of social (and psychosocial) factors on health across social groups. For this reason, we limit this review to theories for racial and gender differences in methods for coping specifically with stress stemming from threats to racial and gender identity.

Social identity-related stressors

Social identity-related stressors are a unique class of stressors with far-reaching health implications. Stress stemming from threats to group identity can be both acute and chronic, causing situational as well as general anxiety about the devaluation of a highly valued social self-concept [45,46,47]. Although many identity-based stressors likely impact on health outcomes, this analysis focuses on stressors associated with racial and gender identity. These identities are theorized as the two most salient and highly valued social identities [46,47], among many others. The more central an identity is to self-concept, the greater the effect of identity conflict on psychological well-being [47]. Of social-identity related stressors, those that challenge conceptualizations of one's race or gender, such as discrimination, stereotyping, rigid gender norms, or perceived norm violation, are therefore likely to exert the greatest influence on psychological and physical health. These stressors may act both indirectly through coping strategies that affect health behaviors, and directly through the physiological impact of the psychological distress they can cause among those employing ineffective, maladaptive cognitive coping strategies [48,49,50].

Further, the experience of threats to multiple social identities concomitantly has unique implications for stress management and health [44,51,52] but has only recently been considered within the stress and epidemiological literatures and remains understudied [53]. The ability to successfully investigate causal factors in stress response patterns and their contributions to racial and gender health disparities is limited by conceptualizing management strategies as a function of individual social identities. Drawing on intersectionality theory [54], Thomas, Witherspoon, and Speight [55] emphasize the unique influence of gendered racism on black women's adaptive resources, highlighting the interactive effect of both one's race and gender in the experience of stress. Without considering the specific psychological processes individuals engage at the nexus of racial and gender statuses, a comprehensive perspective on causes of social group variation in stress management is not achievable. An objective of this review is therefore to outline and assess the strength of the evidence for application of intersectionality theory to stress and coping frameworks of health disparities.

Interdependency of cognitive, physiological, and behavioral stress responses

Responses to stress traverse a wide range of cognitive and physiological processes that are thought to be heavily interdependent [27,43,56], and influence how individuals choose to manage stress [57]. For example, sympathetic nervous activity in response to experiences of racism has been shown to be associated with racial identity centrality among black persons [58-60]. Similarly, the effect of gender discrimination on women's neurological activity is tempered by feminist identity [61]. These observations indicate that physiological responses to identity stress are not solely neurobiological in nature but are also directly a function of cognitions related to self-concept that may vary with gender and race. Summarily, psychosocial and cultural factors are hypothesized to influence how individuals manage physiological and cognitive experiences of stress, such as through self-blame, rumination, emotional eating, prejudice, or aggression [9,11,13,15,41,44,45]. Together, these findings provide insight into the complexity of the stress response from appraisal to behavior. However, the evidence also indicates a level of correlation between the distinct stages of the stress process that justifies the inclusion of a wide range of cognitive, physiological, and behavioral factors in assessing differences in stress management across gender and race as a cause of health disparities. This review therefore includes studies that cover a range of exposures and outcomes within different stages of the stress process.

Present study

Theorizing that stress response and management strategies moderate the relationship of social inequities with health, effectively intervening on health disparities requires a clear understanding of the causes of social group differences in strategies for managing social identity-related stress. Although there have been reviews of gender differences in coping strategies (e.g. Tamres, Janicki, & Helgeson, [62]), these reviews have either not evaluated theoretical frameworks or have failed to consider the interplay of race/ethnicity and gender in these effects. Additionally, despite a significant body of evidence on the topic, there has been no systematic review of theories for the unique methods black and white Americans employ to manage social identity threats. A selective review of literature on coping with racism [27] differs from the current review in two ways: the authors emphasize evidence for the effectiveness of certain coping strategies rather than reasons for group differences in stress management, and, secondly, do not explore the role of gender in shaping individual management preferences. To address this lacuna, we reviewed both theoretical and empirical investigations of factors influencing variation in methods for stress management of race and gender identity-related stress among black and white women and men.

Methods

Literature search

Databases searched for potentially relevant studies include Ovid PsychINFO (1967-2016) and PubMed (through October, 2016). Databases were searched for English-language articles using keywords including 'racism', 'sexism', 'racial discrimination', 'gender discrimination', 'sex differences', 'race differences', 'race', and 'gender', paired with terms such as 'chronic stress', 'stress', 'coping strategies', 'coping', 'self-esteem', 'stigma', 'trauma', 'social identity', and 'identity threat'. See supplementary materials for a complete

list of keyword searches. Titles or abstracts of these articles were manually searched to identify studies relevant for inclusion. Reference lists of full-length articles flagged for inclusion were manually searched to identify additional potentially relevant studies.

Study inclusion and exclusion criteria

All US-sampled, English-language studies of theories for gender and/or racial differences in strategies for coping with social identity-related stressors were considered for inclusion. Both theoretical and empirical studies were considered as long as theory was explicitly addressed in empirical studies. Based on an initial review of select social-psychological literature focusing on social identity threat [47,49,63], we observed that stressors of this type typically fall into five categories which we used to define exposure inclusion criteria: interpersonal or institutional racial discrimination, interpersonal or institutional gender discrimination, unspecified racial identity threat, unspecified gender identity threat, and stereotype threat. Studies in adolescents (aged less than 18 years), those without black or white participants, dissertations not published in peer-reviewed journals, and book chapters were not considered for inclusion. There were no study design limitations for eligible publications.

Data extraction

Search and identification of studies eligible for inclusion, as well as data extraction using a data collection form, was performed by one review author (GB). Extracted data included stressor type, outcome, subject race and gender, and conceptual framework (neurobiological, psychosocial, or sociocultural). Full-text articles of publications flagged for inclusion based on title and abstract review were retrieved, and one review author (GB) screened full-texts, identified studies for inclusion, and recorded reasons for exclusion of ineligible studies. Full-text articles flagged for inclusion as well as extracted data were then verified by a second review author (SP) to ensure reliability. Any disagreement in eligibility and data extraction was resolved through discussion, or, as necessary, consultation with a third review author (CU).

Data synthesis

A descriptive synthesis of important study characteristics was undertaken, including characteristic (race or gender) on which comparison was based, race and gender of primary subject group, stressor type assessed, hypothesized coping moderators, outcomes under study, and study quality based on consideration of bias and limitations, validity of measures, appropriateness of study design for study objective, clarity of analysis presentation, and consistency of analysis with study objective. Due to significant heterogeneity in exposure, outcome, and methodology, we focused our narrative on the theoretical underpinning of race and gender variation in stress management rather than attempting a quantitative synthesis of exposures or outcomes. Attention is also given to concordance between subject race or gender and stressor type across studies.

Results

A PRISMA diagram summarizing identification of potentially relevant studies, as well as those included and excluded is presented in Figure 1 [Figure 1 near here]. 5,638 publications were identified through a search of two databases, of which 160 met inclusion criteria. Manual examination of reference lists yielded another seven articles identified for inclusion, resulting in 167 total studies. The majority were cross-sectional ($n=108$), but other study designs—40 theoretical, and 22 qualitative—were included (some studies included multiple designs). Due to the large number of included studies, an overview of study characteristics, including hypothesized coping moderators, is presented only in supplementary materials. Table 1 reports the number of studies assessing each type of social identity-related stressor by participant race/ethnicity and gender [Table 1 near here].

Seventy-nine studies addressed racial/ethnic differences in identity-related stress management without theoretical regard to gender; 45 of 49 empirical studies confirmed a priori hypotheses. Fifty-four focused on gender variation without distinguishing race/ethnicity, with 27 of 31 empirical studies confirming theory. Fifty-four considered the interplay of race and gender; 26 of 37 empirical studies found evidence of interactive effects. Theories were either conceptualized or tested quantitatively in demographically diverse populations. Drawn from both high and low socioeconomic backgrounds, participant age ranged from 18 to 93 years [46,57,64]. Although eligibility criteria required studies to include Americans of African or European descent, Latinx, Arab, Native, and Asian persons were also among those sampled in the included studies. Consistent with other community-based research designs, female participants tended to outnumber male participants in mixed-gender empirical studies, ranging from 46% [61] to 72% [65] of the total sample. The inclusion of studies with qualitative design permitted small sample sizes; these ranged from six focus group participants [33,64] to 161,165 in the largest cross-sectional study [66].

Stress management strategies are posited to moderate a wide range of psychological and physical health outcomes. Anxiety [67], aggression [13,45], depression [52,68-71], metabolic disorders [2,72,73], and substance abuse [74-76] are the most commonly studied outcomes, but the compiled literature also addresses the impact of stress management strategies on health-related behaviors such as smoking, care-seeking, and eating habits [41,77-81]. Strategies for managing stress are also linked to broader social outcomes such as generativity [64]; political beliefs [66]; academic performance, educational attainment, and occupation [63,82-90]; social activism [91]; parenting practices [92]; and prejudice [93-99], factors which are frequently positioned as downstream causes of health [100; 101]. For clarity, we organize the results into theories focusing solely on causes for racial/ethnic variation, those focusing only on gender variation, and those considering race and gender variation simultaneously.

Theories for racial/ethnic variation in stress response and management

Three distinct categories of theories emerged from within the 79 studies addressing only racial/ethnic differences in managing social identity-related stress without theoretical regard to gender, suggesting variation as primarily a function of social status, culture, or the unique nature of racial stressors. These categories were not established a priori but determined

based on assessment of the reviewed literature. Despite failing to consider potential within-race gender variation, 45 of the 49 empirical studies in this group confirmed a priori hypotheses. All seven qualitative studies yielded results concordant with these empirical findings, with the remaining studies being 24 theoretical papers.

Social status—Within the compiled evidence, social status was proposed as a contributor to racial/ethnic differences in coping in 30 of the 45 empirical studies with positive findings. These findings were consistent with data gleaned from the six qualitative studies (of seven total) exploring social status as a moderator of racial/ethnic differences in coping. These empirical studies also tested and confirmed theories proposed in 21 of the 24 theoretical commentaries.

This group of studies posits a prominent role for one's social position as a member of what is considered a racially dominant or subordinate group in shaping stress response and management. Within this paradigm, the methods black persons employ to manage identity-based stress are attributed directly to their uniquely disadvantaged social positions. Being previously and chronically targeted by racial discrimination [70,74,75,86,89,103-120]; being subject to racial humiliation [117]; perception of oneself as having a stigmatized identity [121-128]; and recognition of one's membership in a negatively stereotyped group [16,43,65,129,130] are characterized as experiences specific to occupying a subordinate social status. According to the reviewed literature, these psychosocial risk factors increase physiological and behavioral reactivity [2,28,105,112,113,115,131,132], passivity [132], hypervigilance [106,113,134], and use of avoidant or numbing coping strategies [111,116], while reducing self-efficacy [72,83,107,134-138], sense of belonging [65,90,116,117], and self-esteem [71,112,116]. The latter three self-evaluations have been shown to act on health through social attainment and health behaviors [72,83,116,118]. Furthermore, stress stemming from occupation of a marginalized social position is shown to consume cognitive resources [126,127,132] and in turn limit the strategies individuals feel are accessible or effective in managing stress [105,111,112].

On the other hand, the literature offers that as members of a dominant racial group, white persons are geared toward shame [135], aggression [96], outgroup derogation, and distancing [94,96-98,136,137] in perceiving threats to their social identities. Preference for active and high self-efficacy coping strategies among white persons as the dominant racial group in the United States are proposed as stemming partly from a lack of legal or social repercussions for interpersonal or structural violence toward black Americans and other non-white ethnic groups under the historical contexts of systemic racism [16,138,139].

Cultural context—In 17 of the 45 studies empirically confirming theory, evidence suggested that the diversity in stress management strategies across racial/ethnic groups results more from the distinct cultural contexts in which these groups are situated. The centrality and content of racial/ethnic identity [33,58,59,74,79,82,106,140-148], personal or familial beliefs about race [105,134,135,148,149], and dominant racial narratives [40,79,108,148,150] are theorized as some of the primary contributors to coping preferences and are framed as products of culturally-indoctrinated principles and practices.

Each cultural paradigm is argued as shaping an individual's appraisal of racial stressors [40,151] and the culturally-permitted responses to that appraisal [13,40,102,108,151,152] through racial and ethnic identity formation [33,58,95], which in turn yields disparate coping styles [148,153]. According to the literature, the racial narratives permeating dominant white American culture emphasize unalterable traits and abilities characteristic of each race [136,154]; multiculturalism and racial integration as violation of traditional norms and authoritarian beliefs [93]; and cultural inferiority of racial minorities as the primary drivers of criminal, educational, occupational, and health inequities [16,109,136,137,155,156]. These culturally-informed beliefs manifest in competitive victimhood [157,158] as well as prejudiced attitudes and behaviors [144,159] in the contexts of identity-based stress stemming from threats to white racial identity. In addition to the at times fatal consequences for members of racial minorities that some of these stress responses among white persons can bear (e.g. shooter biases [159]), these culturally-shaped methods for coping with identity-based stress are thought to impact on health behaviors such as problem drinking, self-harm, and domestic violence, as well as psychological well-being [160] within this group.

In contrast, culture theorists contend that Africentric coping [105]—reliance on spirituality and social support, for example [33,40,146,161]—stems from devaluing and disengaging [89] dominant narratives to recreate positive black identities consistent with the group's cultural history [146,148]. The centrality of racial/ethnic identity is demonstrated to affect both adaptive [33,86,146,150] and maladaptive [33,75,109] stress management behaviors.

Unique nature of racial stressors—The nature of racial stressors is thought to differ essentially from those of a non-racial nature and therefore requires unique management strategies that will be prominent within groups mostly likely to be exposed to racial stress [40,67,112,149,163-166]. Indeed, neurobiological studies demonstrate differential neural responses to race-related stress compared with generic life stressors [2,59]. These models suggest stressor-specific appraisal, which subsequently yields stressor-specific management strategies.

Some frameworks theorize the immediate psychosocial environment as one pathway over which social status, culture, and the unique nature of racial stress act to inform coping. Identity-triggering cues [163] are covert or overt reminders of one's stigmatized identity and are embedded to varying degrees in the social environment. Signifying a psychosocial threat, these triggers activate the stress response system and amass the variety of coping resources dictated by an individual's personality traits, social position, culture, and the type of stressor to which the individual is exposed [126-128,152-154]. For example, being in the numerical minority as one of few black persons in a majority white workplace [43,103,106,153] can trigger racial identity salience, generate racial identity-related stress, and require identity-specific coping, such as disidentification with previously valued social self-concepts [43,65]. For those likely to encounter environments highly saturated with such identity-triggering cues, these coping styles can subsequently influence occupational performance and satisfaction [127,128], trust in the medical profession [67], and goal setting [16], along with other behaviors and emotional states with implications for psychological and physical well-being [41,58].

Theories for gender variation in stress response and management

Fifty-four studies focused on gender variation without distinguishing race/ethnicity. Among these, 27 of 31 empirical analyses confirmed a priori hypotheses. Like racial/ethnic theories, culture and the unique nature of gender stress are hypothesized to account for variation in management of social identity-related stress between women and men. However, where racism and racial discrimination are envisaged as products of the unequal social statuses of black and white persons, gender prejudice is generally conceptualized more as a function of cultural traditions delineating strict gender roles. Finally, there is a school of thought which hypothesizes that the distinct physiological constitutions of women and men may partially catalyze differences in coping but none of the included theories propose such physiological differences as the central drivers of gender variation in coping.

Cultural context—Twenty-two of 31 empirical studies confirmed hypotheses that encultured gender norms are the most significant contributors to coping differences between women and men (the remaining five empirical studies with positive findings supported a personality trait framework for coping differences). Although black and white persons are observed as subscribing to contrasting cultural norms, culture theorists contend that hegemonic masculinity is centrally located within both of these cultural paradigms and drives gender differences in stress response and management irrespective of race/ethnicity [61,45,71,81,85,97,174-180]. Dominant narratives place men as the head of the social and family structure holding decision-making power [169,175-177], as the primary bread-winners [39,122,150], as more mathematically oriented [65,85,88,161,167-169], as bearing a biologically-based inclination for physical aggression [45,181-183], and as more capable of effectively managing stress [133,184,185].

As the salience and composition of racial/ethnic identity lends itself to specific management styles, so too does gender identity moderate the effect of cultural norms on responses to social identity stress. In contexts of a perceived threat to their gender, men adhering to this type of culturally-prescribed masculinity are more likely to demonstrate sexual aggression and prejudice toward women [45,170,181,187], general aggressive tendencies [13,159,163,182], reduced help-seeking behavior [79,81], cognitive rigidity [187], homonegativity [170,189], victim-blaming in rape and racially-motivated crimes [136,174,175,190], social dominance orientation [93,96,182], and suicide [171,173,188]. Similarly, the degree of women's subscription to a culturally-constructed gender identity affects stress management through increasing likelihood of cognitive flexibility [188], as well as risk of stereotype threat [65,88,179,191,192], rumination and other depressive symptoms [71,192,193], racial and gender prejudice [96,98,186], avoidant and emotion-focused strategies [124,185,190,194,195], and poor eating behaviors [73,196,197]. Some empirical studies focus on the role of "unsafe" identity environments which cue women's awareness of the stereotypes attached to their performance in certain social, academic, and professional domains [86,88,176,177,191,198], and subsequently affect sense of belonging, physiological reactivity [191], and self-evaluation [71,176,177].

Unique nature of gender stressors—Another school of thought characteristic of the present studies proposes that gender stress is appraised differently than other forms of stress

and therefore requires unique stress management strategies. Like racial stressors, the perceived pervasiveness of gender inequity leads to distinct neurological and cognitive processes based in a need to manage chronic threats over which one has no control [61,126,186,199-201]. The resulting strategies produce a proclivity for deference [187,188,199], internalized stigma [44,82,84,119,175] and emotion-focused coping [52,69,185,191], all of which are risk factors for the mood disorders such as PTSD and depression which are more prevalent among women [23,24,31,57].

Interaction effects of race and gender

Beyond the individual contributions of race/ethnicity and gender to coping differences between black and white persons, the literature offers some support for an interactive effect of these two types of social identities in explaining variation in stress response. Although only 65% of the studies in this review exploring intersectionality support a statistical interaction, a moderate theoretical base bolsters these empirical findings. These frameworks assert that at the junction of socially-constructed race and gender, distinct cultural prescripts bear upon one another, demanding resources uniquely shaped by the stressors individuals face as a result of occupying multiple social positions [52,67,92,202-213]. Gendered racism, as an example, is proposed as a contributor to the Superwoman Schema, a culturally-scripted role for black women as the source of community and family cohesiveness, simultaneously primary earner and household caretaker, expected to bear an extensive burden often at the cost of their own emotional and physical needs [203,209,213].

Adhering to these cultural norms predispose black women to a higher level of automated coping such as emotional eating [41,196,197], and avoidance [52,76,80,161], in addition to social support seeking [92,161], and faith and spirituality [161,202,210] when compared with black men. Black women's internalization of sociocultural expectations also influences perceived efficacy in career development; members of this group are more likely than black men or white women to enter service professions consistent with their limited historical opportunities in order to minimize exposure to racism and sexism [83,86,213]. Though often considered maladaptive "passive" strategies, evidence shows that disengaging and devaluing dominant racial and gender narratives also allow for the development of empowered self-concepts such as the Superwoman Schema among black women that subsequently reduce the likelihood of long-term psychological harm under chronic identity threat [55,83,92,127,161,204,207,213-216].

Black men, on the other hand, most likely of the groups under study to be victimized by racially-motivated physical violence [130] and to perceive racism as a threat to their culturally-prescribed gender identity [13,39,103,217], have adapted to gendered racism in ways distinct from those of black women according to the reviewed literature. Through anger repression [35,130,148], generativity [64], 'healthy' paranoia [131], negative coping [33,108,135], distancing [33], racial identity building [108,138], and intimate partner violence [13], members of this group demonstrate unique gendered race-specific responses to identity stress. With the exception of two studies [66,96], none of the included literature distinguished the strategies for coping with identity-based stress and associated health outcomes unique to white women or white men.

Discussion

This systematic review revealed a number of important characteristics of published literature on theories for the factors contributing to disparate stress management strategies employed by black and white women and men to manage social identity-related stress. First, these theories appear to fall into distinct categories that were not established a priori. Secondly, researchers predominantly use psychosocial models to interpret stress management differences. There is also some theoretical support for an interactive effect of race and gender but less empirical evidence. Finally, studies disproportionately focus on how women and black persons cope with being targeted by prejudice and discrimination as opposed to how stress response and management strategies of men or white persons are affected as perpetrators.

Distinct theory categories emerged from the compiled literature. Among the included studies, racial/ethnic theories describe social status, culture, and the unique nature of racial or ethnic stressors as the primary drivers of stress management differences. Across theory categories, empirical studies found that black persons are more likely to cope with racial discrimination or racism using both passive (e.g. reliance on spirituality and social support [33,40,146]) and hypervigilant strategies [106,111,113,116,132,134]; as well as racial identity development [33,86,150], while white persons under racial identity threat are shown to commonly employ prejudice and aggression [149,155]. The compiled literature also identifies distinctions between the coping behaviors of black women, who are more likely to engage in emotional eating and form close-knit social circles, and those of black men, who rely more frequently on racialization and hypervigilance when exposed to racial identity threat. As noted, few studies distinguish the coping behaviors of white women and men under identity threat.

Likewise, gender theories hypothesize culture and the unique nature of gender stress as moderators of the distinct management styles used by women and men. Empirical studies found that women are more likely to cope with gender identity threats through ruminant, avoidant, and emotion-focused strategies [71,192,193,124,185,190,194,195]. In contrast, the literature highlights certain coping strategies among men exposed to gender identity threat including sexual aggression and prejudice toward women and queer persons [45,170,181,187,189], as well as general aggressive tendencies [13,159,163,182]. Because of the complex interaction of social environments with cognitive processes, these categories should not be considered rigid or mutually exclusive. Instead, they are offered as a way of organizing an extensive yet disjointed body of research around potential points of intervention in a manner consistent with the range of theoretical frameworks underpinning the literature included in this review.

Theories suggesting social status inequities as the primary causes of coping differences among black and white women and men were the most frequently tested and supported. Although no formal assessment of study quality was conducted, studies based on primary data typically employed rigorous methodology consistent within the social psychological disciplines, using standard, appropriate analytic techniques and measures previously validated within the populations under study. However, while methodology was clearly

outlined and justified in the majority of studies, limited sample sizes and the cross-sectional design of many of these studies hinder generalizability beyond the university-level students among whom studies were typically conducted. Still, results from studies using primary data were often consistent with those of studies analyzing large national datasets, suggesting broader application of findings regarding a compelling role of social status in moderating differences in strategies for coping with identity-based stressors. A complete listing of characteristics of the included studies can be found in supplementary table 1.

Overwhelmingly, even among those studies which did not assess the intersectional effects of race and gender identity, empirical evidence supported social status theory which contends that contrasting experiences of occupying marginalized versus dominant social positions inform the contrasting stress responses among black and white persons in the context of identity-based stress. Such variation in strategies for coping with stress may partially explain patterns in disease outcomes across these groups [163].

The majority of papers outlining theoretical frameworks without the inclusion of empirical analyses proposed hypotheses which were tested and confirmed in the studies using empirical methods. Only three hypotheses generated from these theoretical frameworks regarding the causes of differences in coping between black and white persons were not directly tested using empirical methods: the 3D (deny, distance, or dismantle) framework for strategies of managing threats to white racial identity [143]; the theory proposing sexual addiction as a response to race-based PTSD among African-American men [111], and the identity triggers theory of health inequity [163]. Although such theories are consistent with previous findings, additional research is necessary to generate conclusive evidence of their validity.

As noted earlier, many studies included in the review failed to consider the interplay of race and gender on coping preferences in the context of identity-based stress. That these studies uncovered differences by race or gender individually indicates that while the effect of social status or culture on the ways an individual copes with stress associated with prejudice and discrimination may operate differently at the junctions of race and gender, there are some experiences of stress that impact on coping behavior in a consistent manner within race and gender groups. Still, the compiled evidence does build some theoretical support for an interactive effect of race/ethnicity and gender on stress response and management style [64,83,181,184,201,203,207,209]. Particularly among black women and men, race and gender identities as unique cultural scripts and adaptive processes are thought to feature prominently in their distinctive reactions to social identity stressors [64,131,141,142,203].

In contrast, although a moderate amount of evidence exists, empirical support for either an additive or multiplicative effect of interacting race and gender identity on coping preferences in any of the four gendered race groups lags. The empirical studies that do apply intersectionality to a stress and coping framework for health disparities largely focus only on black women, suggesting that the strategies for coping with identity-stress they employ results from cultural ideals of black womanhood that developed out of the unique stressors black women endure as a result of their race and gender. Whether these coping strategies can be attributed to the experience of being a black woman remains inconclusive because very little empirical research explores stress responses among white women following exposure

to gendered racial identity stressors. Likewise, while noting some maladaptive behaviors among black men, few empirical studies highlight how such coping strategies employed by members of this group in contexts of gendered racism can also be adaptive and reduce the risk for poor psychological and physical health. Only two of the included studies applied the intersectionality framework of stress management to white men, and although both studies empirically confirmed theory, few conclusions can be drawn from such little data.

Study design limitations could also partially account for inconsistencies within empirical analyses of the intersectionality framework. In some of the included studies (e.g. [212]), the operationalization of intersectional exposures may have been inconsistent with the manner in which these constructs were conceptualized. Because of the highly subjective nature of perceived discrimination, the measures frequently used to evaluate an interactive effect of race and gender discrimination may not fully capture the conceptual definitions outlined by intersectionality and multiple identity theory [51,52]. Such misclassification could potentially bias effect estimates and reduce the likelihood of uncovering an intersectional effect. Still, despite the disproportionate focus on black women and some methodological drawbacks, the current literature indicates that identity-related stress may be experienced and managed according to the synergistic effects of gender and race.

Like previous reviews of gender [62] and racial/ethnic [27] influences on stress management, ours suggests that researchers primarily rely on psychosocial or sociocultural frameworks for explaining differences in stressor-specific management strategies among black and white persons. Comparatively few studies explore a neurobiological basis for differences, although these models are more frequently drawn upon for gender theories than theories for racial/ethnic differences—likely because notions of biologically-based sex differences are often extended to stress management theory [61,182,184,188]. The preference for psychosocial explanations could be due to a recognition and proactive shift away from the controversial history in which scientific investigation was used to promote racist and sexist ideology [49,138]. The disproportionate focus on psychosocial or sociocultural models could also stem from technological limitations which have until recently prevented the empirical testing of hypothesized differences in neurological activity. With the recent advancement in neuroimaging technology, exploring the role of neurobiology in shaping stress management techniques has become more feasible and may lead to a refocusing of stress theory. This may enable greater insight into group differences in stress management, as neurobiological methods allow for objective measures of physiological stress. A recent shift within the scientific community recognizing the legitimacy of social scientific theory [1] may also factor into the predominant use of psychosocial and sociocultural frameworks in explicating social group-based strategies for coping with social identity stressors. Irrespective of the reasons for the disproportionate use of these models, theories positing social status and culture as drivers of group differences in coping strategies are more frequently supported by empirical evidence than other explanations.

Another characteristic of the reviewed literature is that the majority of included studies investigate the manner in which women respond to being the target of sexism or gender discrimination or how black persons manage being targeted by racism or racial

discrimination. Very few studies explore how subscribing to racist or sexist ideologies, or the ways in which masculine identity threats or threats to white racial identity affect stress management strategies. A historical dearth of racial, ethnic, or gender diversity in social psychological research likely contributed to a previously imbalanced focus on understanding the psychosocial causes behind racism and sexism rather than the effects of prejudice on those victimized. In efforts to address this historical disparity, some argue that a purposeful effort was made to shift the perspective from perpetrators to targets of racial and gender discrimination [71,217]. While correctly considering the need for contextualizing the experiences of those who suffer social oppressions, this reorientation limits the capacity to examine the role that dominant social status and subscription to prejudiced ideology plays in health outcomes while simultaneously weaving a counterproductive narrative that social inequities only negatively impact those occupying subordinate positions within the social hierarchy. Such a conceptualization has potential to both increase the difficulty of achieving effective public health interventions on social inequity and reduce incentives to do so.

There are some limitations to this review requiring acknowledgment. We excluded studies not published in English, not including US samples, dissertations not published in peer-reviewed journals, and book chapters, so it is likely that relevant literature on the topic was omitted. Still, this decision was made to standardize the quality and scope of included studies in order to optimize comparability and utility of the compiled evidence, which was extensive despite the exclusions. Additionally, only one reviewer selected articles and extracted data from included studies. However, the introduction of bias into the selection process was minimized by using a data extraction form and a second review author to confirm. While we have chosen to focus only on the intersectional effects of race and gender on strategies for coping with stress, we recognize other important demographic characteristics that contribute variation to stress management preferences, including socioeconomic position, sexual identity, and geographical location. A complete analysis of these characteristics within a single study would be neither achievable nor informative. Our intention is to provide insight on the two characteristics we argue accounts for the largest proportion of this variation. Finally, because we limited our analysis to studies including only black and white participants, our findings may not be generalizable to other groups. An individual's unique cultural and social context is thought to play heavily into the stress management process; any effort to explain the root causes of this process within specific cultural groups therefore requires an analysis of those groups specifically.

Our review also has notable strengths. This is the first review of its kind, an extensive endeavor attempting to amass and synthesize scattered evidence of the individual contributions of race and separately gender to the management of a unique class of chronic stressors. Furthermore, we build on previous reviews of gender differences in coping, and a review of racism-specific coping, by evaluating the effect conferred by experiences of identity at the junction of race and gender, and by focusing specifically on theory for why these experiences differ between black and white women and men.

Conclusion

In identifying major categories under which theories for racial/ethnic and gender differences in strategies for managing social identity-related stressors fall, we highlight areas of needed systematic theory and empirical research on the causes of variation in coping processes and the effects of such variance on health inequities among black and white Americans. The evidence appears strongest for theories proposing social status influences on racial/ethnic and gender identity formation as a moderator of methods for managing social identity-related stress. Support for these theories could be strengthened through the use of prospective cohorts and nationally-representative samples, as well as study designs accounting for potential within-race and within-gender variation in the effects of such stressors. As this review highlights, a large proportion of research exploring the role that psychosocial stressors such as discrimination play in promoting health disparities focuses on racial or gender differences without considering the theoretical and methodological implications of grouping individuals among whom the effect of exposure may differ. In order to more fully understand the implications of multiple intersecting identities that may simultaneously operate to shape an individual's experience in the context of psychosocial stressors, additional empirical data on the interactive effects of race and gender on coping are needed, particularly among black men, white women, and white men. With greater consistency in methodology, future empirical studies may yield additional information pertinent to clarifying mechanisms for the health consequences of exposure to social inequity among black and white women and men in the U.S.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1.
PRISMA diagram detailing article selection criteria.

Table 1.
**Number of Studies within each Social Identity-related Stressor Type by Participant Race/
 Ethnicity and Gender**

Stressor type	Specified gender and race				Unspecified gender		Unspecified race	
	Black female	Black male	White female	White male	Black	White	Male	Female
Institutional discrimination	38	23	18	17	14	3	5	15
Interpersonal discrimination	39	25	15	15	16	3	11	19
Stereotype threat	21	14	7	5	0	0	3	4
Unspecified gender identity threat	10	7	2	3	2	0	16	10
Unspecified racial identity threat	13	7	1	1	7	1	6	5