

THE CRISIS IN WHITE WOMEN'S MENTAL HEALTH

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Abstract

Mental health can be challenging for individuals of varying racialized and gendered identities. However, not everyone experiences mental health in the same way. Contemporary research and literature have suggested that white women, especially within the United States of America, experience significant difficulties and disadvantages that result in poor mental health experiences and states. In this paper, I adopt an intersectional life course approach to consider how race and gender intersect to affect mental health and overall wellbeing across the life span. This approach will allow me to understand an interesting paradox in mental health wherein white women experience poorer mental health because of various cultural and social stressors that have less of an impact towards the mental health of men and minority populations. Findings situate that white women's poorer mental health experiences are a result of not only racialized and gendered differences, but can also be attributed to age, income, marital status, trust, and education.

Keywords: Gender, race, mental health, life course, intersectionality, white women

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Thesis Introduction & Overview

Introduction

This thesis presents a review of current literature and an original analysis of secondary data to provide an intersectional life course understanding of white women's mental health. Specifically, it will examine racialized and gendered disparities and differences in mental health to understand why white women experience poorer states of mental health. The data set utilized for the purposes of this thesis will be the 2022 General Social Survey, hereon also referred to as the GSS, conducted in the United States. The chapters that follow provide statistical and literature-based evidence that support my research focus surrounding the poorer mental health among white women in the United States.

Current debates surrounding gendered and racialized gaps in mental health discuss the thriving state of minority, primarily Black, mental health because of various support systems and coping mechanisms they access and possess, while noting that male mental health is among the most positive experiences across various racial demographics (Breslau et al., 2006; Carter et al., 1996). The power of Black mental health is highlighted in current debates as it is often attributed to the resilience derived from dynamic support systems, religious commitments, diverse family dynamics and networks, strong intergenerational care networks, and fulfilling community engagements (Keyes, 2009). Men, across many racial categories, experience stronger and more positive states of mental health compared to women. Findings for gendered differences discuss how the stressors that fall on the shoulders of women tend to be more chronic and cumulative in nature that can lead to more aggressive mental health issues and can further impact physical health, daily functioning, and overall productivity (Avison et al., 2012). Current research on the

mental health of white women attributes role strain and a variety of stressors, such as division of labor and income, that cumulate a disadvantageous mental health state. When left untreated or unaddressed, mental health issues within white women can cause additional health risks, behaviors, and issues. I approach the research and literature on the debates of white female mental health to examine both the gendered and racialized gaps and experiences, alongside the GSS 2022 dataset, to produce a concrete paper on the explanation of what produces these poor mental health issues in white women, an examination of the social determinants of mental health, and why this research is important for the health sociology discipline and for mental health research.

My dataset of choice, the General Social Survey 2022, allows for the self-expression and identification of one's mental health occurrences that allow me to capture a range of responses from individuals who experience mental health issues in a variety of ways. I acknowledge that how an individual defines, perceives, and experiences mental health is a unique subjective state that can be based on a variety of personal, social, and cultural views and opinions. No two instances of mental health occurrences are identical, while medical classifications of psychological issues and disorders are necessary to identify and diagnose the presence of such issues, there can be significant variation among those who experience similar or the same mental disorders and challenges. For the purposes of my thesis, I emphasize the importance of the subjective experience of mental health to measure psychological responses. This means that individual responses of mental health, especially within the GSS 2022, will be of significance in understanding white women's mental health issues. Within my dataset, and among most of the literature and research presented in this paper, subjective experiences of mental health, primarily assessed through diagnostic interviews and surveys, are used to capture one's authentic thoughts

and perceptions regarding their mental health states. The 2022 General Social Survey allows respondents to indicate how many days in the previous 30 days they have experienced poor mental health. This question welcomes diversity and interpretation in responses as each respondent can classify their response based on their subjective experience. Stress and anxiety disorders are some of the most common and easily diagnosable mental health disorders that are tested and accounted for in the literature and research presented throughout this paper.

Understanding the uniqueness of each mental health instance is important to my research to acknowledge the full scope of issues and disorders that challenge the mental health of my target group, white women.

'Chapter 1: White Women's Poor Mental Health' examines the poorer mental health states among white women, most commonly in the United States. I outline some of the existing literature, research, and studies that situate white women as having poorer mental health states than other gendered and racialized groups, as well as identifying some of the most common explanations that help to understand these issues. I pay specific attention to groups that are compared to white women to understand their poorer mental health, most commonly Black populations and men. While I do acknowledge some research of non-binary gendered individuals and additional racial populations, such as Asian and Latinx groups, I will mostly focus my efforts on Black populations and male categories as they are most prominent in sociological research as well as among the General Social Survey 2022 respondents.

'Chapter 2: Gender and Race as Social Determinants of Mental Health' examines race and gender as critical social determinants of mental health that allow for a better understanding of white women's psychological experiences and states. I will also address the stress process theory to understand its impact and insights on mental health to better assess white women's

psychological processes. Additionally, I will outline and discuss racialized and gendered gaps present within mental health and the greater understanding they provide for the examination of white female mental health. For the purposes of my research, I will mostly focus on research, literature, and data that pertains to Black and White populations as they not only account for the majority of the United States population, according to census data published in July 2022, but most of the research pertaining to racialized mental health gaps is centralized around white and black populations. Conclusively, male and female categories are the most common gender classifications utilized in both my literature review and within my dataset, those classifications are what will be used to address and compare gendered gaps and differences in mental health experiences and research.

‘Chapter 3: Understanding White Women’s Poorer Mental Health: An Analysis of the General Social Survey 2022’ will address my unique intersectional life course approach to examine mental health. I use such theories to address how they are beneficial to the study of mental health gaps and inequalities across gender and race categories over the life course. I discuss how this approach can contribute to future mental health research and how my research can contribute to the debate in the theories of mental health. With the context of my research being based primarily in the United States, I hypothesize that my results from the General Social Survey will be in line with contemporary sociological research to show white women having some of the poorest states and responses of mental health across other gendered and racialized groups surveyed. This final chapter will include a regression analysis to represent results for the GSS 2022, that will be supported by contemporary research and literature to understand the white female mental health issues and disadvantages present.

Contribution

The contribution of my research stems from incorporating intersectional theory and life course theory to address the mental health phenomenon associated with the rise in poor mental health experiences among white women. Intersectional literature predominantly focuses on Black women, and minority women, while research pertaining to white female mental health requires further analysis. My research bridges a gap in health sociology and mental health research as I aim to contribute, within this paper, an understanding of white female mental health, some of the explanations associated with the decline in positive mental health states among white women, the overall importance of researching this topic, and how my research can contribute to the future of mental health research of the white female demographic.

With this research, I aim to acknowledge research on female and white populations respectively and to bridge the gap between them both. By identifying findings, underlying themes, and key components, my contribution brings forth new information on the mental health experiences of white women that addresses the unique intersectional mechanisms of gender and race playing a critical role in coping ability, psychopathology, healthcare options, and social support systems.

Plan of Analysis

My analysis includes several stages that evolves over the course of my three chapters. The analysis involves a mixed methods approach where I utilize qualitative research and literature to support my thesis research focus and employ a quantitative aspect wherein, I utilize the GSS 2022 to empirically address white female mental health issues and disadvantages.

My first stage is to simply address the key problem of white women often showing poorer mental health. I support this by incorporating existing research, literature, and findings

from studies that uphold mental health gaps across various racialized and gendered groups. The goal is to understand and identify that there are noticeable issues among white women, in the United States, that not only impact their current mental health states and experiences but can also cumulate towards additional mental health risks and physiological health issues across the life span.

In my second stage, which takes place in Chapter 2, I use the General Social Survey 2022 to present a portion of my quantitative analysis where I use the dataset to produce visual distributions of gender and race responses along with mental health responses from the question where respondents are asked to numerically answer how many days, in the previous thirty days, they have experienced poor mental health. I identify and acknowledge literature that supports the distribution of race and mental health responses to indicate the presence of racialized gaps in mental health in the United States and some of the common findings and explanations that help to understand such prominent issues, such as socioeconomic issues and marital aspects. Additionally, I recognize the presence, size of, and significance of the gender gaps in mental health as reinforced by my literature review as well as the incorporation of the distribution of mental health and gender responses from the GSS 2022.

My final stage discusses the unique intersectional life course approach I take in understanding white female mental health issues and experiences. This approach allows me to look at my variables, of gender and race primarily, as vital intersectional components that produce unique mental health experiences and how such components can introduce compounding stressors and health issues that can be chronic and negatively impact health over the life span. I then conduct a regression analysis of the General Social Survey 2022 to assess, not only, my primary variables of mental health, gender, and race, but also include additional

secondary independent variables of marital status, age, income, education, and social trust to understand their impacts on the course and experiences of white female mental health.

Research Questions

Primary Question:

Do white women have poorer mental health, than compared to other racialized and gendered groups, and why?

Throughout this paper, I will be comparing white women and their poor mental health to other racialized and gendered groups to identify, not only, the potential successes and coping mechanisms adapted by other groups but to also understand what white women specifically have issues with and what they lack to not be able to cope effectively and access support systems.

Male and female groups are the gender categories I am using, as most of the research available on mental health, especially within the United States, adapts a binary approach to understanding gender differences. Male and female differences in mental health can be attributed to a variety of components and processes ranging from socioeconomic status and employment to marriage and division of labor. Additionally, male and female gender categories allow me to investigate the differences in psychopathology, healthcare service usage, diagnostic rates, and use of psychopharmaceuticals.

White (and/or Caucasian) and Black (and/or African/American) groups are the racial categories of groups I will be using for my research. Significant research, especially in the United States, has investigated racialized gaps and paradoxical racial shifts in mental health that are primarily centered around Black and White groups. Using this distinct group categories allows me to investigate racial differences in mental health diagnostic rates, experiences, coping

abilities, and group processes. I will use and cite some literature addressing Asian and Hispanic groups, where necessary, however my primary focus remains on assessing Black and White group differences to examine white women's mental health issues and disadvantages.

Supporting Questions:

A. How does the gender gap in mental health illustrate the specific mental health disadvantages white women face?

The role of gender is undeniably central to my research topic. Women generally experience poorer states of mental health, compared to men due to a variety of psychosocial stressors that interact to produce such events and processes. Common findings in mental health research indicate that mental stressors are more chronic and longstanding for women that suscept them to aggressive mental health outcomes and issues (Avison et al., 2012; McDonough et al., 2008), depression is one of the oldest and most prominent mental illnesses for women that is nearly twice as present than men (Mirowsky, 1996), division of labor and marital stress contribute to women's role strain as well as physical and mental fatigue (McBride, 1990; Lennon et al., 1992), and the significant surge in substance use and abuse disorders is often attributed to elevated stress levels and depressive episodes (Sevilla et al., 2020).

I regard gender as a highly crucial dimension of intersectionality that helps to understand the individual, group, and social experience of gendered differences, which allow for a better understanding of the inequalities and difficulties that exist in the mental health spectrum for women (Hamana et al., 2012). Women experience different forms and rates of psychopathology than men do (Bracke et al., 2015), which is something I wish to explore further as I have noticed, through my literature review, how certain illness and disorders are more commonly present among women due to specific life outcomes and social circumstances. Additional attention will

be paid towards specific psychosocial stressors that negatively affect women more than men, such as traditional gender roles associated with marriage, child raising, wage, and independent income.

B. How does the process of racialization account for racialized gaps in mental health?

I noticed, through my literature review, a significant black-white paradox of mental health that is present, in which racial minority populations, primarily black communities, report similar or better mental health perceptions and experiences than their white counterparts (Erving et al., 2021). Racialized minority populations tend to have higher levels of self-esteem, family social support, and religiosity when compared to white individuals (Erving et al., 2021), which may account for the differentiation in mental health perceptions, coping abilities, and outcomes. The need for further assessment of white mental health stems from current literature that suggest the improved mental health states of minority populations while white mental health continues to worsen because of poor self-esteem, lack of social support systems, less religious and community engagements, and additional factors.

C. Why is it essential to include life course theory and intersectionality theory in the analysis of white female mental health issues and states?

My research is framed around a health sociology perspective as I investigate why one group, white women, is psychologically less healthy than others. To research this, I need to incorporate both intersectionality and life course theory into this paper to understand the development and course of mental health issues among white women in the United States. I do not treat mental health as something stagnant or static, instead I treat it as a dynamic process that can create cumulative disadvantages and outcomes for health as mental health evolves over time and through circumstances.

Life course theory addresses how stages of life influence one another based on social, economic, political, and physical environments that can impact one's health and the health of those around us. Life course theory is of particular interest to me, especially through a health sociology framework, to address the dynamics and shifts that occur within mental health processes and the further implications they have on both physical and mental health over the life span. Life course theory research identifies critical periods of mental health progression wherein certain developments of mental health issues at certain periods of time can have intense effects on social processes and personal productivity (George, 2012). This theory looks at length of exposure to mental health issues and stressors that can facilitate further psychological developments that may produce unfavorable health outcomes while also addressing duration dependences wherein specific states and environments can heighten and trigger mental health responses and states (George, 2012). All the focuses of life course theory are critical in not only understanding the presence of mental health issues in white women, but also to identify age demographics that may be susceptible to developmental issues, address certain environments and roles that contribute to negative mental health experiences, and recognize the presence of social stressors and stimuli that trigger mental health behaviors and issues.

The use of intersectionality theory helps to identify the different factors of advantage and disadvantage within an individual or group. The factors, of which I am primarily interested in, are gender/sex and race which will contribute to a better understanding of white women's mental health while also using additional factors of age, income, marital status, education, and trust to measure and address poor mental health in white women. Intersectionality theory helps to combine whiteness and femaleness to assess mental health risks, behaviors, vulnerability, and experiences. This theory examines the intersections of vital dimensions of one's life, including

social position, to garner an understanding of how mental health is perceived and experienced. The frequency and severity of mental illness and health issues vary between populations. Understanding the white female experience of mental health helps to identify plausible issues and disadvantages that are unique to the population of study.

Methodology

The data set of choice for my research is the General Social Survey, also referred to as the GSS, conducted in 2022 and further released in May 2023. The GSS 2022 Cross-sectional data features a multi-mode design to monitor Americans' shifting attitudes on social issues. The General Social Survey covers a range of topics that encompasses issues of mental health, social inequalities, gender roles, religion, race, and age in the United States of America. The overall goal of the survey is to track societal evolution over time, ever since the General Social Survey began its assessment and monitoring in the early 1970s with the purpose of understanding society over an evolutionary standpoint to acknowledge how and to what degree attitudes and perceptions have shifted in American society. This survey accompanies my research well as the focus of my topic and the General Social Survey examines the health differences and attitudes among individuals within the United States, which can be used to isolate issues on the rise among various gendered and racialized demographics with respect to mental health.

The GSS introduced some minor methodological changes in the 2022 cross-section survey, compared with previous GSS Cross-section studies. The changes relate to shifts in the mode of data collection, experiments related to mode of data collection, oversamples of Hispanic, Black, and Asian respondents, and a new design which allowed for follow-on studies. Most notably, the 2022 GSS Cross-section is a multi-mode study, with respondents able to

complete via a face-to-face interview, a web-based self-administered questionnaire, or, if necessary, a phone interview (General Social Survey, 2023). The GSS 2022 sample was split into two conditions. The first condition contacted sampled households for an in-person field interview first and then nonrespondents were given the option of taking the survey online. In the second condition, sampled households were presented with a web survey first and then nonrespondents were approached to participate in an in-person field interview. The first codebook and available data for the survey were published in May 2023.

I selected this dataset to address my research interest in understanding the disadvantages and issues associated with the poorer mental health states among white women in the United States. The dataset classifies responses about racial self-identification with codes for White, Black, or Other while sampling populations within the United States and codes gender responses as Male or Female. A significant portion of the literature review and available research presented in the following chapters is mostly conducted and published within the United States primarily addressing male and female gender classifications and black and white racial categories. The GSS 2022 excludes other gender identities and other racialized categories, including individuals of mixed backgrounds, and there is no disaggregation of these broad racialized categories. The dataset includes a range of health-related questions that pertain to perception, behavior, economics, and safety which are of particular interest to my research on white women's mental health. My emphasis, while using this data to support my research interest, is to understand numerical responses from the question pertaining to an individual's reported state of poor mental health within the previous 30 calendar days. Such responses of mental health, gender, and race can provide critical insight on concerning issues and perceptions present within the American

population to help identify psychologically vulnerable groups who experience greater challenges and disadvantages towards their mental health than others.

Chapter 1: White Women's Poor Mental Health

Introduction

The presence and impact of mental health on western society is undeniably significant. Mental health issues and illnesses can affect anyone in any age, race, or gender category and can have profound impact on physical and psychological health. Mental health can be impacted by various social, cultural, economic, and personal factors, such as employment and marital status, that can cause certain demographics and populations to experience poorer states and outcomes of psychological health. The social issue of white populations, especially women, experiencing elevated rates and risks of mental illness is of major concern in the sociology of health discipline as many racialized communities are experiencing better psychological health (Breslau et al., 2006), as there has been significant increases in research and analysis on paradoxical shifts in the realm of mental health. Most importantly, it is because white populations are seen as privileged and successful in society, that this paradoxical nature of mental health is made significant as it represents new, unforeseen shifts where minority groups have relatively better mental health despite discrimination and inequalities (Keyes, 2009).

While some studies indicated otherwise (Carter et al., 1996; Cairney et al., 2013), there is substantial evidence and research that support this thesis of white women's unique position and relationship to poor mental health reports and experiences (Grote et al., 2007). Gendered and racialized characteristics and relations, alongside cultural and socioeconomic components, are indicative of the processes and reinforcement of white women's continued psychological disadvantages and difficulties (Keyes, 2009; Erving et al., 2018). Due to the presence of such factors, intersectional theorists and scholars often acknowledge the compounding stressors

placed upon white women which subjects them to overall worsened states of mental and physical health (Smith, 2021), these issues are especially detrimental to women as age increases due to cumulative health issues and disadvantages.

A large and growing body of research aims to connect these varying intersectional components to establish a larger understanding of the psychological experience of white women's mental health (Hill et al., 1999). I use both a literature review, as presented in *'Literature Review Table 1. An Overview of White Female Mental Health'*, and an analysis of the General Social Survey 2022 dataset to assess my main variables of mental health, gender, and race. I also address additional components of income, education, age, generalized trust, and marital status to incorporate a wider understanding of how mental health issues impact individuals, specifically white women, at certain social intersections.

What is Mental Health?

Mental health is the embodiment of a person's psychological condition and emotional well-being that is not only a resource of a healthy lifestyle but is also a primary component of overall health. It is important to acknowledge that mental health and mental illness are not synonymous. They are often used interchangeably as terms such as 'poor mental health' indicate mental illness and mental health difficulties, however the term mental health itself does not imply any negative connotations about health or irregularities. Mental illness issues encompass mood, anxiety, personality, psychotic, eating, substance abuse, and trauma-based disorders that each come with their respective set of symptoms and difficulties. For my research, I use the term 'poor mental health' to encompass mental health issues and illnesses together as I present my research on white female mental health problems and experiences.

Mental health issues can be impacted and influenced by genetic factors, substance use, biological factors, early life environment, trauma, stress, and personality factors. Mental health issues range in their intensity and frequency from person to person, as no two instances of mental health issues are identical. While individuals may have the same symptoms and diagnoses, their experiences and states of mental health can differ entirely. For the purposes of my research, I acknowledge these individual experiences of mental health issues and illnesses as they provide unique insight on the variations of psychological health across various groups, demographics, and populations.

How is Mental Health Measured?

While mental health illnesses and issues exist and function in a variety of ways, there are various ways in which mental health illnesses and issues are classified and measured. Most commonly, across both my literature review and the General Social Survey 2022, mental health is measured through the means of employing a survey or through the conduction of a diagnostic interview. Surveys allow for the observers to set their own scales to measure mental health issues and symptoms for research purposes and can classify and target their survey to identify specific symptoms and disorders. Diagnostic interviews are the gold standard for measuring and diagnosing an individual's mental health status as the interview is generally conducted by a trained clinician who employs various psychiatric techniques.

For my research here, I mostly examine the subjective experiences of mental health using my literature review and dataset to analyze the variations in mental health responses and produce ideas surrounding some of the plausible explanations as to why such variations exist. I pay most attention to looking at depressive, anxiety, and stress-related disorders as they are some of the

most common and easily identifiable mental health issues. I do acknowledge additional mental issues surrounding trauma-based, eating, and body dysmorphia issues, however they are present less in the literature and data used for this research and will be used in support of understanding white female poor mental health issues and experiences.

The Mental Health Crisis

Across the globe, mental health issues are a rising concern as social, economic, and political shifts bring forth waves of challenges and obstacles that impact various demographics and groups differently. While mental health challenges and illnesses operate on a wide psychological spectrum, there is an undeniable reality of the looming presence of surges in mental health issues and difficulties. The impacts of mental health indicate that individuals and groups at different intersections in society, such as white women in the United States, may suffer from their psychological issues more than others.

In the contexts of North American culture, mental health illnesses and issues are a continued topic of concern as surges in diagnostic rates, medication use, and healthcare service needs indicate the struggle of American society to cope with and access appropriate care for psychological issues (Carey et al., 2018). Concerning trends among North American society indicate how the COVID-19 pandemic has further worsened and exaggerated already present mental health differences and disparities (Jeste, 2020; Pietl, 2020). The COVID-19 pandemic is a prime example of a social, political, and economic shift that highlights the unprecedented crisis of mental health issues and diagnoses being on the rise (Nielsen, 2020). While the pandemic has impacted the global population in varying ways, North American societies saw strict lockdowns, social distancing, medically mandated stay at home orders, and other hinderances to daily social

life and mental health outcomes (Nielsen, 2020). Both before, during, and after the pandemic, and especially since the early 2010s, mental health issues have been increasing in diagnostic rates, professional medical and healthcare visits, prescription medication usage and continued consumption, and the need for expanded healthcare and intervention service options (Carey et al., 2018).

The importance of studying mental health issues, across various populations and demographics, stems from the significance of studying the variations in which mental health disorders and issues exist. Challenging periods of time, like the COVID-19 pandemic, reveal concealed disparities and issues that help to shed light on groups and individuals who are being adversely impacted by poor mental health. The reality of mental health is that all people experience mental health differently and certain inequalities exist, such as socioeconomic and educational issues, that negatively impact certain groups more than others. The heart of my research is showcasing and describing the issues surrounding the mental health issues and disadvantages of white women in the United States who are unable to cope and manage their mental health as effectively and appropriately as other gendered and racialized demographics can.

The Problem

My research addresses the problem of white female mental health, in the United States, that suffers due to a variety of challenges and obstacles that are found at the unique intersection of whiteness and being female. *'Literature Review Table 1. An Overview of White Female Mental Health'* provides a comprehensive overview of decades of research that examines the intersectional relationship between gender, race, and mental health. This list is not meant to be an

all-inclusive compilation of all published articles, findings, and data. However, it does offer a thorough overview of the current literature and research on this subject. The table shows that researchers have studied the intersectional relationship of gender, race, and mental health within various disciplines and fields, including Sociology, Psychology, Social Work, Medical Psychology, Gender & Sexuality Studies, Family Studies, Health Sociology, Psychiatry, and Epidemiology. Conclusions on whether white women have poorer mental health have been relatively consistent and significant: wherein many studies find that white women have poor ability to cope with mental health, rarely access resources and social supports for psychological intervention, and often fail to create meaningful opportunities for employment and financial stability outside of marriage and the home (Smith, 2021; Simon, 2002; Rosenfield, 2012). While other studies produce mixed or inconclusive findings (Mcilvane, 2007; Kimerling et al., 2005), or find that women have greater advantages in certain areas that more positively impact their mental health (Carter et al., 1996), there are findings present in my literature review that support my research. In what follows, I argue that the findings on white women's poorer mental health experiences can be attributed to the intersectional relationship between gender, race, and mental health.

The history of whiteness is one that comes with power and privilege in political and social systems that simultaneously disadvantage racialized and gendered categories outside the white heteronormative ideals. Here I discuss mental health as it relates to the reflection of white populations, especially women. Inadequate means and mechanisms of coping with psychological issues which stem from generalized trust issues towards other members of society and to mental healthcare services, the role of marriage and the division of household labor, certain age demographics being especially vulnerable, the role of education, and how income and

employment contribute to socioeconomic disadvantages are the prominent issues that impact white women's mental health.

While white populations benefit from the privilege of not experiencing racism or discrimination as minority groups often do, they experience obstacles to their mental health that increases their lifetime risk of developing a variety of psychological disorders, most commonly mood and substance abuse disorders (Breslau et al., 2005). White groups, especially women, experience the greatest rates of internalizing disorders. Researchers suggest that this is because they often do not possess the strong social support systems and resources, that minority populations often possess, to cope with mental illness effectively (Breslau et al., 2005).

White populations benefit from the ability to access and acquire mental healthcare and intervention services; however, services are often ineffective and highlight the overall fragility of white mental health states (Grote et al., 2007). With the need for mental healthcare for white groups, comes a common finding, namely that, higher rates of psychological issues and higher self-reported unmet psychological needs are most prevalent within white populations compared to Black/African American, Asian, Indian, and Alaskan/Indigenous populations (Harris et al., 2005). Consistent findings identify that white groups are unable to cope with the poor experiences of mental health as they do not possess the diverse range of coping mechanisms that are displayed in Black populations which are often attributed to their better mental health states and outcomes. These include, but are not limited to, religious and spiritual engagement, expansive family and intergenerational care networks, significant relationships maintained through community engagement, and restructured family dynamics.

Isolating gender as a primary focus of the white female experience helps to acknowledge and examine how certain personal, physical, and social components disproportionately impact

mental health. Women commonly, especially within white populations, are responsible for full time household work and child raising as patriarchal gender norms and traditional divisions of household labor are still practiced among some white groups. The increased burden of motherhood corresponds to women's feelings of dissatisfaction in the gendered division of labor within marriages (Hill, 2002). Marriage and unpaid household work increases women's proneness to suicidal symptoms, depression, and fatigue (Hill, 2002). Outside of the home, job opportunities and satisfaction for women can be limited in availability and accessibility which negatively impacts female mental health (Cohen et al., 2003), especially considering that many areas of work are still, to this day, male dominated which also results in systematic inequalities and unequal wages for women who do enter these areas of work. Due to the lack of financial and employment opportunities for women, women are more prone to poverty and socioeconomic issues than men (Grote et al., 2007). While men are more likely to experience stressors related to employment and wages, such as the stress for providing for a household, they are also likely to experience substance use and abuse disorders as a means of coping with stress (Cohen et al., 2003).

Through poverty and socioeconomic obstacles, women have an increased likelihood of experiencing a variety of psychiatric disorders which have longer term impact on their mental and physical health states (Grote et al., 2007). Socioeconomic issues and rates of poverty account for mental health and mental healthcare use differences between men and women (Harris et al., 2005). Due to the abundance of psychosocial stressors present in the lives of women, there are elevated rates and higher unmet psychological needs in female populations (Harris et al., 2005). While men do experience their own respective issues within the mental health spectrum, they

greatly benefit more from marriage, full time employment, and financial independence that does not burden them to nearly the same extent as women (Simon, 2002).

Intersectionality emphasizes that we must consider social determinants of health in a manner of not merely being isolated components of one's life, such as gender or race, but to examine such components as interacting processes and relations that are dynamic and influence daily life and health outcomes (Cairney, 2013). Certain populations and demographics are healthier psychologically than others due to how processes and the variables that capture them intersect and because of the impact they have on health experiences and outcomes. Through the influence of health sociology, and current literature pertaining to intersectionality and mental health, we see clear distinctions when looking at mental health reports wherein an interaction effect takes place among the various mechanisms and disadvantages in the lives of white women to produce mental health difficulties and irregularities. Despite the presumed jeopardy that minority populations may face because of gender and race, white women experience substantially poorer states of mental illness due to their unique states of whiteness and femininity (Rosenfield, 2012). I address the interaction effect here to acknowledge how not only do whiteness and femininity condition one another in the realm of mental health, but also how the variables of trust, age, income, marital status, and education can further exaggerate mental health behaviors, risks, and outcomes among white women.

Existing Studies

Mental health issues have been more prominently studied and observed over recent decades, especially within the discipline of health sociology. I aim to highlight some important studies that help to contextualize mental health experiences and some of the causes and effects of poor

mental health experiences. This is not meant to be an all-encompassing analysis of sociological and psychological studies, but rather a comprehensive overview of critical research and studies that help to reinforce my research topic of white women's poor mental health states and experiences. The studies mentioned below have produced information to understand some of the most prominent explanations behind mental health experiences and how they translate to a better understanding of white female mental health.

Through my initial literature review on race and mental health, conclusions on whether racialized gaps within the mental health realm exist are relatively consistent and significant that situate white populations as having and reporting poorer mental health than other racialized groups, however other studies have produced mixed results (Pamplin II et al., 1021; See also Louie et al., 2019; Hill-Joseph, 2019). Some studies produce findings that indicate Black chronic illness may disrupt their mental health resilience (Hill-Joseph, 2019). A second, less developed and studied, paradox exists wherein while Blacks experience a lower prevalence of depressive disorders, they instead identify higher levels of physiological illness than whites (Barnes et al., 2017; Mouzon, 2013). In what follows throughout this paper, I argue that the significant findings on the racialized gaps within mental health research can be attributed to various paradoxes and irregularities that exist which reveal the difficulties in white mental health experiences. White populations lack the efficiency and ability to appropriately cope with mental health issues as well as some racialized communities do, most commonly Black groups tend to display strong resilience's when challenged with a variety of psychological issues (Keyes, 2009). When looking at racialized groups, there are noticeable gender-based differences that were present as I conducted my literature review.

There is a growing body of research that indicates a wide range of gender-based stressors and experiences, which can be upheld and reinforced by men and women across various cultural and racial backgrounds, that heavily contribute to gender gaps in mental health (Swinkels et al., 2017). However, some conclusions have been mixed on how men and women experience mental health crises and the psychopathology that accompanies them (Pattyn et al., 2015; Rosenfield et al., 2010). Some studies suggest that men and women have similar experiences and rates of psychopathology (Pattyn et al., 2015) and that both men and women also experience similar symptoms of pain that coincide with prolonged mental illness (Helmer et al., 2009). But the overwhelming body of literature on the topic of the gendered mental health gap maintains that women's experiences of mental health and diagnostic rates are more severe and negative than men's (McDonough et al., 2018; Hwang et al., 2023; Astbury, 2001) and that the gap is further widened as age increases to the detriment of women (McDonough et al., 2018). For the purposes of this paper, based on the body of literature that supports my research, gender will be primarily classified in the binary nature of men/male and women/female categories. This is because most of the research on gender gaps in mental health is and has been conducted through a binary lens. While more current literature addresses non-binary and 2SLGBTQIA+ gender identities (Harnois et al., 2018; Pattyn et al., 2015; Roberts et al., 1998; Sevilla et al., 2020), there is overwhelming historical and current literature that uses binary classifications of gender as they relate to the gendered mental health gap.

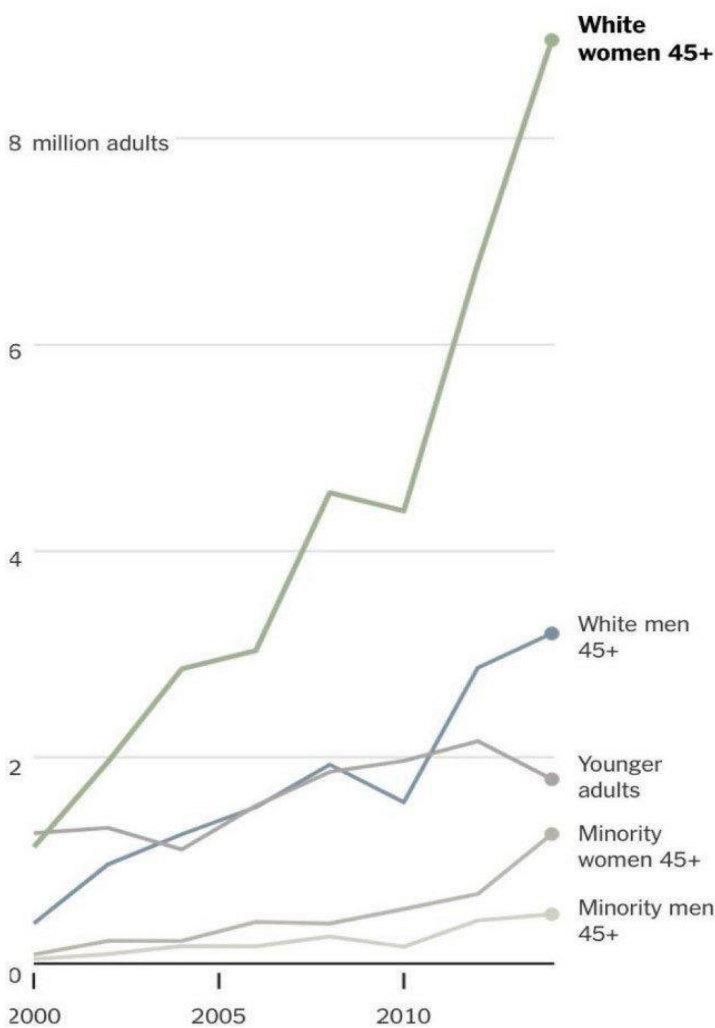
Mental Health and Psychopharmaceutical Studies

An interesting publication of use for the support of my research comes from The New York Times where the usage of psychopharmaceuticals is being documented to show dramatic

increases in usage across the United States. White women, especially over the age of 45, display some of the highest rates of antidepressant use and continued consumption, compared to other racial groups and gender demographics (Carey et al., 2021). This directly relates to some of the findings present in my initial literature review that situates white women as having prominent mental health issues that may be aided by the accompaniment of mental health services and

Demographics of Long-term Antidepressants

Older white women account for 58 percent of adults who have used antidepressants for at least five years.



By The New York Times | Source: National Health and Nutrition Examination Survey

Note: Image retrieved from The New York Times article 'Many People Taking Antidepressants Discover They Cannot Quit', published on April 7th, 2018

prescription medications (See

The use of and

dependence on

psychopharmaceuticals, such as

antidepressants and mood

regulators, has surged in the

United States over the past

decade (Carey et al., 2021). The

increase in demand for and

usage of

psychopharmaceuticals is

directly proportionate to the

increases of mental health

issues across the country

wherein more individuals,

especially white people, are

seeking professional medical

help for psychological issues

(Carey et al., 2021). Among the available psychopharmaceuticals, antidepressant medications saw dramatic increase in usage since 2010 in the United States. Antidepressants are perhaps the most common prescription medication used in the United States that can help in the treatment of depressive disorders, anxiety, and obsessive-compulsive disorder (Carey et al., 2021).

Considering their widespread applications and availability, the increase in white women experiencing mental health issues may be proportionate to increases in antidepressant consumption among white women. The '*Demographics of Long-Term Antidepressants*' graph indicates not only how white women are using the medication at some of the highest rates, but also can become reliant on antidepressants throughout the life span. This is of particular significance to my research as I examine the course of mental health issues over the life course, and the presence of being dependent on prescription medication may indicate chronic and cumulative mental health issues among white women.

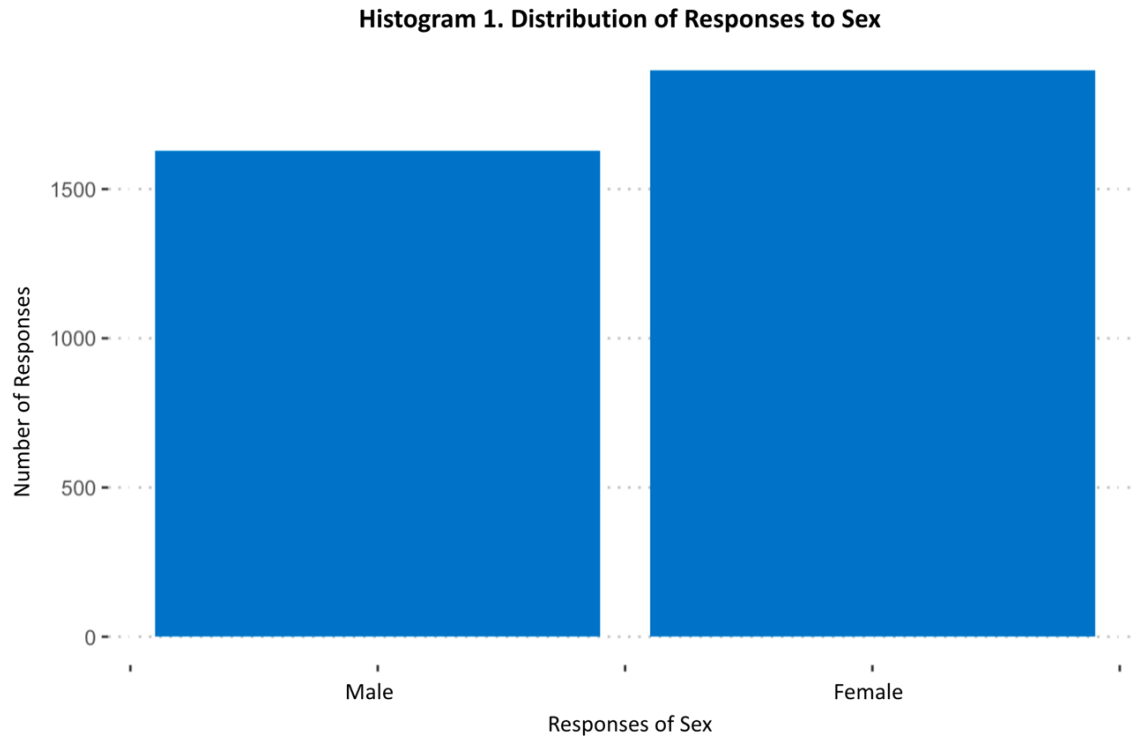
Groups of Comparison

My initial literature review presented me with common findings that, when examining racialized and gendered gaps in mental health, Black and White populations and Male and Female demographics are of primary focus. While some studies introduce additional racial and gender groups for analysis, there is an overwhelming amount of research and literature that focuses on Black and White group comparisons while primarily adhering to a gender binary for analytical purposes.

Male and Female Demographics

Male and female binary gender classifications are widely used across sociological research and national surveys. Across my literature review, male and female demographics are nearly

exclusively attributed to the measurement and classification of gender which also aligns to the measurement of gender displayed on the General Social Survey 2022. *'Histogram 1. Distribution*



of Responses to Sex' shows the distribution of responses to the question of the respondent's sex, not including the dropped observations, from the GSS 2022. Both my dataset and the literature used throughout this thesis classify gender in male and female demographics which allows me to appropriately study and acknowledge gender differences in mental health experiences and psychopathology. As highlighted in Histogram 1, both male and female response distribution are nearly identical with the only difference being a slightly higher female presence in responses. This distribution is significant to and representative of my research as the responses here will near equally address both male and female mental health differences which will be further supported by the research and explanations below. According to United States census data from July 2022, female persons represent 50.4% of the total population while male persons account for 49.6% of the total populations (United States Census Bureau, 2022). The ratios present in the

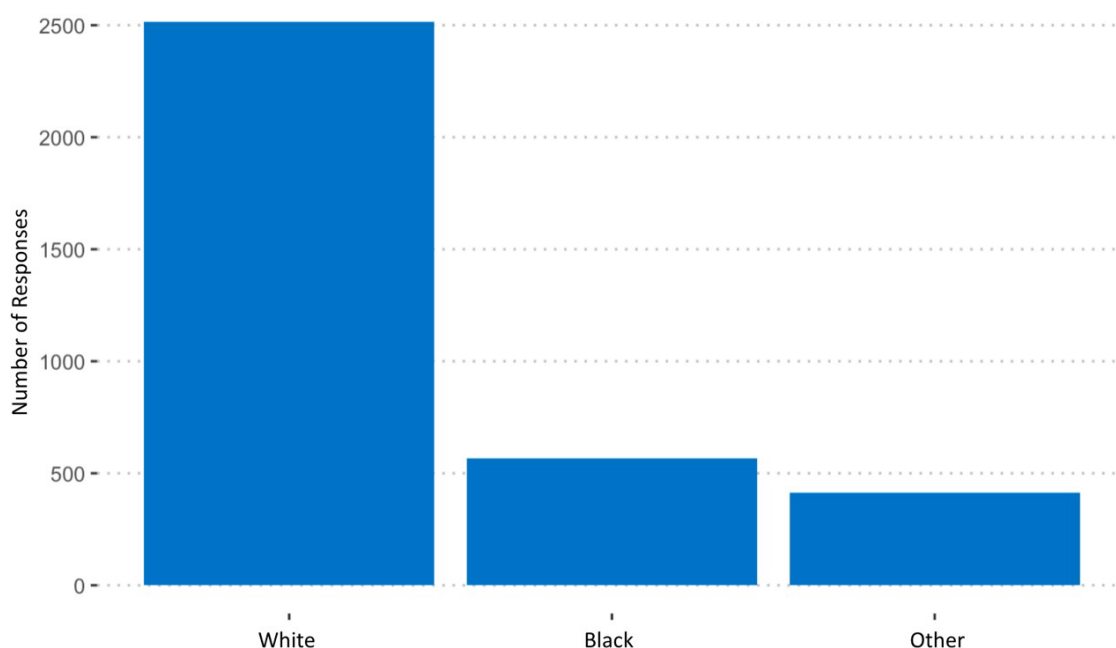
US census data are in line with the ratios of sex responses from the GSS 2022 survey wherein women are slightly more present than men.

For the purposes of mental health, male and female gender categories are used to identify gender specific differences that account for variation in psychological responses, experiences, and illnesses. The presence, abundance, and prominence of stressors differ among male and female categories in different aspects. Women experience more difficulties and threats towards their mental health due to the presence of traditional patriarchal gender roles and responsibilities imposed upon them (Van De Velde et al., 2010; Hwang et al., 2023; Swinkels et al., 2017; Kessler et al., 1982; Astbury, 2001; Mirowsky, 1996), the impacts of marriage on mental healthcare access and usage (Gyasi et al., 2019; Pattyn et al., 2015, Gove et al., 1977; Mirowsky, 1996), the impacts of globalization (Astbury, 2001; Okasha, 2005, Avison et al., 2012), how economic crises and socioeconomic issues contribute to psychological illness (Zamarro et al., 2012; Del Boca et al., 2020; Sevilla et al., 2020; Mirowsky, 1996; McDonough et al., 2008; Afifi, 2007., Etheridge et al., 2022; Hwang et al., 2023; Avison et al., 2012), and the proneness to various forms of violence (Coker et al., 2002; Rosenfield et al., 2010; Roberts et al., 1998; Harnois et al., 2018., Zamarro et al., 2021).

Black and White Populations

The focus on my research is situated in the context of the United States as both my dataset and a large portion of research focuses on that region. According to the United States Census Bureau that published census data on July 1st, 2022, White groups account for 75.5% of the total population, Black/African American groups account for 13.6% of the total population.

Histogram 2. Distribution of Responses to Race



Such census findings are important to acknowledge, in relation to my dataset, as they indicate that the distribution of responses from the GSS 2022 are of similar ratios to census data collected around the same period wherein most US residents are White, with the second most racialized group being Black/African American. Census data reinforces that the need to study and identify Black and White mental health differences can help to understand the disadvantages and issues faced by White populations and what Black populations have done to lessen the impact of such issues and disadvantages on their mental health.

As I examine the relationship between race and mental health, I look to challenge the idea of whiteness as affiliated with high status and favor wherein white individuals are the most privileged and successful members of society. Current literature surrounding the black-white paradox presents significant support for my research where I seek to understand the challenges that white individuals fall victim to when experiencing and coping with mental illness, while black populations, and ethnically diverse groups, seemingly have better success with mental

health coping ability and lower reported rates of such illnesses. Recent development in the literature surrounding the racialized gap within mental health discuss how the mental health of minority individuals has evolved over decades to cope with and recover from sources of stress that white populations have not been exposed to, such as racism or discrimination (Do et al. 2020). Such resilience in minority mental health accounts for the flourishing of psychological responses in Black and Asian groups (Keyes, 2009)

However, while Blacks are well-known to be able to cope effectively and appropriately with their mental health, chronic physical illness is still of grave concern to Black populations as they are significantly more susceptible to chronic illness which can threaten the resilience of their mental health (Hill-Joseph, 2019). Despite such issues, minority groups continue to display an improved mental health experience. Research pertaining to the black-white paradox of mental health positions white individuals as being more susceptible to a wide range of psychological stressors and illnesses than Black populations (Erving et al., 2018). Within white groups, women are especially vulnerable to depressive and trauma-related disorders (Erving et al., 2018).

Literature Review Table 1. An Overview of White Female Mental Health

Author(s)	Year	Field	Race & Gender Gap	Explanation	Findings
Breslau et al.	2005	Medical Psychology	Significant	White populations have more persistent disorders, upholds Black-White paradox	<ol style="list-style-type: none"> 1. White groups found to have greater lifetime risk of mood, anxiety, and substance use disorders 2. These rates were significantly lower in Non-Hispanic Blacks, but were most pronounced in white women
Breslau et al.	2006	Medical Psychology	Significant	Race-ethnic minority groups experience a significantly reduced prevalence of psychiatric disorders than white groups	<ol style="list-style-type: none"> 1. Minority groups have lower risk for common internalizing disorder, such as depression and GAD, than whites 2. Blacks specifically have lower rates of substance abuse than white groups 3. Women across many racial demographics suffer the most from internalizing disorders and more chronic psychiatric illness
Carey & Gebeloff	2018	Health Psychology	Significant	Women. White adults, and older populations are more likely to	<ol style="list-style-type: none"> 1. Long-term use of antidepressants is surging in the United States,

				<p>take antidepressants than younger adults, men and minorities due to their addictive nature and at the direction and diagnoses of medical professionals</p>	<p>according to a new analysis of federal data by The New York Times – rate of use has nearly doubled since 2010</p> <p>2. Little data about their effects on people taking them for years, antidepressants were originally intended for short term use</p> <p>3. White women over 45 account for about one-fifth of the adult population but account for 41 percent of antidepressant users, up from about 30 percent in 2000, the analysis found. Older white women account for 58 percent of those on antidepressants long term.</p>
Carter et al.	1996	Psychology	Minor Gap	<p>Link women’s identity development to mental health, among white & black women</p>	<p>1. White women have a wider range of depressive responses than Black women who display better resistance to depressive disorders and stressors</p> <p>2. More whites included in study than Blacks, and black women</p>

					included had an older age mean than white women
Cairney et al.	2013	Epidemiology	Minor Gap	Age and gender are predictors within racialized populations that younger individuals are more likely to exhibit health seeking behaviors that show the presence of psychological illness but may not possess financial or accessible means for medical services, but older groups are more likely to engage in medical services	Multiple intersecting statuses (race, gender, age) indicate health and behavior patterns, albeit difficult to test within certain circumstances
Cohen et al.	2003	Sociology	Significant	Overwhelming devaluation of paid work and pay gaps within women's work, impacts mental health negatively	<ol style="list-style-type: none"> 1. Occupational gender segregation at the labor market level exacerbates the female wage penalty 2. Composition of jobs and within-job inequalities impact women's mental health and subsequently their performance and function, most noted in white women as they have experienced the most opportunity out of other female

					groups to enter the labor market
George	2013	Health Sociology	N/A – does not discuss gender or racialized mental health gaps, provides life course approach to examine mental health	Long-term dynamics and interrelationships among social risk factors, protective social resources, and psychiatric disorders/ psychological distress	<p>Introduces three components to studying mental health through a life course approach:</p> <ol style="list-style-type: none"> 1. Critical Periods: timing of onset and development of mental health in relation to other social and health risks present 2. Length of Exposure: how time affects a given state or outcome of mental health (Ex. Job stress, and financial strains lead to stress exposure) 3. Duration Dependence: length of time spent in a specific state can strongly affect the odds of moving out of that state
Grote et al.	2007	Social Work	Significant	White women lack external support and coping resources	<ol style="list-style-type: none"> 1. Women who experience poverty and are of racial/ethnic minority status are less likely to pursue and mental healthcare services 2. White women most likely to

					engage with services, but lack effectiveness and highlights the fragility of white mental health
Harris et al.	2005	Sociology	Minor Gap	Wide variation in mental health morbidity and care usage across racial and ethnic groups in the United States	<ol style="list-style-type: none"> 1. Higher rates and higher self-reported unmet psychological needs found in White and American Indians/Alaskans 2. Lowest mental healthcare use among African Americans and South & Central Americans 3. Socioeconomic issues and rate of poverty to account for mental health and healthcare use differences
Hill et al.	1999	Gender & Sexuality Studies	Significant	Gender roles practiced differently in White and Black families	<ol style="list-style-type: none"> 1. Gender role socialization does not apply to African American families, mostly practiced in White families 2. Gender neutrality of roles exists in the socialization and caregiving of Black children 3. White families often maintain traditional nuclear family gender roles

					4. Black children instilled to be resourceful, strong and independent; translates to better mental health later in life and is emphasized in young Black girls
Hill	2002	Family Studies	Significant	Role of Black parents as active agents in the lives of their children and expand our knowledge about child socialization processes in Black families	<p>1. Black parents instill children with beliefs of gender equality</p> <p>2. Distribution of work in Black families heavily impacted by social class and wives' employment</p> <p>3. Full time household work and child raising by mothers, most common in White households, corresponds to increasing burdens and dissatisfaction in the gendered division of work and marriage</p> <p>4. Married white women more prone to depression, suicidal symptoms, fatigue, and physical exhaustion</p>
Kimerling et al.	2005	Psychiatry	Mixed Gap	Significant racial and ethnic variations were	1. Black, Hispanic, and Asian women less likely than

				<p>observed in accessing specialty mental health services</p>	<p>white women to access specialty mental healthcare services</p> <p>2. Insurance impacts Black and Asians women's access to mental healthcare services the most</p> <p>3. Hispanic women less likely to commit to mental healthcare services out of fear of poverty</p> <p>4. More research needed on gender and culture specific variable to identify further disparities</p>
Lipsky et al.	2007	Psychiatry	Significant	<p>Partner violence functions as a stressor that leads to adverse physical and mental health outcomes</p>	<p>1. Women are overwhelmingly found as victims of intimate partner violence, overwhelmingly perpetrated by male partners</p> <p>2. Contributes to lifelong presence of PTSD in women</p> <p>3. Abused white women more likely to seek professional mental healthcare support, while women of ethnic minority groups most likely to seek help from</p>

					community resources
McGuire	2008	Health Sociology	Significant	Equal or better mental health is reported among minority groups, in the US, compared to white groups	<ol style="list-style-type: none"> 1. Improve access to and quality of healthcare services for women and minority groups 2. Diverse mental healthcare workforce needed 3. Provide staff and patient education needed to help eliminate mental health disparities
Mcilvane	2007	Psychology	Minor Gap	Coping strategies albeit stronger in Black females compared to White women	Black and white women of lower SES nearly equally as likely to experience depressive symptoms when physical pain occurs (arthritis in this instance)
Meyer et al.	2014	Epidemiology	Significant	Socioeconomic status linked to mental health through neighborhood safety	<ol style="list-style-type: none"> 1. Lower SES is linked to greater neighborhood safety concerns, primarily among women who feel unsafe 2. Leads to increased psychological and behavioral issues that impact mental health, most commonly among women and

					ethnic/minority groups
Proto et al.	2021	Psychology	Significant	Demographic and socioeconomic characteristics identify race and gender gaps in mental health during the pandemic in the UK	<p>1. Women, regardless of ethnic minority status, experience a greater increase in psychological distress than men, during the COVID-19 pandemic</p> <p>2. Gender gap is maintained across nearly all ethnic populations</p>
Rosenfield	2012	Sociology	Significant	Gender, class, and race interact in paradoxical ways in the realm of mental illness	<p>1. Women internalize their problems more than men, like depression, that are more self-destructive to their mental health</p> <p>2. Despite the presumed double disadvantage, Black women experience much better rates of mental illness compared to black women as they are low in both internalizing and externalizing mental health problems</p> <p>3. Traditional roles instilled in white due to industrialization, gender and class redefined in</p>

					minority populations
Roxburgh	2009	Sociology	Significant	Race and gender influence variation in the relationship between resources and mental health	<p>1. Black and white men less depressed than white and black women</p> <p>2. Women accrue greater mental health advantage from marriage, home ownership, and education</p> <p>3. non-Hispanic white women experience less benefit from full-time employment, while Black men and women benefit more</p>
Simon	2002	Sociology	Significant	White women's elevates rates and experiences of psychological distress due to unrewarding and stressful nature of social roles	<p>1. Marriage is advantageous for men and disadvantageous for women</p> <p>2. Marital status correlated to women's elevates reports of mental health problems</p> <p>3. Gender inequality in power and authority in both the family and society</p>
Smith	2021	Psychology / Sociology	Significant	Socioeconomic mechanisms and racial stressors accounts for	1. Women have higher rates of morbidity than men

				gender and race differences in mental and physical health symptoms and rates	<p>2. Intersectionality scholars acknowledge compounding stressors on women due to their marginalized state</p> <p>3. Black women most susceptible to physical illness and mortality due to varying socioeconomic factors, white women more susceptible to mental illness</p>
Thomas Tobin et al.	2020	Sociology	Significant	Stress theory predicts and upholds women are at elevated risk of poor mental health and have limited access to coping resources	<p>1. Black-White differences are less pronounced among older adults, life course theory needed here to provide context for how we understand the paradox in older age demographics</p> <p>2. Lifetime mood, anxiety, and substance abuse disorders most pronounced among women, especially White women</p>

Chapter 2: Gender and Race as Social Determinants of Mental Health

Introduction

When examining the poor mental health experiences of white women, the power associated with gender and race to specifically coordinate a psychologically disadvantageous state for white women in the United States is one that is ever-present. Gender and race have the power to uniquely intersect with one another to produce specific health outcomes that can create additional cumulative health issues and risks over the life span. I approach gender and race as distinct social determinants of mental health as they interact to shape mental health inequalities.

Research on current gendered and racialized gaps in mental health help to uphold the modern idea of white women's poor mental health experiences that can be a result of their social position. Male demographics and racialized groups show less prevalence of common mental health disorders, like obsessive-compulsive disorder and chronic anxiety. This chapter will address contemporary research on gender and race as key social determinants of mental health and the gaps and paradoxes currently present that reinforce white women's poor mental health experiences and states.

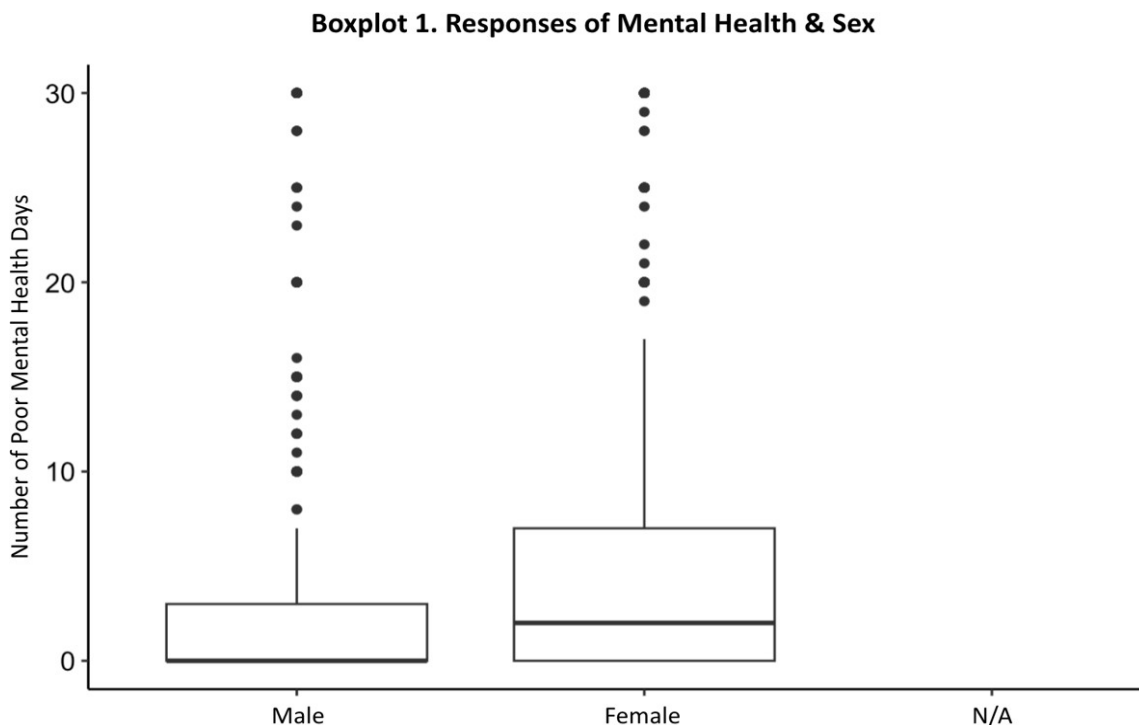
Social Determinants of Mental Health

An important contribution of this research is to not only highlight gendered and racialized gaps in mental health, but to explain how those gaps coordinate disadvantageous experiences for white female mental health processes. The history of the white female identity and roles will be explored in relationship to mental health to help understand what prolonged issues and disadvantages are present for white women that may negatively impact their perception of their

mental health and how and why white women experience more elevated rates of and greater variations of psychopathology compared to men and racial minority populations. This research offers an additional and significant contribution to sociological research wherein white populations were historically thought to be elite and superior, but now present surging levels of mental health issues that are not nearly as prevalent in other racial and gendered populations. Mental illness experiences and outcomes of white women indicate the presence of psychopathological risk factors, such as adverse reactions to and presence of psychosocial stressors, that can predispose these women to further mental illnesses and disorders in the future (Keyes, 2009).

1. Gender

The first social determinant of mental health I examine will be gender. Gender is a powerful component in my intersectional life course approach that provides unique insights on the lived experiences of mental health variations across male and female demographics. Gender can help



identify, and in some cases predict, concerning issues and disadvantages that certain individuals experience that can result in poor mental health experiences and states. The General Social Survey 2022 dataset helps to produce '*Boxplot 1: Responses of Mental Health and Sex*' which is a visual distribution that shows female respondents in the United States report a higher mean of poor mental health in the previous 30 days than their male counterparts. Considering that male and female respondents are nearly identical in their quantity of responses, Boxplot 1 is indicative of greater gender related differences at hand that account for both gender gaps in mental health outcomes and experiences as well as a significant presence in the lives of women in experiencing greater instances and episodes of mental health related issues.

Gender Gap and Mental Health

The importance of assessing gendered gaps in mental health allows for the insight on how certain gendered groups are more psychologically healthy than others and how that represents certain strengths and abilities to seek care for and cope with mental health issues and difficulties. I incorporate '*Literature Review Table 2. An Overview of Gender & Mental Health Research*' to provide an overview on the decades of research that have examined and considered the relationship and evolution between gender and mental health. This list is not an all-inclusive gathering of published articles and studies, but instead offers a comprehensive overview of the current and prominent research on this subject. The table shows that scholars, philosophical doctors, medical professionals, economists, and others have studied the presence of a gendered gap in mental health from various disciplines and fields, including Sociology, Economics, various branches of Psychology, and Nursing, as well as across the various social, health, and medical sciences. Conclusions about whether there is indeed a gender gap within mental health can be slightly mixed but are generally in support of women experiencing the most substantial

and prominent diagnostic rates and negative experiences in mental health (Afifi, 2007). Some mixed findings have concluded that men and women are equally as likely to experience mental health issues following intimate partner violence (Coker et al., 2002), while others have found no gap whatsoever in the impacts of mental health on individual daily functionality and subsequent physiological illness development (Helmer et al., 2009). Through the conduction of an extensive literature review, which allowed for the construction of *Literature Review Table 2*, I identify the pattern wherein women, across various demographics and races, experience some of the most negatively impactful mental health processes and experiences compared to men. Such issues are present due to the weight of social and personal mechanisms, such as the stresses of motherhood and marriage, that cumulate a disadvantageous psychological state for women.

In what follows, I argue that women overall, across a variety of fields and social spaces, not only experience intense and chronic psychological issues due to the conflicting roles and responsibilities they occupy but are also more susceptible to having more elevated and severe instances of psychological and physiological issues, especially as age increases (McDonough et al., 2008). Additionally, while there is continued support that the gender gap exists, research suggests it will continue to widen to the disadvantage of women if changes in social and health policies are not implemented to better aid female contemporary demographics and communities (Afifi, 2007). I acknowledge that some of the mixed findings are attributed to the distinct approaches' scholars have taken at the time of their research.

Presence of a Gender Gap

While reviewing current literature and research on gendered mental health issues it is clear there is a gendered mental health gap present that is inherently disadvantageous to and negatively impacting women. This approach aims to address the presence of the gender gap in mental health

and the current research and literature that support this finding. Current literature maintains that the presence of the gendered mental health gap is a direct result of specific intersecting roles, ideals, and traditional norms that are increasingly impacting the negative psychological states of female populations. Reinforcement of traditional gender roles (Astbury, 2001), intimate partner violence (Coker et al., 2002), socioeconomic stressors and disadvantages (Avison et al., 2012), increases in health seeking behaviors (Afifi, 2007), and employment related harassment and difficulties (Etheridge et al., 2022) are some of the dominant supporting explanations.

Through research and literature on the gendered gap in mental health, there is an overwhelming presence of relationship-related, social, socioeconomic, and financial difficulties women experience that not only negatively impacts their mental well-being, but also hinders their ability in seeking healthcare and intervention services more than men. This approach addresses the paradoxical nature of how women are experiencing new forms of independence and opportunities in current social and economic settings but are still experiencing some of the worst experiences and outcomes related to mental health and psychological difficulties compared to male counterparts (Etheridge et al., 2022). This approach presents how women's mental health is consistently declining, while new forms of independence and freedoms may be accessible and available to women who engage with those aspects. Such issues may present themselves because of independence creating more tension, stress, and perhaps forms of violence based on the responsibilities and roles women must occupy and sustain.

Size of the Gender Gap

With the presence of the gender gap in mental health already established and recognized, the second step here is to address both the size and continued widening of the gender mental health gap that disproportionately impacts the psychological states of female mental health more so

than men. When discussing the widening of the gap, it is not directly referring to psychopathology but instead refers to diagnostic rates, self-reported states of psychological health, lack of access to healthcare services, and differentiation in use of and confidence in healthcare services that all coordinate an indication of women's increasingly negative mental health experiences and outcomes. Due to women being more prone to experiencing a large range of psychosocial stressors, the gender mental health gap is widening (Mirowsky, 1996). Across various psychological profiles and measurements, women are increasingly susceptible to depressive symptomology and disorders, body dysmorphia and eating disorders, generalized anxiety spectrum disorders, and trauma-related disorders because of extreme social and gendered stressors placed upon them (Hwang et al., 2023). The widening of the gender gap in mental health is largely attributed to current personal and social circumstances that burden women with overwhelming motherhood responsibilities (McBride, 1990), create environments where marriage is demanding and demoralizing for women (Van De Velde et al., 2010), and make transitions into work and financial stability especially difficult for women to participate in (Zamarro et al., 2021). While the gap itself remains relatively large, as research consistently finds lower diagnostic rates and psychological instances of distress among men (Okasha, 2005), female mental health continues to worsen as age increases and the presence of psychosocial stressors becomes significantly more burdening for women compared to men. Life course theory is significantly important in understanding the widening of the gender mental health gap as not only do experiences of chronic stress and anxiety maintain and increase with age for female populations, but women are also more prone to experiencing deteriorated physical health conditions as age increases as result of psychological strain and illness (McDonough et al.,

2008). The gap continues to widen as gender related issues are going virtually unaddressed and continue to worsen as age increases and as social climates shift.

Taken together, addressing both the presence of and the size of the gender gap in mental health identify the state of exceptional susceptibility and vulnerability that women face towards psychological illness due to a variety of factors. While men experience similar rates of specific psychological disorders in certain instances (Rosenfield et al., 2010) and can have masculine gender roles reinforced by women (Pattyn et al., 2015), women are experiencing consistent threats towards their psychological wellbeing that are often perpetrated by men. Women are in a unique position of occupying the roles of spouse, caregiver, and wage earner simultaneously. Such role strain on women, when trying to balance and occupy multiple roles at once, increases their risk of psychological illness more than men (McBride, 1990).

Explaining the Gender Gap in Mental Health

In this section, I review the various explanations for the gender gap in mental health that are present in contemporary social research (see also *Literature Review Table 2. An Overview of Gender & Mental Health Research*). Many explanations have been proposed, focusing dominantly on the traditional role's women have occupied and the consequences they have on female mental health. However, given the weight of current literature and evidence surrounding other explanations of the gender gap in mental health, female roles and their reinforcement are only one approach in examining the gendered gap of mental health, albeit one that is substantially proven and documented (Gove et al., 1977). In what follows, I provide a discussion on how additional components of marriage (Gyasi et al., 2019; Astbury, 2001; Pattyn et al., 2015), socioeconomic issues (Sevilla et al., 2020; Del Boca et al., 2020), and globalization (Avison et al., 2012; Astbury, 2001; Okasha, 2005) negatively impact and hinder female mental

health experiences and outcomes. Additionally, I outline a gendered healthcare trajectory that has been heavily impacted by the recency of economic hardships primarily marked by and present from the COVID-19 pandemic which identified and worsened the gendered mental health gap. Toward the end, I address and outline the various forms of violence that specifically impact female mental health, their coping ability, and access to recovery, intervention, and legal services (Coker et al., 2002; Rosenfield et al., 2010).

I. Traditional Roles & Responsibilities

The reinforcement of traditional patriarchal family roles and responsibilities imposed upon female partners is a dominant explanation for the gender gap of mental health, as it incorporates aspects of financial dependency and generational caregiving responsibilities. Children, employment, and marriage intersect in the experience of female partners, as these stressors are predominantly and exclusively assigned and downloaded onto women (Van De Velde et al., 2010). Women are still, to this day, mostly situated as the primary caregiver for children and elderly relatives despite the new wave of opportunity for employment and financial independence for women (Hwang et al., 2023). The gender differences between partner caregivers are primarily due to the abundance of primary stressors placed upon women who spend a significant number of hours per day caregiving while receiving little-to-no help from relatives and one's spouse (Swinkels et al., 2017). The burden of caregiving on women has unrivaled consequences for their mental health. Such burdens contribute to the development of longstanding and chronic mental illness and depressive episodes (Swinkels et al., 2017). Depressive disorders are twice as common in female populations, while stressors stemming from childcare, marriage, and employment make married women more susceptible to mental health issues. This explanation of the gender gap sheds light on the social and psychological stressors

that are attributed to the female experience of partnership and caregiving which accounts for mental health variations between men and women (Van De Velde et al., 2010).

Additionally, both male and female partners can reinforce traditional nuclear gender roles and thus both aid in the reinforcement of the gender gap in mental health. Married couples often still participate in traditional gender roles that situates the female partner as the primary caregiver and homemaker (Kessler et al., 1982) Women tend to pay a psychological toll for how much care they provide for their children, friends, elderly family, and spouse by experiencing substantial constraints on their personal productivity and mental capacity (Mirowsky, 1996). Such tremendous added responsibility and labor onto the shoulders of already overloaded women increase their susceptibility to mental illness through submission to such gender roles that are historically disadvantageous to women (Astbury, 2001). The social constructs of the gendered divisions of labor are not necessarily bad as the acts of motherhood and being a partner are roles many women are glad to occupy, it is instead the devaluation of care work due to its unpaid nature is what takes a toll of female mental health (Kessler et al., 1982).

II. Marital Status & Health Service Use

Many scholars and researchers maintain that the distinct differentiations in mental health care and intervention service usage can be attributed to the varying circumstances associated with marital status and income (Gyasi et al., 2019; Astbury, 2001). Sociologists have noticed trends associated with marital status and health service use such that married women are substantially less likely to utilize and pursue mental health services than married men (Gyasi et al., 2019). This relationship is seemingly attributed to income, as mental health services are noticeably difficult to access and afford in countries of middle- and low-income (Gyasi et al., 2019), especially for women.

Considering that married men and married women often occupy different roles that are coupled with different psychopathology (Pattyn et al., 2015), women's mental health challenges are ones that are best addressed through health service provision and usage. Psychiatric illness is impacted by the different roles married individuals occupy (Gove et al., 1977). The effects of employment, sexuality, number of children and their ages help to understand the sex role differences and mental health outcomes of married couples (Gove et al., 1977). Women occupy a place where they often prioritize the responsibility of others, such as children and spouses, before themselves which negatively impacts their mental health and their confidence in pursuing mental healthcare services. The gender gap in mental health, especially when examining depressive disorders, remains one of the oldest and robust findings in mental health studies and surveys, there is an explanation that service usage and differentiations in gender categories exist because women experience greater role stress and tensions within family and work responsibilities than their male partners (Mirowsky, 1996). Conclusively, women often do not have as many options when marriages fail to work out, especially after years away from paid work. Women may experience financial setbacks if employment does not come soon after a marriage dissolves, which can create financial issues which not only contribute to mental health issues relating to stress and uncertainty, but also makes it unlikely for women to afford and access appropriate healthcare services if such issues arise (Gyasi et al., 2019).

III. Globalization

The impact of globalization on mental health is indisputably negative in nature. Globalization is the process of economic and social changes that have come because of how trade, technology, and global markets interact, which can accentuate existing disparities. Globalization has involved a dramatic widening of inequality within and between countries, populations, and demographics,

especially when looking at gender-based income disparities (Astbury, 2001). Rapid changes in various social, economic, and cultural climates provide a threat to modern psychiatry and to the psychologically vulnerable as delivery and efficiency of mental healthcare services are jeopardized in terms of accessibility, affordability, and establishing community confidence that such services are reliable (Okasha, 2005). Poverty and low income are closely correlated to mental illness development, wherein individuals among lower income demographics show elevated rates of depressive and substance abuse disorders while experiencing job and home insecurities that can further uphold mental health issues (Okasha, 2005).

With continued cuts from funding opportunities towards mental health care services and research, women are actively being denied access to adequate and appropriate health services for psychological treatment and intervention (Okasha, 2005). These issues are worsened for women who reside in middle- and low-income countries where opportunity for women to gain financial independence is difficult (Astbury, 2001). Poor living conditions and lower socioeconomic status culminate for women at this intersection to experience greater kinds and more exposure to stress-related illnesses, and illnesses in general that can contribute to and reinforce mental health issues (Avison et al., 2012). These stressors can be chronic in nature and longstanding, as they are often linked to additional stressors like financial difficulties, low job security, and poor job opportunities that can require women to experience longer working hours, lower wages, and poor employment conditions that can be detrimental towards mental health. Individuals in lower socioeconomic brackets are more likely to engage in risky health behaviors, such as smoking, substance abuse, obesity, and lack of physical exercise, which can transition into the development of depressive, eating, and substance abuse disorders (Avison et al., 2012: 51). The prominent and continued impact of socioeconomic stress on women is significant in

understanding the disposition women face when developing and coping with psychological threats.

IV. COVID-19 Pandemic and Economic Crises

In times of political and economic hardships and great uncertainty, women experience the greatest threats to their mental health. The COVID-19 pandemic is a current and prominent example of the effects of economic hardship on partners and women independently. The pandemic put excessive stress on the backs of women who had to bear the heavier load of childcare (Zamarro et al., 2021). Not only do times of economic stress present financial issues, but they also bring health and social issues as well (Del Boca et al., 2020). Stay at home orders and health mandates have made it near impossible for grandparents and other family members to help with childcare responsibilities (Zamarro et al., 2021). Health mandates have downloaded further burden onto the backs of women who may have already been struggling with mental health and socioeconomic issues prior to the presence of the pandemic (Del Boca et al., 2020).

The culmination of stressors has impacted women's ability to cope with their mental health but also to cope with their children's perceived state of health as well (Sevilla et al., 2020). The significant shock on the demand for remote and isolated childcare decreased women's ability to participate in the workforce and increased susceptibility to depressive and substance abuse disorders that are not nearly as prevalent in male populations and partners (Sevilla et al., 2020). To summarize, the COVID-19 pandemic identified and widened gender differences in a variety of social, health, and economic spheres that adversely impacts female mental health outcomes. With the presence of the pandemic nearing an end, there is no doubt that the gender gap of mental health has been disproportionately impacted to disadvantage and hinder women's psychological experiences. The question of whether or not this can be reversed is one without a

favorable answer, female mental health issues are often more than certain to arise at times of great financial and health-related stress wherein women not only fear for their own futures but also burden themselves with the fear of their spouses, children, and loved one's futures as well.

V. Socioeconomic Issues

One of the most prominent explanations of gendered mental health differences is socioeconomic related issues. Socioeconomic issues tend to encompass a variety of dimensions, such as financial status, income and employment, job quality, housing access, and healthcare access. Such issues impact mental health experiences and outcomes. Women are especially susceptible to mental health difficulties as they often suffer from higher rates of poverty and financial issues (Mirowsky, 1996). Women in this position do not often possess the means to afford and access adequate healthcare options to cope with psychological issues, which is a plausible explanation as to why women's psychological issues advance more dangerously as age increases than men's (McDonough et al., 2008). Utilizing a life course theory approach, there are noticeable issues present that once female populations fall victim to mental health issues because of poverty and economic difficulties, the likelihood of psychological illness advancing as age increases is significantly likely as their living and economic conditions are expected to worsen alongside (Afifi, 2007). If female mental health does improve, the damage is done, as health issues become chronic and represent a cumulative disadvantage.

Women who work for pay also experience socioeconomic forms of violence that contribute to poor mental health states. Longer hours worked, financial hardships, wage disparities, sexual harassment, and difficulties in advancing are some of the most common issues women experience in employment sectors (Etheridge et al., 2022). Women experience greater

instances of job loss and insecurity which leads to financial hardships, that more often become chronic in nature and difficult to recover from (Hwang et al., 2023).

The scope of this explanation aims to understand how women in various socioeconomic fields and spaces fall victim to similar mental health conditions and outcomes because of their lived experiences. Life course theory is highly applicable to the gender gap and mental health approach as it relates to the focus of socioeconomic and financial aspects that are chronic and generationally present in women due to an abundance of psychological, economic, and social stressors present (Avison, 2012). These stressors can be chronic in nature and long lasting, as they are often linked to additional stressors like financial difficulties and low job security which can be detrimental to health. Women in lower socioeconomic brackets are more likely to engage in risky health behaviors, such as smoking, substance abuse, obesity, and lack of physical exercise, to cope with psychological health issues which can lead the development of depressive, eating, and substance abuse disorders (Avison et al., 2012). Income and economic issues also prevent many women from accessing intervention and mental healthcare services. These issues are further exacerbated for single mothers who depend on their individual wage to support their households and do not possess additional means to pay for psychological health services. Financial and socioeconomic stressors often linger for women and become a longstanding battle that contributes to their psychological health issues, they are not exclusive to poorer women but are noticeably more prominent and potent in lower economic populations.

VI. Violence

This final explanation addresses the various forms of violence and inequalities women endure that culminate in their poor mental health experiences. Violence can exist in intimate, social, and financial ways that may overlap with one another in occurrence and severity. Most commonly,

women are more prone than their male counterparts to experiencing intimate partner violence, which most commonly exists as physical, emotional, and financial violence (Coker et al., 2002). While men and women experience psychological violence and symptoms from intimate partner violence, the effects and outcomes are often more severe and prominent for female victims (Coker et al., 2002). Women, in such instances, are at increased risk of poor long term overall health and have a high propensity to develop severe substance and alcohol abuse disorders (Rosenfield et al., 2010). Men are often perpetrators of such violence on women, which is made even worse for women if children are involved (Roberts et al., 1998). Intimate partner violence subject's women to immense stress, which predisposes female populations to experience depression, post-traumatic stress disorder, drug dependence, and alcohol abuse (Roberts et al., 1998). Additionally, individuals outside of the gender binary experience elevated levels of partner related and social violence that impacts their lived psychological experiences for the worse (Harnois et al., 2018). Female and 2SLGBTQIA+ individuals are populations of individuals who share similar likelihood rates of proneness and encounters with partner-related violence which is not only a psychological issue but one that is also a social and economic issue as those who fall victim to partner related violence often do not possess the ability or means to flee their situation or seek healthcare services to assist with their psychological and physical care.

Furthermore, women also experience employment and financial-related violence that stem from their opportunities in the workforce, such perception of violence can aid in the onset of mental illness (Harnois et al., 2018). In times of economic decline and higher un-and under-employment, women are at significant risk to financial violence. For example, the COVID-19 pandemic heavily impacted female-dominated work sectors, which saw more women than men

losing jobs entirely or having a drastic reduction in paid hours and earned wages (Zamarro et al., 2021). Women who are unable to provide themselves, and their dependents, with necessities derived from wage earning increases the presence and morbidity of psychological events. Additionally, women experience sexism and sexual harassment in the workplace at significantly higher rates than men. Psychological distress among women increases significantly when women perceive sexist events within work environments (Harnois et al., 2018). Perceptions of gender discrimination, sexual harassment, and other forms of employment-related violence adversely affect multiple dimensions of women's health (Harnois et al., 2018).

Significance of the Gender Gap in Mental Health

The presence of various psychological, social, cultural, and economic stressors provides a significant explanation into understanding the various experiences of women that culminate in an overall poor psychological experience. Health seeking behaviors are powerful indicators of gender differences in mental health studies, women being more likely to internalize their psychological struggles is a pattern associated with women's lack of comfort and confidence in seeking healthcare services (Afifi, 2007). The significance of studying the gender gap in mental health is to not only acknowledge the psychological and psychopathological differences between men and women, but to also examine ways to improve women's access to appropriate and affordable healthcare services that are equipped to assist their psychological needs.

I. Improvements to Healthcare

Historically, women's healthcare has been heavily focused on reproduction, which not only isolates women outside of reproductive ages, but also limits the range of healthcare issues that need to be addressed in women, such as breast cancer and psychological issues. Women who engage with mental healthcare services may feel that the confidentiality of their information and

diagnoses they receive in medical spaces is not appropriate nor adequate to their psychological needs (Afifi, 2007; see also Bentley, 2007). The significance of the gender gap and mental health relationship in this realm is that women require trained medical personnel able to confidently diagnose and assist with female psychological issues, as many doctors and psychiatrists often incorrectly attribute certain symptoms to other illnesses or issues and rely on the intervention of medication (Afifi, 2007). Additionally, Women's higher rates of mental and physical morbidity are reason to investigate and reform current health policies to be in line with the needs of women, especially in lower income or developing countries where there is low confidence that current healthcare services are thorough enough to assist with psychological issues (Afifi, 2007).

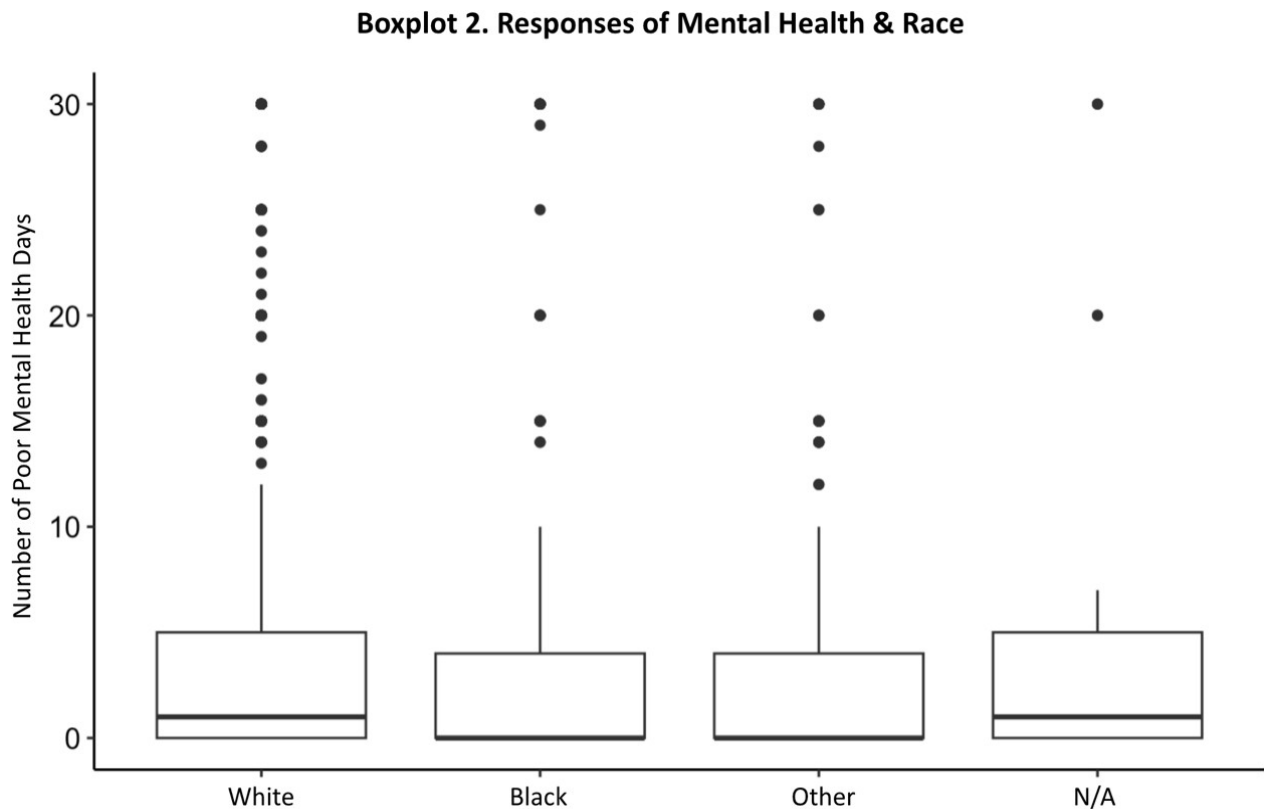
II. Motherhood Experience

The experience of motherhood, as discussed earlier in this chapter, is one that may not be a rewarding experience for women, which is impacted by the number of children, ages of children, and the presence of a spouse (McBride, 1990). It is a series of physically and mentally taxing experiences that essentially forces women into taking on the responsibilities of multiple roles, which creates role stress and psychological fatigue (Etheridge et al., 2022). The discussion I presented earlier helps to establish concern to the study of the gender gap and mental health relationship; women's household spaces and the role of motherhood must be one that is more positive and rewarding to mothers and female caregivers (McBride, 1990). Due to women encountering role strain through mothering responsibilities, there is an increased susceptibility to mental illnesses; especially ones pertaining to alcohol and substance abuse disorders. The restructuring of family dynamics between a marital couple is one that can provide new opportunity for both partners to experience an appropriate balance of professional and personal

responsibilities. The traditional nuclear model of roles and caregiving are ones that do not benefit women in the long term and need to be addressed to aid with the gender gap in mental health.

II. Race

My second social determinant of mental health is race. The component of race is one that is vital in shaping one's mental health experiences as it can impact employment, education, marriage, household labor, social trust and support systems, and other aspects of life. The General Social Survey 2022 primarily addresses white and black respondents, which is in line with much of the



current literature on racialized gaps in mental health. ‘*Boxplot 2: Responses of Mental Health & Race*’ shows the distribution of race responses together with responses of poor mental health in the past 30 days. Within boxplot 2, mental health response distribution is shown for White individuals, Black individuals, Other, and a separate plot for ‘non-Applicable’ responses that

were dropped but still indicate mental health responses. As noted within boxplot 2, white responses average a higher mean of poor mental health in the previous 30 days than any other racial category surveyed. The data produced here is in line with current literature and projected results that centralize white populations and demographics as representing a paradoxical shift in mental health research, wherein minority and racialized populations were originally believed to possess some of the poorest mental health states, as they endure and show some of the most significant negative mental health reports and patterns across race and ethnicity studies. The elevated levels of mental health issues present within white populations, which will be discussed throughout this chapter, are representative of a wide range of psychological issues, barriers, and stressors that are either exclusively or more prominently present in lives of white individuals than some other racialized and minority populations. The elevated responses addressing higher poor daily mental health instances across a 30-day span indicates that white mental health issues may not only be more potent, but also more chronic and lingering in nature that are particularly interesting to examine through my intersectional life course perspective.

For the purposes of this research, I incorporate various racial groups and classifications. I do situate an emphasis on Black and White populations as the paradoxical mental health gaps present between these two groups significantly support my research. However, I also include Asian, Hispanic, and non-Hispanic populations to situate additional racial differences to develop an understanding of how other racialized groups experience mental health. Race is often a self-reported measure, especially among GSS 2022 data collected in the United States where individuals are asked to select a racial category that they self-identify with. Self-reported measures are mostly administered through interview and survey-based data collection methods.

Additionally, mental health is most often measured through survey data or by medical testing and interviews. Both are indicative of alarming issues and trends that can occur in specific populations and demographics of interest. My review encompasses research that pertains to both self-identified states of mental distress and medically tested instances of psychological distress and illness. I also utilize research pertaining, but not limited, to depressive, anxiety, trauma-based, eating, and substance abuse disorders which highlights different rates and instances of psychopathology in diverse racial groups and demographics. The presence of specific disorders may be of interest to life course theorists due to the prolonged and worsening nature of physical and mental health as age increases.

The Black-White Paradox

I first draw attention to the Black-White paradox and its development through current research as it upholds the issues white populations face towards their mental health. As I examine the relationship between race and mental health, I look to challenge the idea of whiteness that is affiliated with status and privilege wherein white individuals are the finest most successful members of society. Current literature surrounding the black-white paradox present support for the statement above and my research questions where I seek to understand the challenges and obstacles that white individuals fall victim to when experiencing and coping with mental illness, while black populations seemingly have better success with mental health coping ability and lower report rates of such illnesses (Keyes, 2009; Thomeer et al., 2023; Upenieks et al., 2022).

The Black-White paradox of mental health is the examination of visible-minority mental health reports being significantly more positive than white individuals across a large spectrum of common mental illnesses. The paradox begins to explain how community engagement, strong family relationships, and religious membership help to aid in strong mental health reports among

minority populations (Louie et al., 2021). Although minority status individuals generally have greater exposure to financial, social, and political stressors; their mental health reports are still more positive than compared to white individuals. This then presents a new and relatively unresearched sociological trend in which diverse and minority populations are coping most effectively with their mental health even throughout discrimination and social inequality (Keyes, 2009), while white individuals, specifically young women, continue to report the greatest mental hardships as they continue to internalize their mental struggles and fail to seek social and medical support. White individuals, especially women, do not have as expansive and engaging relationships or social support systems as Black groups do (Upenieks et al., 2022). White women internalize their mental struggles and often do not externalize their symptoms or need for support, they do not possess the same levels of healthy social behaviors and support systems that Black groups do. Black individuals are more likely to turn to religious and community outlets for assistance (Mouzon, 2017). Women however, across all racial demographics, continue to report the poorest mental health. The Black-White mental health difference is most pronounced among younger age demographics, making the paradox more dependent on age group and gender than any other additional factors (Thomas-Tobin et al., 2020). Considering the influence of life course theory thus far, age seems to be an indicator for mental health processes wherein if psychological issues become present in younger stages of adult development, and potentially go untreated or unaddressed, they can spiral into worsened mental health issues that can create additional health risks and issues.

White Health Issues

I now focus on the examination of the white experience of mental health, and the various issues white populations are exposed to. Within the paradox itself, white individuals are often noted to

experience higher psychiatric rates than compared to Hispanic, Asian, and Black adults (Thomeer et al., 2023). A wider range of psychological illness are more likely to affect white populations, specifically women (Erving et al., 2018). White individuals are more susceptible to education and employment related stressors than nearly any other racialized groups. For example, white individuals are more likely to complete a 4-year bachelor's degree than Blacks and develop substantial mental health issues during the process (Eller et al., 2018).

White individuals are often prescribed medications more commonly than black individuals (Louie et al., 2021), as they have the best access to mental healthcare and health insurance; health policy is often in favor of whites allowing for minimal financial barriers towards healthcare services (Lê Cook et al., 2016). For example, the racial gap is even wider in the United Kingdom, as white individuals are less likely to access mental healthcare due to the perception that the medical professionals administering such services are not qualified and in touch with the actual experiences of their community (King, 2019). There is a common concern in many racialized groups, especially within white groups, that psychological services and the medical professionals who provide these services may provide a misdiagnosis, improper service, or have lower confidence in mental healthcare services that they do not adequately cater to the needs of the community in which they are set to serve.

Black, and Diverse, Health Issues

Although my focus is on the white female experience of mental health, the Black mental health experience is one that cannot be overlooked as its acknowledgement reinforces the focus of my research. While multiple explanations have been proposed for the Black-White paradox, there are still some additional findings that are mixed and inconclusive. While some studies have identified Blacks have higher levels of physiological distress than whites (Barnes et al., 2017,

and that Blacks experience higher levels of traumatic stress exposure (Louie et al., 2019); the Black-White paradox maintains even in the face of changing social and economic conditions (LaMotte, 2022). While Black populations have overall better mental health than white populations, there is a notable concerning trend in Black physical health that presents shortened life expectancies than compared to white populations, which is heavily attributed to decades of inequality and discrimination (Keyes, 2009). Minority mental health has improved and evolved over decades of racially charged stressors that help to explain the psychological resilience identified in Black populations (Do et al., 2020). Additionally, black populations show remarkable results when studied alongside white individuals for chronic mental illness. For example, Assari et al (2015) found that the higher number of chronic medical conditions, at baseline, predicted greater increases in depressive symptomology over 25 years for White populations, but not within Black populations. Such conclusive findings not only support the Black-White paradox, but also reinforce it. The multiple dimensions of health highlight black resilience within mental health, and their downfall within physical health. Different findings across studies and research may be due to the approach taken by the researcher or towards the research topic, I acknowledge that the support for the strength of minority mental health, and the challenges of white mental health, has been commonly present in most of the literature used to support my research. Although black physiological health remains a cause for concern, their mental health improvements and resilience is attributed to their strength in the face of adversity and racism.

The Black-White Racialized Gap in Mental Health

In this section, I review the various explanation for the race gap and mental health relationship (see also Table 2). While many explanations have been proposed, focusing primarily on mental

health outcomes due to socioeconomic issues, there is growing evidence that additional components of the racialized gap are also due to self-esteem differences, familial relationships, and religion and spirituality. Additionally, I bring in research among Asian and Hispanic individuals to account for a greater understanding of how far the paradox of mental health extends and what it means for minority populations in comparison to white populations. In what follows, I provide a brief discussion on explanations that focus on the additional components of the race gap in mental health. Towards the end of this section, I explain the impact and significance of the racialized mental health gap, including research and literature on additional minorities, to understand the larger scope and occurrences of paradoxical mental health experiences and outcomes.

I. Religious & Spirituality

Many scholars and researchers suggest that the role of religion and spirituality help to explain the racial differences in the Black-White paradox of mental health. Religious involvement helps with the maintenance and formation of significant high-quality social relationships that are closely linked to beneficial mental health outcomes (Mouzon, 2017). Relationships aid in self-esteem, self-perception, and community engagement which benefit one's ability to perceive and cope with one's mental health issues (Upenieks et al., 2022). Within the Black-White paradox and the role of religion and spirituality, there is an apparent association between religiosity and health. This association accounts for the higher levels of healthy behavior, social support and integration, personality development, self-esteem, and positive coping among those who regularly practice religion and engage in religious celebration (Mouzon, 2017). Considering that religion is more widely adopted and practiced within Black populations than whites (Upenieks et al., 2022), it is unsurprising to note the more positive relationships, coping resources, and mental

health outcomes among Black populations experience (Upenieks et al., 2022). While previous research on the paradox often overlook religion entirely, the multiple dimensions of religion and spirituality help to understand the paradox in new ways.

II. Self-Esteem

Self-esteem is a significant component of the reinforcement and maintenance of the paradox, even in times of great economic hardships. Black populations experience an overall better state of mental health compared to white populations (Louie et al., 2019), which is largely attributed to black self-esteem and resilience. Self-esteem is one of the most effective coping methods noted in mental health research as it reinforces strong social bonds and community integration (Thomeer et al., 2023), which is necessary for racially diverse groups to create and maintain significant relationships outside of the household. Even when experiencing barriers in accessing mental healthcare services, marginalized groups, especially Black groups, find solace in themselves and the communities they have helped to foster around them thus creating more positive experiences and perceptions of their mental state. Despite the perception and presence of racially motivated stressors, Black populations can effectively cope with mental illness through the various resources they have accumulated because of high levels of self-esteem. These resources encompass strong community engagement, religious participation, and reaffirming the power they occupy as a racialized group (Thomeer et al., 2023). Within literature on black self-esteem and resilience, there appears to be a cyclical affect wherein processes, such as relationships and religiosity, create more positive mental states in Black individuals which then reinforces them to continue to participate in community engagements which then again allows for significant relationships and practices to be maintained and continue to have beneficial impacts on mental health.

White populations often lack the self-esteem of their Black counterparts as white groups have not had to endure the same challenges and issues faced by racially diverse communities. White groups have not had nearly as many challenges placed upon their social locations as racialized groups have and, as a result, experience poor outcomes and perceptions of mental health as they do not engage as meaningfully with themselves, and their surrounding communities as Black groups do. Even with severe economic and social issues present, the paradox is maintained due to the presence of Black self-esteem and resilience.

III. Family

Familial relationships and dynamics are a consistent and integral component of understanding black mental health. Through literature on the Black-White paradox, family has been a significant mechanism associated with positive black mental health. Stronger black family networks and dynamics have been developed over decades of racism and employment difficulties that now account for improved mental health outcomes for Black groups, while white families often benefited from nuclear models and employment and did not have to restructure family dynamics and roles, as much, as Black communities did (Mouzon, 2013). Over decades, black families have experienced varying hardships and inequalities that challenged their ability to cope with mental health issues and economically survive (Keyes, 2009). Black families have often relied on intergenerational care networks, mostly through extended family and neighbors, for the purposes of raising children while black adults sought out higher education and employment (Keyes, 2009). This type of bond is passed on generationally and creates a stronger family dynamic, strengthened further in the face of physical or mental illness (Mouzon, 2013). White populations do not experience the same racially based discrimination Black populations do and, because of this, have not been forced to reorganize family structures (Keyes, 2009).

Through strong family networks, established over decades of racism and hardship, Black populations are coping with their mental illness in better ways than white populations, even flourishing in the face of adversity (Keyes, 2009). Family networks and dynamics are one of the most promising mechanisms that explain the Black-White paradox of mental health, the establishment of such significant relationships also translate into the ability for Black populations to have better community engagement, religious participation, and maintain external social relationships outside the family (Mouzon, 2013).

There is additional support for such findings when Asian and Hispanic groups are brought into the discussion of the race gap in mental health. Hispanic groups experience different familial issues than whites, in the form of high divorce and separation rates, but still experience mental health issues and disadvantages, similarly to whites (Lê Cook et al., 2016). Moreover, Asian groups replicate the resilience of black individuals and experience positive mental health experiences because of family dynamics and adaptation in the time of discrimination. Studies on Asian groups reveal there is an intergenerational transmission of valuing education, thus leading to intelligent and highly successful Asian individuals who attribute their success to positive parental influence (Lê Cook et al., 2016) Through positive experience, more beneficial mental health outcomes among Asian populations, due to values passed along from family, are common.

Why the Race Gap in Mental Health Matters & What to Do

The racialized gap in mental health represents the various disadvantages that white populations experience because of their inability to cope through the utilization of effective mechanisms often adapted by racialized minorities, these include restructured family dynamics, establishment of social systems and relationships, religious and spiritual practices, and community commitments. White populations need to adequately adapt to the mental health challenges that

affect them to find new means to effectively cope. There also needs to be additional policy and procedure reform to better deliver services that appropriately address the needs of the community. I present a brief overview of health perceptions and social support systems and argue for further research and improvements to explore the realm of white mental health, and mental health as a whole.

I. Healthcare Perceptions

Understanding how communities perceive mental healthcare and the professionals who administer such services is proportionate to how and how often individuals utilize such services. The significance of understanding which racialized groups are most psychologically at risk can help to reform healthcare policies and barriers to better serve underrepresented and vulnerable groups. Considering the overwhelming rates at which white individuals experience chronic psychological illness indicates that mental health services and professionals need to be appropriately tailored to the communities they service (King, 2019). Additionally, because white populations are statistically most likely to be able to afford and access mental healthcare, they are at elevated risk of misdiagnoses and being prescribed psychopharmaceuticals (Louie et al., 2021). This indicates white individuals do not have the social relationships and resources to cope with mental illness, and instead turn to the usage of healthcare intervention, which may not be perceived to be effective or reliable thus contributing to the mental health of white groups worsening. Reforming policies and barriers, through sociological research and study, can address the needs of susceptible groups and encourage other racialized groups to turn to medical assistance if necessary. Although Black mental health is resilient and evolving, elevating accessibility and affordability of healthcare services to assist lower income and socioeconomic individuals, such as Black and Hispanic groups, allows for racialized minorities to receive care

that is appropriate to their mental health issues and further increase the resilience of minority mental health (Louie et al., 2021).

Additionally, specific healthcare services are needed to benefit those who suffer from mental illness because of physical illness. The life course literature on racialized mental health gaps indicate that the morbidity of physical illness increases with age in both Black and White populations (Do et al., 2020). Therefore, further research and healthcare infrastructure is required urgently to assist individuals whose mental health stems from other health issues. If physical afflictions worsen, mental health states can worsen and therefore widen the gap of various racial and gendered mental health issues.

II. Social Support

White individuals may struggle across the social spectrum to engage meaningfully in social relationships, religious practice, and family. Racial paradoxes in mental health are commonly attributed to racial minority populations often relying on familial and interpersonal relationships as a means of coping with mental health. Minority populations have strong generational ties within their family and significant community relationships that have historically aided with child raising and household responsibilities as parents and older family members engaged in the workforce to provide livable wages. Through such dynamics, minority groups have formed strong relationships among generations of family, with community members, which is strengthened through religious practice (Upenieks, 2022). White individuals have, historically speaking, not experienced significant hardships through discrimination as other minority groups. Therefore, white populations have not been forced or influenced to change their family dynamics as other minority populations have. The resilience and evolution of minority mental health is a testament to overcoming such historical challenges (Louie et al., 2019). The lack of social

support within white groups may be a result of the lack of hardships they have had to endure, such hardships that are present for racialized communities allowed those groups to find additional support systems to adapt and cope with changing social and political climates. The significance of the racial gap in mental health is that the history of stress and adversity minority groups face would seemingly impact their mental health in negative ways. However due to a range of social support and outreach opportunities, minority groups, especially Black populations, are flourishing in the face of racism and discrimination (Keyes, 2009). White populations can benefit from the ability of strong social support networks as a means of coping with more common mental illnesses. While white populations can, for the most part, easily access and afford mental health care resources (Erving et al., 2018). It seems white individuals experience the most struggle with common mental health disorders, such as depression or trauma-related illness, which can benefit from coping skills established through social relationships and community engagement, as displayed within Black populations. Understanding the racial gaps within the study of mental health help to understand the disadvantages white individuals experience, and to create spaces where white individuals can engage meaningfully as a hopeful means of coping with mental illness more effectively.

Stress Process Theory

With the weight of gender and race being significant social determinants of mental health, it is critical to recognize stress process theory as it relates to the understanding and development of my research. Stress process theory introduces important ideas and fundamentals that help to introduce my intersectional life course approach as I examine the poorer mental health states and experiences of white women in the United States. Stress process theory proposes that chronic

stress inhibits an individual's self-efficacy and ability to cope, which puts that person at significant risk in developing subsequent negative health outcomes. It is most common that intense episodes of depression are noted for those high-risk individuals, including mothers and female caregivers (Hish et al., 2019). The application in introducing stress process theory helps to situate aspects of the white female experience to be examined through an intersectional life course perspective. Throughout my literature review and initial data analysis thus far, white women in the United States often frequent the roles of mother, wife, and caregiver simultaneously which can put them at high risk of developing mental health issues and experiencing additional symptoms of psychological illness.

The process itself discusses how certain stressors can influence the course of physical and mental health. The stress process model encompasses three primary components that can be utilized to better understand white female mental health experiences. Sources (such as chronic life events surrounding caregiving and marriage), outcomes (poor mental and physical health among white women), and mediators (lack of social support systems and coping mechanisms) uphold the integration of social process theory in my analysis of white female mental health (Hish et al., 2019). This process highlights the dangers of ongoing and chronic stress and stressors that can result in negative physical and mental health outcomes, as these stressors can produce cumulative health disadvantages that inhibit the individual from addressing them appropriately and subsequently further impact physical and mental health. White women experience various stressors, such as patriarchal gender roles through employment and marriage, that result in negative mental health experiences. Degree of stress and coping issues play a significant role in the development of stress and mental health issues (Karademas et al., 2004), as those with more intense stress and stressors often lack appropriate mediation through coping

means and therefore experience additional symptomology. Stress exists in various forms and may not necessarily be harmful to an individual, it is when the stress is chronic and compounding that it produces negative health risks and behaviors because of burnout and depression (Hish et al., 2019).

Self-efficacy, wherein an individual's belief in their ability to execute behaviors to produce personal goals and attainments, is at the heart of stress process theory as it enhances personal well-being and ability to regulate and cope with stressors (Karademas et al., 2004). Low self-efficacy may be common among white women as they employ emotional coping strategies, such as denial and self-blame, and produce symptoms of high anxiety, depression, psychosomatic issues, and additional health issues (Bandura et al, 1997). High self-efficacy seems to be more common among male demographics and black populations as they not only have better health outcomes, but also exhibit health enhancing and health protecting behaviors which accounts for improved mental health outcomes and experiences.

Outcomes of stress vary in intensity and prevalence. White women, in the United States, who experience mental health issues commonly experience such issues because of emotional or physical exhaustion, reduced personal accomplishment, decreased efficiency, or cynicism (Maslach et al., 2006). Stress can often become prolonged and unresolved as it begins to take significant tolls on mental and physical health (Hish et al., 2019). This process helps to provide an understanding as to why poorer experiences and states of mental health are common among white women in the United States. As these women experience stress, depression, and additional mental challenges, they accumulate and become increasingly harmful and irreversible thus rendering this population vulnerable to additional health related issues.

The importance of stress process theory here is to introduce the chronic nature of white female mental health issues that will be examined through my intersectional life course perspective to understand how variables of gender and race, and additional characteristics, can produce chronic issues and stress that result in poorer mental health experiences. Stress process theory also helps to address and recognize existing issues among white women and the identification of chronic stressors that produce negative health outcomes and additional health risks.

Literature Review Table 2. An Overview of Gender & Mental Health Research

Author(s)	Field and Year	Mental Health Measurement / Focus	Gender Gap Significance & Explanation	Key Findings
Afifi	Health Psychology (2007)	Focus on depressive, anxiety, and eating disorders & schizophrenia	Significant Gap – Health seeking behaviors are powerful differences in mental health problems	Looking through a gendered lens helps to improve women’s access, affordability, and appropriateness to health services by targeting such services for women and their medical issues
Astbury	Health Sociology (2001)	Focus on depressive, anxiety, and psychosomatic disorders.	Significant Gap – Gender roles further increase susceptibility by stressing passivity, submission and dependence	Women have duties imposed on them to take on the unremitting care of others and unpaid domestic and agricultural labor Globalization has overseen a dramatic widening of inequality within and between countries including gender-based income disparities
Avison et al.	Sociology (2012)	Focuses on psychological distress and psychiatric illness but discusses depressive and eating disorders as common female mental	Significant Gap – Socioeconomic stress is especially detrimental to women; lower income countries are not equipped to help with mental health	Stressors are more chronic and longstanding for women, suscept them to more disruptive and aggressive mental health issues that increase in intensity

		health issues.	<p>Issues</p> <p>Increased susceptibility to poverty, lack of job and housing security, lack of financial security, and fear</p>	<p>Poor living conditions directly impact female mental health</p> <p>Wide range of mental illnesses are especially present in female populations (exaggerated by lower income as well)</p> <p>Indicates the susceptibility women may face because of being placed on medication that can evolve into dependency and active addiction.</p> <p>Rise in psychiatric diagnoses is especially prevalent among women, with an emphasis on younger women both seeking and requiring mental health care interventions and services at higher rates than older female demographics</p> <p>Vulnerability of younger women is 18 -29 years of age</p>
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Coker et al.	Medical Science (2002)	Self-reported – Focuses on mental health issues as a result of physical, sexual, and/or psychological abuse, refers to PTSD most commonly	Minor Gap – For both men and women, physical IPV victimization was associated with increased risk of current poor health; depressive symptoms; substance use; and developing a chronic disease, chronic mental illness, and injury.	Both physical and psychological IPV are associated with significant physical and mental health consequences for both male and female victims.
Del Boca et al.	Economics and Sociology (2020)	Self-reported – Focuses on female stress and depressive disorders as a response to the overload of household work	Minor Gap – Mandates and COVID-19 pandemic provisions impacted ability to work and provide care for children and elderly	Women downloaded with a larger childcaring responsibility with little-to-no help from extended family and spouses, pandemic presented additional social and economic stressors that impacts women’s mental health
Etheridge et al.	Psychology (2022)	Self-reported – Focuses on general and subjective health experiences to encompass physical and mental health states	Significant Gap – Economic impacts, ie. Hours worked or facing financial difficulties, is the primary explanation for gender gap differences in mental health. Type of work also contributes	Identifies paradox in declining female mental health, which is contrasted by the increasing female success in economic and social spheres. Type of employment may narrow the gender gap

			Physically demanding work may contribute to additional health risks	
Gove et al.	Gender and Sexuality Studies (1977)	Focuses on psychiatric illnesses and symptomology	Significant Gap – Different roles occupied by married men and women impact psychiatric illness	Effects of employment, number of children, and age of youngest/oldest child explain sex role differences in mental health outcomes
Gyasi et al.	Sociology (2019)	Interviewed based self-reported measures – Focuses on health-seeking behaviors	Significant Gap – Marital status and income contribute to explaining gender differences in use of health services, especially in later life.	Mental health service disparities vary by marital and socioeconomic status. And are especially low for women in low- and middle-income countries Married women were less likely to use mental healthcare services than men
Harnois et al.	Sociology (2018)	Self-reported – Focuses on relationship between physical and mental health	Significant Gap – Women perceive sexist events more often than men, within work environments, that increases psychological	Perceptions of gender discrimination, sexual harassment, and other forms workplace mistreatment adversely affect

			distress	multiple dimensions of women's health
Helmer et al.	Medical Psychology (2009)	Self-reported – Focuses on mental health because of pain	No Gap – Address link between pain and mental health on daily functionality	Pain and mental health concerns must be addressed explicitly.
Hwang et al.	Public Health Studies (2023)	Diagnostic Interviews – Focus on depressive and stress disorders as they relate to fears and perceptions of physical illness	Significant – Women's mental health has been more impacted by the COVID-19 pandemic than men's, due to a variety of social and economic components	Job loss, financial hardships, and reorganization of household roles have been concentrated on women during the pandemic resulting in greater experiences of psychological distress than men Paradoxical shift as men have previously had their mental health more impacted by economic recessions and hardships than women
Kessler et al.	Sociology (1982)	Self-reported – Marital stress and women's psychological symptomology	Significant – Gendered attitudes and perceptions of child raising and seeking employment differ between married men and women	Children and child raising has left effect on father's mental health, married women's mental health more influenced by child raising as they move into the labor market
Lennon et al.	Health and	Diagnostic	Significant –	High familial

	Behavioral Studies (1992)	Interviews – Measured psychological distress on symptom scales to examine the presence of depression	Differentiation in gendered responsibilities	demands and low control in employment contribute to elevated symptoms in women
McBride	Nursing Studies (1990)	Focuses on gender-role stress in women and how they are of high risk to mental illness	Significant – Motherhood is an institution that needs to be more positive for women, than detrimental	Women encounter role strain when trying to balance and occupy multiple roles at once, role strain increases reliance on and abuse of alcohol and substances
McDonough et al.	Sexuality Studies (2008)	Self-Reported – Focuses on a life course approach in examining the prevalence of stress and anxiety symptoms as age increases.	Significant – Women report and experience more psychological distress than men, and the gender gap of mental illness widens with age	Chronic stress experiences increase with age Women are more vulnerable to the effects of chronic stress on distress with age
Mirowsky	Psychology (1996)	Self-reported – Examines gendered mental health differences through a life course perspective	Significant – Women face a greater series of difficulties than men as they carry a greater burden of total housework and paid work hours, pay greater “costs of caring” for the problems of family, children, and friends, face	The gender gap in depression remains one of the oldest and most robust findings of mental health surveys, much of the gender gap exists because women experience greater trade-offs and tensions from both work and family than men do

			substantial constraints on personal employment and advancing opportunities, and experience greater difficulty with autonomy, authority, recognition, and pay when employed	
Okasha	Psychiatry (2005)	Focuses on psychiatric illnesses present more commonly in lower income individuals	Significant – Government funding cuts towards mental healthcare services and research	Lower income/poverty associated with declining female mental health outcomes on a global scale, opportunity for women to get ahead is nearly impossible based on certain social, economic, and cultural conditions
Pattyn et al.	Psychiatry (2015)	Diagnostic Interviewing and Biological Measurements – Focuses on depressive and schizophrenic symptom	Significant – No differentiation in rates of psychopathology, but men and women experience different types of mental health issues	Significant gender gap in mental health service use; men seek mental healthcare services and visit medical professionals less than women due to the socially structured norms surrounding maleness and masculinity, which can also be reinforced by women

Roberts et al.	Psychology (1998)	Biological Measurements (EEG Brainwave Monitoring) – Focuses on lifetime psychiatric illnesses that are associated with abuse.	Significant – Men are significantly less likely to experience partner related abuse than women	Effects of physical, emotional and sexual abuse by intimate partners on women’s mental health is overwhelmingly perpetrated by men, double abuse of child and adult further impacts women’s mental health. Due to such stress, women are more likely to develop and experience depression, PTSD, dysthymia, phobias, drug dependence, and alcohol abuse
Rosenfield et al.	Psychology (2010)	Focuses on the developmental experience of men and women and the influence of development on variations in psychopathology	No Gap – Women suffer from higher rates of depression and anxiety (referred to as internalizing disorders), and men have higher rates of substance abuse and antisocial disorders (referred to as externalizing disorders)	No differences in their overall rates of psychopathology, but men and women do differ in the type of psychopathology experienced
Sevilla et al.	Economics (2020)	Self-reported – Focuses on depressive symptomology in	Significant – Pandemic identified and widened gender	Significant surge in female depressive and substance abuse disorders

		pre- and post-COVID-19 life	differences in social, health, and economic spheres that negatively impacts female mental health	<p>which is attributed to the shock of at home childcare demands.</p> <p>Women unable to actively participate in the workforce compared to male partners</p>
Swinkels et al.	Gerontology (2017)	Self-reported on a couple's basis – Focuses on couples mental and physical health states associated with caregiving responsibilities.	Significant – Gender differences between partner caregivers are primarily due to primary stressors, help from others, hours of caregiving, and secondary stressors and how strong these effects are	<p>Women experience greater caregiving burden than their male partners due to the abundance of secondary stressors; relationship issues, financial problems, and problems with multitasking.</p> <p>Women's burdened experiences contributes to the development of chronic and longstanding mental illnesses and depressive episodes</p>
Van De Velde et al.	Social Science and Medicine (2010)	Self-reported – Depression and stress disorders in relationship to heteronormative gender roles	Significant – Biological, psychological, and social factors best account for mental health variations and the gender gap	<p>Depressive disorders are twice as common in female populations (in clinical and general population samples)</p> <p>Childcare, employment, and marriage are cause for concern in assessing the gender gap of</p>

				depression
Zamarro et al.	Economics (2021)	Self-reported – Stress and depressive disorders in relationship to employment and perceived health risks	Significant – Childcare has put strain on both working parents however, mothers have continued to carry a heavier load on the provision of childcare during this COVID-19 crisis than fathers	<p>Pandemic heavily impacted female-dominated work sectors, which laid off women more than men</p> <p>Childcare needs soared during pandemic, resulting in women taking on that responsibility.</p> <p>Stay at home orders and health mandates have made it near impossible for grandparents and other family members to help with childcare responsibilities</p>

Literature Review Table 3. An Overview of Race & Mental Health Research

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
Assari et al.	Sociology (2015)	Significant Gap - White individuals are more susceptible to long term psychological illness	Increased access and affordability to both medical and mental healthcare, especially as age increases wherein physical and mental health states rapidly decline	Higher number of chronic medical conditions at baseline predicted a greater increase in depressive symptoms over 25 years of follow-up within White populations but not Blacks
Barnes et al.	Social Psychiatry and Psychiatric Epidemiology (2017)	Mixed Gap - Double paradox within epidemiological review and study	Further research is needed on psychiatric differences between White and Black populations to understand how to address the paradox, authors propose that what has been explained and researched thus far is artificial	<ol style="list-style-type: none"> 1. Blacks have less prevalence for major depressive disorders than whites 2. Second paradox which is not as heavily documented or studied that identified higher levels of physiological distress in Blacks than Whites

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
Do et al.	Sociology (2020)	Significant - Most sociological research point to minorities having worse mental health than non-Hispanic whites due to a view that minorities are disadvantaged	Research suggests investing resources in mental healthcare services for those experiencing psychological issues due to physical illness - such physical afflictions are more common in minority groups who can benefit from mental healthcare services if physical health states worsen	<ol style="list-style-type: none"> 1. Maintains that the apparent racial-ethnic advantage in mental health does not align with racial-ethnic disparities in physical health, which is consistent within the majority of literature and research on the black white paradox 2. Minority mental health has evolved to recover from other sources of stress 3. Blacks receive less mental healthcare than whites, and it is generally of lower quality
Eller et al.	Education Sociology (2018)	Mixed Gap - bachelor's degree completion lower in black students than white; lower education is believed to be linked to greater mental health	Increase opportunities for students, of all races, to be involved in the educational process which is perceived to be beneficial to narrowing the race gap in the	<ol style="list-style-type: none"> 1. Blacks more likely to enroll in 4-year college programs than whites, highlights black persistence and ambition 2. White individuals more likely to complete their

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
		issues	paradox	bachelor's degree; develop mental health issues in the process
Erving et al.	Epidemiology (2018)	Significant - Blacks experienced lower rates of most common mental illnesses tested for, but did experience slightly higher lifetime rates of PTSD than their white counterparts	<p>1. White populations have greater lifetime stress-related illnesses that need to be addressed through care, intervention, and education to narrow the paradoxical gap</p> <p>2. Additional research needed to understand Black womens risk for PTSD, which can elevate blacks access to healthcare services</p>	<p>1. Identifies and acknowledges black-white paradox in mental health research and studies</p> <p>2. White individuals more susceptible to a wide range of psychological illnesses at higher rates than blacks</p> <p>3. Within black and white groups, women are most vulnerable, especially to PTSD</p>
Hill-Joseph	Race & Ethnic Studies (2019)	Minor Gap - Blacks have 'mastered' the relationship with their mental health	Require better healthcare services and infrastructure for both mental and physical health to improve the double paradox in Black and White	Chronic illness may disrupt black mental health resilience

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
			populations	
King	Psychiatry (2019)	Minor Gap - Inappropriate service-led approach results in a variety of issues for not only White groups but for Asians, Blacks, and other ethnic populations	<p>1. Support healthcare infrastructure through training, education, and designated medical professionals to deliver mental healthcare services to reinforce communities' confidence in seeking such services</p> <p>2. Additional support needed to reduce financial and accessibility barriers so individuals are able to afford adequate psychological care services which can narrow any racial gaps in the UK</p>	<p>1. Black, Asian, and other ethnic minorities may be misdiagnosed due to bias from medical professionals</p> <p>2. White mental health gap even larger in United Kingdom, mental health professionals may be out of touch with their community's actual experiences and are not adequately educated to assist</p>
Keyes	Psychology (2009)	Significant - Poor economic	1. Religion and spirituality are	1. Despite discrimination,

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
		outcomes, exposure to violence, low levels of education, and poverty has led to substantial resilience in Black populations	<p>effective in Black groups in coping with and reducing psychological distress - not commonly practiced in westernized white groups but is beneficial to reducing inequalities in coping</p> <p>2. Blacks noticeably have reduced access to mental healthcare services but seem to flourish otherwise - improved access to mental healthcare services should be in place to further improve and sustain minority mental health</p>	<p>black mental health is flourishing</p> <p>2. Black populations have shortened life expectancy due to inequality and discrimination but still experience better overall mental health than white populations</p>
LaMotte	Health Studies (2022)	Significant - Coping resources help to maintain the paradox	Reduce socioeconomic barriers for minority populations to increase health-	Despite pandemic and racial stressors, the black-white paradox holds during the COVID-19 pandemic, owing

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
			<p>seeking behaviors and likelihood of seeking healthcare services at a rate similar or comparable to White populations.</p>	<p>part of this explanation to African American elevated self-esteem levels</p>
Lê Cook et al.	Psychiatry (2016)	<p>Minor Gap - White populations access the most mental healthcare services compared to Hispanic, Asian, and Black populations and still report some of the worst mental health experiences</p>	<p>Clinical interventions that improve identification of symptoms of mental illness, expansion of health insurance, and other policy interventions that remove financial barriers to access may help to reduce these disparities</p>	<ol style="list-style-type: none"> 1. White populations have the best access to mental healthcare and health insurance; other policy interventions remove financial barriers for Whites 2. Black-white paradox upholds black and white differences 3. Higher education among Asians is believed to contribute to better mental health outcomes 4. High divorce rates and marital difficulties in Hispanic populations is closely linked to

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
				poorer mental health experiences
Louie et al.	Sociology (2019)	Minor Gap - Self-esteem and stress exposure offset each other, resulting in a null association between race and mood Disorders, and a reduced association between race and distress.	Reducing stress risks and exposures of populations help to better decrease mental health inequalities - This, however, is a macro-sociological issue and requires health and policy changes to support communities that they serve	Blacks experience overall better self-esteem and awareness and also experience higher levels of traumatic stress exposure.
Louie et al.	Sociology & Human Behavior (2021)	Significant - Identifies the additional research and	Educate white populations on the benefits of various coping	1. White individuals are often prescribed medications more commonly than

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
		progress made when studying the black-white paradox	resources and social support systems available to improve mental health experiences and narrow the gender and race gaps in mental health	black individuals 2. Black individuals are more equipped to cope with mental illness through a variety of resources
Mouzon	Biomedicine (2013)	Significant - Family dynamics help to explain the black-white paradox of mental health	Understanding how Black families implement emotional, financial, and instrumental supports can be beneficial to improving the mental health of White populations - Black populations family dynamics come from years of racism and discrimination that White populations have not experienced	1. Black populations have worse physical health but better mental health than whites - reinforces the double paradox in Black-White health studies 2. Stronger black family networks and dynamics aid in better mental health outcomes, noted over decades of study - family transforms to survive
Mouzon	Sociology (2017)	Significant - Religious involvement	Strong empirical evidence	1. Religious involvement helps with social

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
		closing linked with better mental health outcomes in the Black-White paradox	supports that the multidimensional participation in religious involvement can help to re	<p>integration and maintaining high-quality social relationships that are associated with beneficial mental health outcomes</p> <p>2. Religion-Health association: higher levels of healthy behaviors, social integration and social support, self-esteem and personal efficacy, positive coping resources and behaviors, and positive emotions among those who practice their religion frequently</p>
Pamplin II et al.	Sociology (2021)	Minor Gap - Depressive symptomology in Blacks upheld by paradox	Social support systems can be utilized to narrow gaps in mental health experiences and opportunities based on type of support, quantification of support, and the source of support	Blacks more likely to have depressive symptoms in chronic nature throughout life, but less likely to be diagnosed and to have psychological distress
Rockett et al.	Sociology (2006)	Significant - White	Improve mental healthcare and	1. Blacks appear more suicide prone

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
		populations more at risk of suicide than Blacks	medical services to avoid the misclassification of suicide deaths - Many Black suicides are often misclassified in their cause of death as medical professionals are either uneducated or lack the resources to accurately report mental-health related deaths	despite presence of risk factors 2. Lower education commonly associated with suicide risk; Black households overrepresented in lower education and still are not as suicide prone as white (paradoxical)
Thomas Tobin et al.	Sociology (2020)	Significant - Black-White mental health paradox generally extends across lifetime mood, anxiety, and substance use disorders and is consistent across age and gender groups	Further research using life course theory needed to explain the Black-White paradoxical differences as age increases to understand the epidemiological patterns of mental health, type of disorder, and severity of disorder	Education and employment do not play a significant role in this race gap. Black-White mental health differences are most pronounced among younger age groups. Black-White paradox more dependent on age group and gender.

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
			Gender and age differences may also help to identify chronic health issues	
Thomeer et al.	Race & Ethnic Studies (2023)	Minor Gap - COVID-19 pandemic shed light on racial and ethnic differences in mental health and mental health care services	Economic crises reveal additional inequalities and disparities that need to be addressed through revised health and insurance policies to narrow the gender- and race-gap in mental health	<ol style="list-style-type: none"> 1. Lower psychiatric rates in Black, Hispanic, and Asian adults in the US, during the pandemic, compared to White adults 2. Minoritized populations experience barriers in accessing mental health care services; most commonly minoritized populations face discrimination from mental healthcare professionals 3. Black and Hispanic adults are more likely to endure more severe and debilitating episodes of mental

Author(s)	Field and Year	Significance of Race Gap & Explanation	Suggestions to Address Mental Health Inequalities / Differences	Key Findings
				illness that go untreated for longer periods of time compared to White adults
Upenieks et al.	Sociology (2022)	Significant - Presents the negative aspects of religious and spiritual obligations in the Black-White Paradox when looking at	More research needed on non-psychological distress; the presence of diagnosis can heighten one's awareness of the mental issue. Since white groups are more likely to receive mental healthcare and a diagnosis, white responses to mental health are overwhelmingly negative.	<ol style="list-style-type: none"> 1. Multiple dimensions of religion and spirituality help to understand the Black-White paradox, as previous research ignores this approach 2. Religious and spiritual struggles are more present in white populations than blacks 3. Black populations better at identifying earlier experiences of mental distress

Chapter 3: Understanding White Women's Poorer Mental Health: An Analysis of the General Social Survey 2022

Intersectional Life Course Approach

While researching the mental health experiences of white women, I felt it necessary to incorporate both life course and intersectionality theory into my approach for this research. Both theories serve as critical perspectives in assessing the variations and prevalence of mental health issues among white women in the United States. Adopting an intersectional life course perspective helps me to identify the key stressors and issues that are uniquely present for white women because of their social positions while examining the chronic nature of certain stressors that can produce additional health and behavioral risks if left untreated or undiagnosed over the life span. The intersectionality and life course approach considers both the timing and interconnection of multiple factors that condition and impact individual mental health experiences in various ways and capacities (Sher & Wu, 2013). Using this approach to research the presence of and compounding issues surrounding mental health experiences can provide valuable insights on why health disparities persist among racialized and gendered groups across the United States (Sher & Wu, 2013).

Through this approach, intersectionality theory is used to understand how individuals within certain racialized and gendered demographics, including white groups, experience specific instances of mental health issues and outcomes that pertain to their unique location in society. Intersectionality theory maintains that components affecting individuals are intersecting and not exclusive. Such components do not exist or function without the presence of others and are helpful in indicating specific challenges for those in distinct social locations. Therefore, when

assessing the severity of mental health issues among white women, I must look at both gender and race together as they shape those unique experiences of mental health. Mental health inequalities can benefit greatly from being assessed through intersectional perspectives to identify the extent of how deep and wide such inequalities extend to (Fagrell Trygg et al., 2019). Coordinating intersectionality and life course theory together helps to examine the dynamic aspects of gender and race that produce unique experiences over one's life that can impact the course and development of mental health issues and illnesses.

Life course theory helps to address and recognize the course that mental health takes as one ages, and what gender and racial disparities exist as age increases. The relationship between mental health and age is one that is non-linear and can represent an accumulation of underlying issues that results in often irreversible mental health issues that continue to worsen. Life course theory will also be used to understand if there are any other health related consequences, primarily to physical health, because of prolonged mental illness. Chronic medical conditions, especially those of psychological nature, tend to worsen as age increases (Assari et al., 2015) and are of interest to both life course theorists and this research in understanding how such psychological issues are prolonged and exacerbated. Intersectionality theory ties in here to look at how specific groups, in this instance white women in the United States, may be susceptible to additional mental health and physical health risks because of their poor mental health experiences.

Beyond my own research, an intersectional life course approach can be a useful approach to a variety of sociological, psychological, and medical topics to understand how specific components of individual life can create compounding issues and disadvantages over the life course. For example, application of this approach on immigrant status and indigenous studies

would be beneficial in understanding the unique mental health experiences of such groups through a health sociology lens to identify prominent challenges and issues. In the context of my own research, this approach is immensely useful in investigating the power and role of gender and race in producing and conditioning mental health experiences and outcomes and how such critical social determinants of mental health can have impactful and lasting complications on health status over the lifetime. Understanding that the life course brings on frequent and dynamic changes that continue to adapt as we do, reinforces the role of this approach as being increasingly important to the centrality of my research and for future research to come.

Studying Gaps Over the Life Course

A major component of developing an intersectional life course approach is to identify ways in which this approach can contribute to the debate in the theories of mental health. Studying intersectional gaps over the life course will be a significant contribution in the field health sociology and among mental health researchers to help identify additional populations, demographics, and groups of vulnerability and susceptibility to mental health issues and illnesses. When examining issues of race and gender over the life course and as they relate to mental health, we can identify a relationship wherein mental health develops alongside the presence of specific stressors and issues that follows no set pattern but instead creates dynamic developments in the lives of those it impacts. Through such examinations are we able to identify vulnerable groups who are susceptible to mental health issues which can help to develop better services and policy reform to serve communities in need.

Why the United States?

The role of contextualizing my research in the United States stems from my literature review and my dataset of choice, the General Society Survey. Male and Female gender categories along with White and Black racial classifications are widely adapted through my literature review as the dominant ways of classifying gender and race in the United States. Additionally, the General Social Survey 2022 and the United States Census 2022 also measure race and gender in these two distinct classifications.

Therefore, the choice for contextualizing my research in the United States is one that perfectly aligns across my dataset, literature review, and within the population composition to allow for a thorough and representative review of white female mental health issues. When comparing overall composition of people in both the United States census and in the General Social Survey, white individuals account for over 70% and black individuals account for nearly 14%. When looking at gender distribution in both the GSS 2022 and the US census, women account for just over half of the total composition. This means that both the gender and race distribution ratios across both the GSS 2022 and US census are nearly identical and help to appropriately address the population at hand when assessing mental health differences using contemporary literature.

Additionally, many countries across the world do not recognize mental health issues to the extent that the United States does wherein certain healthcare services and professionals are designated for such intervention care. Selecting the United States as a focus of my research helps to not only assess mental health in an appropriate climate but to do so in a way where the country has an interesting history of acknowledging, diagnosing, and treating mental health illnesses and issues.

Hypothesis

My original hypothesis upon investigating racial and gender disparities positioned minority populations, specifically minority women, as those to report some of the poorest experiences of mental health because of various gender and racially motivated stressors, forms of violence, and discrimination. After conducting my initial literature review, based on research predominantly from the United States, I hypothesize that white women are a vulnerable and susceptible group of poor mental health because of various psychosocial stressors and disadvantages. White women represent a unique intersection in society as they seemingly benefit from the privileges and powers associated with whiteness while still facing the potential discriminatory aspects of femaleness. This hypothesis stems from common themes and findings arising from my literature review that uphold the poorer mental health experiences of white women that can be a result of patriarchal marriage and gender norms reinforced throughout society and partnerships (Hill et al., 1999; Rosenfield, 2012; Simon, 2002), the unequal distributions of labor and caregiving aspects (Hill, 2002; Simon, 2002), employment and income stressors (Cohen et al., 2003; Grote et al., 2007; Mcilvane, 2007), increased subjectivity to forms of violence (Lipsky et al., 2007; Meyer et al., 2014), and lack of trust and confidence towards healthcare professionals and services (Kimerling et al., 2005; McGuire, 2008).

Data

The data has come from the General Social Survey (GSS) 2022 which was administered by NORC at the University of Chicago (NORC) and funded by the National Science Foundation (NSF) since its inception. The cross-sectional study has collected demographic, behavioral, and attitudinal data from the American society to monitor and explain trends each year since 1972.

Among the topics covered are civil liberties, crime and violence, intergroup tolerance, morality, national spending priorities, psychological well-being, social mobility, and stress and traumatic events. Altogether, the GSS is the single best source for sociological and attitudinal trend data covering the United States. More information on the GSS 2022 can be on NORC's General Social Survey website (<https://gss.norc.org/>). My analysis is based on the recent 2022 cycle only. NORC at the University of Chicago recommends not to compare the data from past cycles due to yearly redesigning that led to major changes to the content of questions and scope of responses. The final sample includes a total of 3,319 eligible GSS baseline respondents from across the United States over the period of September 22nd, 2022 – November 30th, 2022.

Measures

Dependent Variable

My research presents mental health as the dependent variable as I aim to see how it is impacted by independent variables, such as gender and race. Mental health has the potential of being impacted by various mechanisms and social factors, such as my additional variables of income and marital status. Respondents, from the General Social Survey 2022, were asked to declare a numerical answer between zero and thirty to indicate how many days, in the previous 30 days, they have experienced poor mental health. Responses of poor mental health may be reflective of cultural differences, individual perceptions of what constitutes poor mental health, or fear of being judged from interviewers or data collectors. Days of poor mental health, within the past 30 days, responses represent an ordinal variable wherein the responses have a natural ordering that can either indicate more poor mental health days or less.

Independent Variables

My primary independent variables of interest include both race and gender. Both variables have been a major focus throughout this research to assess how their relationships impacts mental health experiences, especially among white women. Gender and race can exist and mutually condition one another to produce poor experiences and responses of mental health, which is a finding that is upheld by contemporary literature referenced throughout this paper.

Understanding the relationship of both race and gender is central to my incorporation of intersectionality theory, where when an individual occupies the spaces of a specific race and gender classification, in this case white women, they may be more susceptible to poor mental health experiences. Sex, albeit gender, and race are categorical variables in this dataset as there are different response options to select but the categories themselves follow no order or rank.

My secondary independent variables of age, education, income, trust, and marital status are introduced as I present my results to identify the specific mechanisms that impact white female mental health, that are supported by both my dataset and contemporary literature review. Age is a quantitative continuous variable rather than a categorical variable, as each respondent was asked to numerically indicate their current age. Education is an ordinal variable in this dataset as it is represented as the number of years of education that the respondent has completed at the time the survey was conducted. The variable of income is ordinal as respondents were asked to identify which income bracket, they, and their household, occupied in the fall of the previous year before filing their income taxes. Income responses were to be selected from a list of twelve predetermined income brackets which gives this ordinal variable a sort of intrinsic way of categorizing and ranking responses. The need to include age, education, and income stem from their presence throughout my literature review. Age is of particular concern, especially as

discussed in relation to life course theory, as not only do psychologically vulnerable age demographics exist in populations, but mental health issues that become present earlier in life, and go untreated, have the potential to worsen one's quality of life, health, and create cumulative disadvantages in the future. Income helps to identify socioeconomic and financial disadvantages present that are largely correlated to mental health issues as such disadvantages encompass psychologically tolling events, such as poor job opportunity and job insecurities. Conclusively, education is knowingly linked to white mental health issues as higher status groups often receive higher levels of education that compound psychological stressors (Eller et al., 2018).

Finally, I introduce the variables of trust and marital status. Trust allows for me to understand generalized perceptions of trust that may impact how one interacts in society, how social relationships are formed and maintained, and the confidence they display in mental healthcare services and professionals. Marital status accounts for spousal commitment and relationship. It also may address issues of number of children, caregiving, and household income. The importance in including the variables of marital status and social trust into this research not only stems from the explanations they provide for explaining mental health gaps, but they also encompass multiple dimensions of an individual's life. Marital status can be indicative of family and spousal dynamics, division of private and public labor, and presence of traditional gender roles which are all cited as viable explanations to mental health difficulties in white women. Additionally, trust is a widely encompassing variable that not only addresses an individual's confidence and comfort in medical and psychological healthcare services but can also aid in understanding the qualities that individuals search for to trust the healthcare service they receive and the trust they extend to additional relationships and engagements (Grote et al., 2007). Trust also can indicate one's ability to trust others and expand their social support systems

to effectively cope with and seek care for mental health difficulties. The integration of these variables into my research is critical in understanding a large scope of white female mental health challenges.

Marital status is a nominal variable here where respondents are given the options to select either married, widowed, divorced, separated, or never married, which follow no ranking but are instead exclusive categories. Trust is also a nominal variable as respondent's selected an answer when being asked if most people can be trusted; such responses are unable to be ranked. Trust is closely correlated to individuals' perceptions of others in society which may cause fluctuations in how social support systems are formed and maintained or influence one's perceptions of how healthcare systems and professionals can be trusted (McGuire, 2008). T-values present within marital status indicate a high reliability in determining their impact on mental health responses. By looking at the chart present, marital status and trust are the best predictors of poor mental health responses within the previous 30 days.

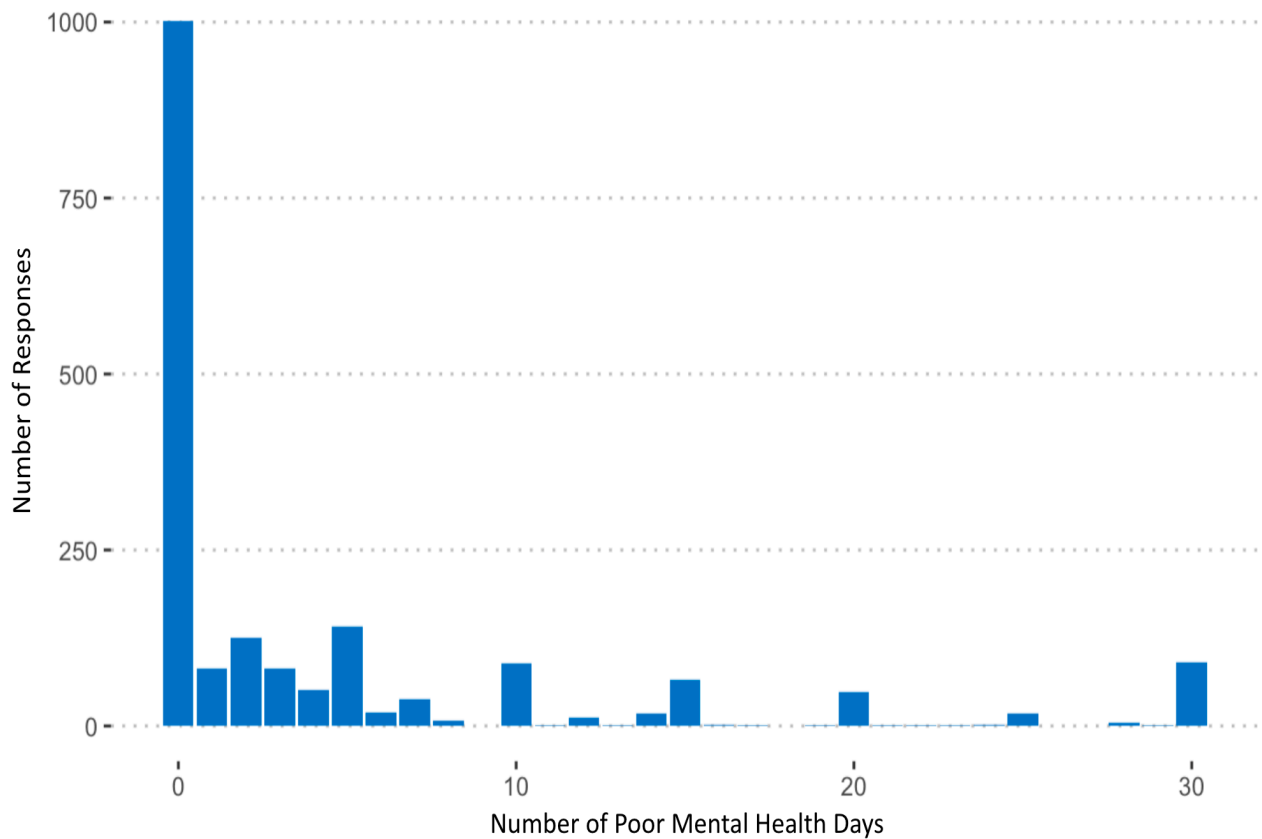
Marital status impacts mental health in negative ways as the presence of a partner, children, and division of labor can be significantly burdening for white women. Non-white and Black women have been able to restructure familial and spousal dynamics that have been beneficial to their mental health, while not all racialized communities have this benefit, it is worth noting because white women, in general, still struggle with patriarchal gender roles in marriages. Black women, especially, have extended familial and spousal responsibilities to intergenerational care networks, which have not been documented, as widely, in literature on white female mental health. Trust is also a mechanism that impacts mental health in negative ways. The GSS 2022 measures trust on a general scale if most people can be trusted. Given current literature, white women often do not trust. They do not engage, as much as Black and

racialized communities do, in community and religious aspects and display low trust in medical services and healthcare professionals out of fear of an incorrect diagnoses and potential overmedication.

Results

For this portion of my research, I will be assessing responses of race and gender and cross comparing them with responses from the question pertaining to a respondent being asked to

Histogram 3. Distribution of Responses to Number of Poor Mental Health Days

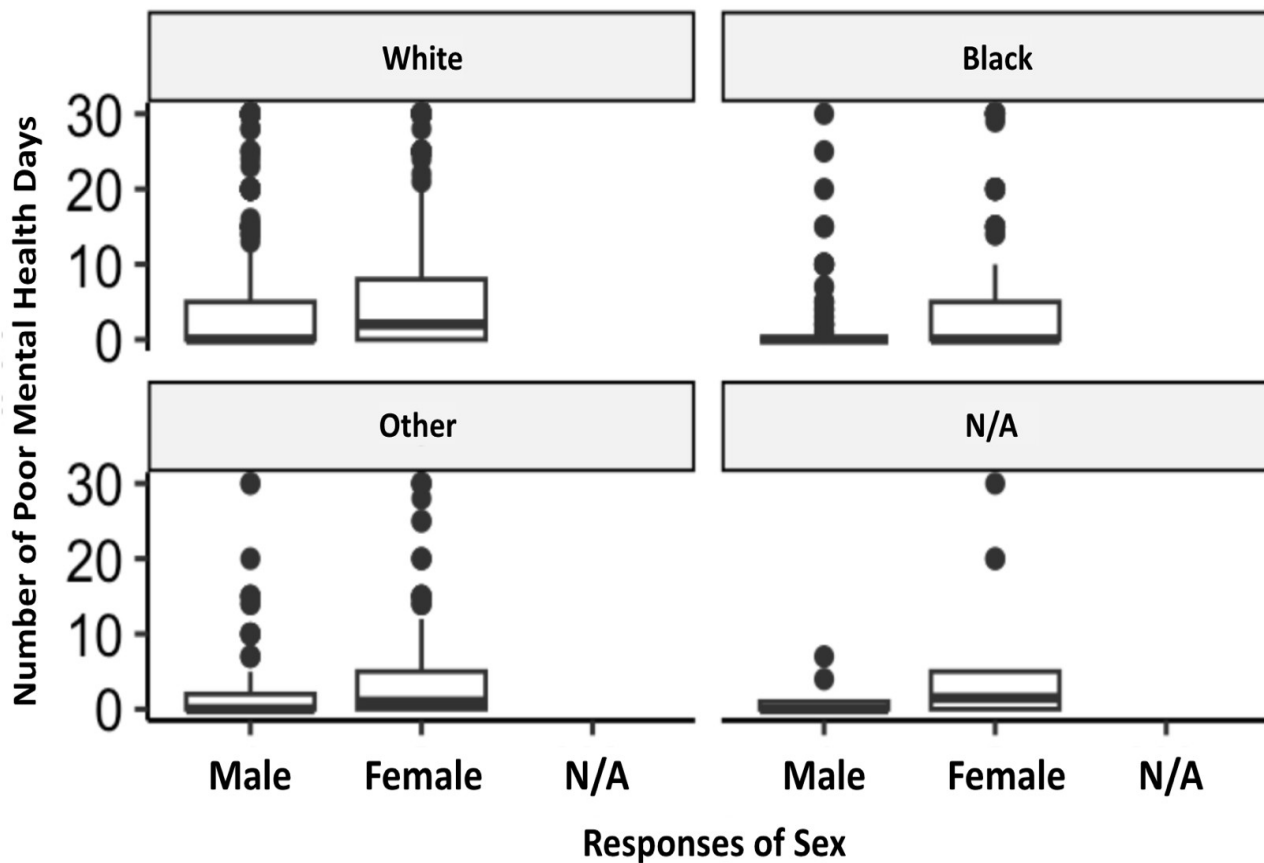


numerically represent how many days of poor mental health they have experienced in the last 30 days. *'Histogram 3: Distribution of Responses to Number of Poor Mental Health Days'*

represents mental health responses from participants being asked to numerically how many days they have experienced poor mental health in the last 30 days. Histogram 3 showcases responses

from US participants' raw answers with no additional variables of gender and race. This simply shows the initial distribution to indicate that there is a significant presence of respondents who report instances of poor mental health within 30 days. Within this distribution there is a fair number of respondents who do not report any days of poor mental health in the previous thirty days. However, there is still a significant share of respondents who identify or perceive poor mental health in the last thirty days, which I cross-tabulate with responses of race and gender together. 'Boxplot 3: Mental Health Responses Distributed by Race and Gender' shows four

Boxplot 3. Mental Health Responses Distributed by Race and Gender



boxplots that categorize responses by race and then by gender. Within the boxplot, there is an indication that white female mental health responses show a higher mean than any other racial and gender categories within this dataset. While numerous explanations can be proposed as to

why this might be, the significant presence of poor mental health responses from white women indicate a concerning paradoxical trend that is not present, or as present, in other racial and gender populations and demographics surveyed in this data set.

Regression

Regression Table 1. White Women's Mental Health: Focus on Gender and Race, and the Introduction of Secondary Independent Variables

	Model (1) Days of poor mental health	Model (2) Days of poor mental health
Male	Reference	Reference
Female	1.776*** (4.43)	1.578*** (3.40)
White	Reference	Reference
Black	-2.177*** (-3.80)	-2.872*** (-3.31)
Other	-1.704** (-2.80)	-1.810* (-2.21)
Young People (18-29)	-0.104*** (-6.55)	-0.104*** (-6.52)
Education in Years	-0.0394 (-0.53)	-0.0375 (-0.51)
Income in Dollars	-0.0000167** (-2.61)	-0.0000173** (-2.69)
Married	Reference	Reference
Widowed	1.529 (1.19)	1.471 (1.14)
Divorced	1.516** (2.68)	1.510** (2.66)

Separated	0.502 (0.37)	0.518 (0.38)
Never Married	1.021* (2.08)	1.017* (2.07)
Male, White		Reference
Male, Black		Reference
Male, Other		Reference
Female, White		Reference
Female, Black		1.216 (1.07)
Female, Other		0.212 (0.17)
_cons	9.171*** (7.16)	9.252*** (7.21)
<i>N</i>	1531	1531
<i>R</i> ²	0.077	0.078

t statistics in parentheses
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

My first portion of the regression analysis focuses predominantly on identifying the role of both race and gender in the analysis of white female mental health. Women in the United States report higher rates of poor mental health as indicated through the higher mean of number of days, in the previous thirty, in which one experienced poor mental health. Black populations average a lower number of recorded days of poor mental health. These initial findings uphold the initial gender and racialized gaps presented throughout this paper thus far. Additionally, the variable of marital status is one that presents significant impact on the reports of mental health as those who fulfill

any classification of marital status report higher means of poor mental health occurrences in the previous thirty days. White women unfavorably experience the burdens associated with marriage, the state, child raising, and mental health simultaneously because women benefit significantly less from employment, partnership, and private sphere work compared to men (Simon, 2002; see also Hill, 2002). The responsibilities of marriage, in white contexts, where it is common to see nuclear relationships still present, is often downloaded on the white mother who experiences the simultaneous burden of marriage and child raising responsibilities as it takes a toll on physical and mental health (Hill, 2002). The experience of motherhood, in white families, is one that is very taxing on women and can increase the onset and development of psychological issues. Reinforcing traditional gender roles onto white mothers increases their susceptibility towards internalizing disorders which may not only discourage them from seeking mental healthcare services, but also have unprecedented tolls on their physical health as well (Carter et al., 1996). Dissatisfaction in the gendered division of work and marriage within a household is a popular explanation for white women's mental health issues (Hill, 2002). Perhaps if black women reported mental health differently, then there may be a presence of the triple jeopardy hypothesis to see how parenting, racism, and doing unpaid work takes a toll on the mental health of black women.

Comparatively, the distribution of labor in ethnic and non-white homes is impacted by wives' employment as mothers are often present within the workforce, less commonly seen in white homes (Hill, 2002). Diverse groups have different familial dynamics that influence how they support their homes through wage and household labor. Due to this restructuring, familial relationships and partnerships are stronger in non-white groups and result is stronger mental health resilience and more positive mental health outcomes.

This initial portion of my regression analysis upholds consistent findings in contemporary social research that the various divisions of marriage can influence poor mental health issues as it impacts additional areas of a white women’s life, such as employment, income, financial freedom, education, and other vital areas. Single white mothers in the workforce tend to suffer the greatest as they must balance the responsibilities of caregiving and wage earning simultaneously which not only increases role strain but also takes a toll on mental health and daily productivity (Cohen et al., 2003). Single motherhood status can be indicated through a divorced, separated, never married, or widowed occupancy where white mothers overtake various responsibilities that can negatively impact their mental health experiences and subsequent outcomes.

Regression Table 2. A Closer Look at Secondary Independent Variables

	Model (1) Days of poor mental health	Model (2) Days of poor mental health
Male	Reference	Reference
Female	1.857*** (4.57)	1.608*** (3.41)
White	Reference	Reference
Black	-2.269*** (-3.91)	-2.994*** (-3.39)
Other	-1.474* (-2.40)	-1.734* (-2.08)
30 or Older	Reference	Reference
Young People (18-29)	-4.156 (-1.21)	-4.713 (-0.61)

Education in Years	-0.0686 (-0.92)	-0.0655 (-0.87)
Income in Dollars	-0.0000199** (-3.08)	-0.0000206** (-3.17)
Married	Reference	Reference
Widowed	0.180 (0.14)	0.132 (0.10)
Divorced	0.875 (1.55)	0.879 (1.55)
Separated	0.629 (0.45)	0.653 (0.47)
Never Married	2.175*** (4.66)	2.162*** (4.62)
Male, White		Reference
Female, White		1.271 (1.10)
Female, Black		0.560 (0.45)
Men, 30+		Reference
Men, Young		Reference
Women, 30+		Reference
Women, Young		0.836 (0.09)
White, 30+		Reference

White, Young		Reference
Black, 30+		Reference
Black, Young		1.394 (0.13)
Other, 30+		Reference
Female, Other, 30+		Reference
Female, Other, Young		Reference
_cons	4.852*** (4.38)	4.956*** (4.46)
<i>N</i>	1531	1531
<i>R</i> ²	0.052	0.053

t statistics in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The second portion of my regression analysis reveals that among white women in the United States, younger white women in the 18–29-year-old demographic, average higher occurrences of poor mental health. This may be due to the abundance of additional stressors present for younger white women that include employment and workplace issues, lower socioeconomic status, and the proneness to intimate partner violence. White women can possess a strong advantage, compared with other female demographics, to enter the labor market. If white women enter the labor market, they may experience potential threats and disadvantages to their mental health that suscept them to common mental illnesses, like generalized anxiety disorder and post-traumatic stress disorder (Cohen et al., 2003). Women are significantly more likely than men to experience poverty and socioeconomic issues due to minimized opportunities in the workforce and failed

partnerships (Meyer et al., 2014). Women in lower socioeconomic status brackets, especially white women, experience depressive symptomology and the feeling of being unsafe in their housing and life situations; this leads to increased psychological and behavioral issues that impact mental productivity and function in abnormal ways (Meyer et al., 2014). These issues often tend to linger for white women as recovering from socioeconomic issues or poverty is nearly impossible and creates significant difficulty in securing employment, housing, and healthcare services which reinforces negative experiences and outcomes in mental health.

While education has less to do with mental health prevalence and lingering; income, age, gender, race, and marital status impact mental health in the greatest ways for white women which contributes to their elevated averages of poor mental health days. Income is especially interesting and presents a paradox itself wherein although it can contribute to positive mental health experiences as the benefit of having higher income may translate into less stress and better access to mental healthcare services, current research upholds that white women often fear mental healthcare services due to feeling that such services and medical professionals do not appropriately serve the communities they need to. Income can impact mental health in both extremely positive and negative aspects which makes it a key variable to research further to determine its specific impacts of populations and groups of interest. White women are exceptionally vulnerable to poverty which indicates how income can be such a significant cause of poor mental health outcomes and responses. Poverty and lower socioeconomic status are a popular explanation for the deterioration of white women's mental health. However, the overall significance of studying this aspect of mental health stems from how it impacts various aspects of the white female experience. Not only can poverty and lower socioeconomic status impact ability to secure healthcare, housing, and employment (Grote et al., 2007), but it also creates a

cyclical recurrence of mental illness in white female populations. Acknowledging this issue helps to address current inequalities directly instead of allowing them to develop into greater psychological issues in the long term. Considering the high likelihood that white women's mental illnesses can develop into longstanding mental problems (Meyer et al., 2014), if left untreated, addressing socioeconomic issues allows for the improvement in the quality of life for white women and can reduce the subsequent health risks associated with untreated mental illness.

Additionally, the significance of the research surrounding race and gender disparities in mental health helps to identify age groups and demographics display who exhibit concerning mental health patterns. For the purposes of this research, young white women have been a primary concern and are revealed in my regression analysis to display more frequent poor mental health occurrences. Young women, especially those who are white, are overwhelmingly vulnerable to intimate partner violence, which is overwhelmingly perpetrated by men (Lipsky et al., 2007). Intimate relationships begin to develop in early stages of adulthood and may come with various forms of violence that threaten both physical and mental health. The increased presence of white female mental health issues because of violence in partnerships may be due to white women feeling more comfortable with reporting issues of partner related violence and potentially possessing the means in accessing appropriate care and legal services to address the issue. These experiences indicate that young white women at this intersection can experience lingering trauma that has the potential of developing into a lifelong presence of post-traumatic stress disorder (Lipsky et al., 2007). There is also a particular age demographic that is susceptible to education and employment related stressors as younger white women, those between 18 and 24 years of age, are often pursuing higher education, full time employment, or both. These life events tend to be more common in younger female demographics, than compared to older

demographics of white women, which present their own kinds of stressors that can impact mental health in various ways. Understanding the intersection of age, race, and gender is needed across mental health studies to identify specific demographics, within populations of interest, that are more vulnerable to additional stressors and mental health issues.

Thesis Conclusion

Key Findings

Throughout the explanations and key themes presented throughout contemporary social research and literature, white women's poor mental health is at an imperative crossroad of developing for the worse. With the abundance of stressors on the shoulders of white women, I have noticed that there are extreme role strains many white women face as they try exploring and adapting to changing political, social, and economic climates that can leave them in an immense state of vulnerability.

Younger white women, those between 18 and 29 years, face immense pressures to pursue higher education, enter the workforce, pursue intimate relationships, and perhaps even begin the process of child birthing and raising. Such pressures contribute to the elevated levels of poor mental health experiences noted among young white women that are continuing to show prevalence. As younger demographics begin to age out of this category, mental health issues that are unresolved or perhaps go undiagnosed can continue to cumulate a disadvantageous state of health that may produce additional health risks throughout the life span.

Additionally, the impacts of income and marital status on mental health are undeniably present in both my literature review and my secondary data analysis. Both marriage and income can intersect alongside the white female mental health experience to produce adverse psychological impacts that subject's white women to additional mental health risks and behaviors. While white women do have the benefit of entering the workforce and earning their own income, the various aspects of marriage, such as household labor and caretaking children and elderly family, may interfere.

To conclude, the white female mental health experience is one that is intersected with the various components that compile the individuals and groups of concern. Gender and race, alongside age, marital status, and income, are the most significant predictors and social determinants of mental health that must be researched further in order to better assist with the psychological health concerns on white women in American society.

Limitations

This paper has highlighted the benefits and significance of the relationship between gender, race, and mental health. Understanding racialized and gendered gaps in mental health helps to create new ways to address and reduce inequalities and disparities, such as through healthcare and policy reform or by implementing affordable and accessible external childcare options. However, I aim to highlight some of the limitations I have encountered while using my dataset, literature review, and research on my topic.

A large portion of existing research and literature focuses on the gender binary of male and female categories. While this can be beneficial to understanding the historical significance and future experiences of the gender gap in mental health, it is limiting to address gender as a simple binary. Even with the gender binary being widely accepted and practiced in sociological research and among many societies and groups, it does not encompass all gender identities. 2SLGBTQIA+ gender identities are often not accounted for within research and literature on the relationship between gender and mental health. This can be due to a variety of factors wherein individuals may have personal beliefs regarding the gender binary, do not want to disclose their gender identity, or have varying gender identities that do not fit a label. Whichever may be the issue, mental health research does not often include gender identities outside the binary because

they may be problematic to measure empirically, difficult to categorize and operationalize, and may not address all gender identities present.

The gender binary is often what is practiced and present in a variety of cultures and data bases. Certain cultures are very firm on their beliefs in male and female roles, therefore when bringing in culture and race into mental health studies, additional gender identities outside of the binary may not be present in diverse and minority groups and can be difficult to measure and cross compare. Male and female categories of gender are dominant in sociological research and help to maintain an equal opportunity of measurement for research to be consistent and presentable. This then means there is an additional gap present in sociological research on gender and health. Consequently, gender identities outside the traditional binary can be studied to understand and identify additional inequalities and gaps in the field of mental health.

Incorporating additional gender identities can be useful in identifying trends that strengthens sociological understandings of mental health while presenting new research that has yet to be explored in depth. Such research can present new opportunities for health policy reform and creating opportunities for better access to and affordability of mental healthcare services for those individuals outside the gender binary. Additionally, understanding how other gender categories can shape the mental health and gender relationship can open new opportunity in sociological research to investigate the trends amongst non-binary gendered individuals.

The absence of incorporating immigrant status in mental health research and literature is a notable limitation I encountered. Within my literature review, immigrant status was not something as prevalent as other components of mental health experiences. Immigrant status can help to indicate one's ability to engage with and access healthcare services that can help to improve mental health states and experiences. Immigrant status can also indicate socioeconomic

and income related differences that exist among individuals in the United States and how those financial aspects can impact mental health experiences and outcomes. Additionally, the lack of Indigenous representation in US literature on mental health experiences is also a critical component that is a limitation. Indigenous populations and individuals of varying immigrant status help to encompass the unique composition of the US population and require further representation in mental health literature and research to understand their full scope of mental health experiences. Indigenous populations may also live on reserves and can experience and cope with mental health entirely different than those in modern societies, therefore further exploration of such topics is vital for future mental health research.

While trust is critically important to the development of social relationships and support systems and can also impact how we view and engage with medical healthcare services and professionals, limitations still exist. The General Social Survey 2022 classifies trust as general social trust in terms of how one perceives their ability to trust others. This idea of trust needs to be further tailored towards specific health-related trust to measure how comfortable respondents are to seek healthcare services for psychological issues and how that can be interpreted to understand specific mental health issues. Such specification of trust can help reveal populations who may neglect healthcare services for a variety of reasons, which can range from stigma to systemic racism. While generalized trust can be beneficial to apply trust responses to a variety of issues, the implementation of health-related trust helps to serve future research more effectively to maintain validity of the research topic.

A limitation when examining race comes from how individuals may occupy multiple racial and ethnic profiles simultaneously. Within the data and research literature used, individuals with multiple racial and ethnic identities may not have their responses and

experiences accurately accounted for as they must select only one option that best suits their identity or potentially have their response disregarded for complicating data. Individuals with multiple racial and ethnic identities may have unique experiences of mental health that may complicate data if they are forced to select an option that limits their intersectional identity and experience. While I acknowledge that accommodating individuals of multiple racial and ethnic identities should be of focus in mental health research, the reality is that this may be difficult to study reliably and validly. There should perhaps be an additional category, perhaps for those of Asian or Hispanic backgrounds, to account for appropriate demographic representation. I also believe there should be some way for individuals to disclose if they occupy multiple racial/ethnic identities. The reality is many individuals occupy two or more racial/ethnic identities which are dependent on their family lineage. Perhaps individuals who present one race, depending how dominant some physical characteristics are, may experience mental health issues differently. For example, an individual who may come from one Black parent and one White parent may have a lighter skin tone and may present a certain way. They may go on to experience mental health advantages and disadvantages associated with both of their racial identities. Understanding and accounting for individuals at these crossroads would be beneficial in further developing my research to understand how gaps and paradoxes are maintained through individuals of different racial compositions.

Additionally, some minor limitations were noted through the examination of additional variables and explanations on the topic of white female mental health. First, some studies that include measures of socioeconomic status do not specify at what economic thresholds constitutes for specific categorizations of lower-, middle-, and upper-class brackets. Therefore, one's subjective meaning and definition of socioeconomic status may differ from one another. This can

potentially lead to non-distinctive results that do not appropriately reflect mental health trends that are associated with white women in specific socioeconomic positions. Secondly, an additional limitation I consider to be significant in this research is the subjective meaning surrounding mental health. Considering how mental health can be individually perceived and defined based on a range of cultural, social, financial, political, and personal factors, there can be some difficulty in ensuring results are representative, reliable, and valid. I understand that some of the variation in the results of the question on poor mental health within the last 30 days can open responses to be filled with much bias and individual perception. A poor day of mental health can range from a minor episode of personal or mental discomfort to a day filled with anxiety and stress provoking stimuli. Considering no set definition or measure of mental health was set in place within the General Social Survey, there can be much room open for interpretation of poor mental health. While the open interpretation of mental health can account for a wide representation of different mental health circumstances and experiences, there is difficulty in ensuring equal understandings of mental health across all active participants.

Finally, and most importantly, most of the published literature and data available comes from the United States of America. The benefit of this is the wide diversity of the US population that can indicate specific gender and racial differences in the mental health realm. However, data and literature from other countries is also needed for purposes of cross comparing findings and results to understand specific trends and patterns. Other countries encompass different histories and unique population compositions that can indicate interesting trends in mental health that can be used to compare findings against white female populations and demographics.

Future Opportunities for Research

While I am proud of how my research addresses white female mental health issues and experiences, I regard that my research represents future opportunities to explore additional variations and experiences in mental health through a health sociology perspective. I consider the heteronormative nature behind my research indicates that there are additional gender and sexual classifications that should be explored to understand their impact on mental health and the mental health experience of those outside the heteronormative gender and sexual spectrum.

My dataset, literature review, and dataset almost exclusively address male and female gender categories. I acknowledge that the study of mental health experiences and their variations among 2SLGBTQIA+ individuals should be further explored to dive deeper into how not only gender and sexuality play critical roles in mental health onset and development, especially over the life span, but to also account for how additional characteristics of socioeconomic status, race, and trust contribute to mental health experiences.

Additionally, I conclude that instead of using education as a secondary independent variable, it can be used a primary independent variable, especially when assessing how mental health development and higher educational attainment are linked. I acknowledge there is significant need to understand the impact on education on the prevalence and development of mental health issues and difficulties. Specifically examining higher level graduate and doctoral students and the relationships with their mental health as they endure some of the highest levels of achievable academics would be interesting to see how specific issues arise for those students. One can also introduce gender and race to identify specific demographics of students experience mental health issues most commonly and some of the explanations that help to understand these differences, such as cultural educational expectations or familial/intergenerational pressures.

Overall, the scope of mental health research, especially in North American contexts, is one that benefits from continued developments and investigation. There is a need to understand mental health policies and issues to understand how to better assist vulnerable and susceptible communities and decrease the stigma surrounding mental health. Additionally, investigating the various realms and explanations of mental health issues, such as education or racialized stress, helps to determine the most impactful social determinants of mental health. Identifying social determinants aids in the delivery and accessibility of mental health services and helps to reform healthcare policy and law to be more accommodating towards psychologically vulnerable groups.

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