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SEX AND GENDER ISSUES IN BEHAVIORAL HEALTH (CN EPPERSON AND L HANTSOO, SECTION EDITORS)

Sex Differences in the Impact of Racial Discrimination on Mental Health Among Black Americans

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Abstract

Purpose of Review Greater racial discrimination is associated with poorer mental health among Black Americans; yet, there remains an incomplete understanding of sex differences in exposure to racial discrimination, and further, of how sex differences in coping with racial discrimination may heighten or diminish risk for poorer mental health.

Recent Findings Black men may experience greater exposure to both structural and communal forms of racial discrimination, whereas Black women may face both a wider range of potential sources, as well as encounter greater variability in the subjective experience of racial discrimination. For both Black women and men, racial discrimination may be similarly associated with maladaptive coping strategies (i.e., emotional eating, rumination) that also are linked to poorer mental health; however, emerging findings suggest that mindfulness may partially buffer these deleterious effects.

Summary Overall, the recent literature reveals mixed findings with respect to sex differences in the experience and negative mental health impact of racial discrimination. Despite this heterogeneity, evidence documents sex differences in the settings, type, and qualitative experience of racial discrimination among Black Americans. Additionally, growing evidence indicating that racial discrimination is associated with physiological markers of stress reactivity and psychopathology risk further bolsters its characterization as a unique form of chronic stress among Black Americans and other minority groups in the USA.

Keywords Racial discrimination · Mental health · Black Americans · Sex differences · Emotion regulation · Biomarkers

Introduction

Following the election of President Barack Obama, many declared that the USA had miraculously transformed into a "post-racial" society [1]. In stark contrast to this optimistic declaration, a recent national survey estimated that roughly 92% of Black Americans report that racial discrimination still exists, with 51–52% of respondents endorsing having

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experienced racial slurs, or people making negative assumptions or offensive comments about members of their racial group [2]. These and other recent reports [3–5, 6•, 7–10] challenge assertions that the prevalence of racial discrimination in the USA is possibly exaggerated [11]. It is clear that America has yet to arrive to the post-racial "Promised Land." Instead, racial discrimination remains a persistent and significant public health concern, undermining both the physical and mental health of racial/ethnic minorities living in the USA [12–16].

Racial discrimination has been defined in several ways including as "a system of oppression based on racial/ethnic group designations in which a pervasive ideology of racial superiority and inferiority provides the foundation for structural inequalities, intergroup conflict, discrimination, and prejudice" [17–20]; and, a phenomenon that results in unfair inequalities in power that can be expressed through beliefs, emotions, or practices ranging from overt threats, to deeply rooted social and structural inequalities [21]. Racial discrimination is further characterized as an uncontrollable environmental stressor for a significant portion of the US population [11]. Perhaps not surprisingly, public spaces (e.g., stores) have been identified as a primary environment where individuals are more likely to experience racial discrimination [22, 23].

Evidence from a number of descriptive and systematic reviews clearly establishes a relation between racial discrimination and poorer mental health outcomes including psychological distress, anxiety, and depression [24–26]. Moreover, longitudinal research has shown that greater self-reported racial discrimination precedes the onset of depression among Black Americans [27–29]. Yet, despite broad evidence of a connection between racial discrimination and poorer mental health, there remains an incomplete understanding of how racial discrimination is differentially experienced as a function of sex, and potentially, other aspects of identity.

Given that Black individuals are not a monolithic group, it is important to examine how the intersection of multiple factors including race, sex, and coping may combine with racial discrimination to negatively impact mental health [6•, 30]. Renowned Black poet Audre Lorde stated, "There is no such thing as a single-issue struggle because we do not live single-issue lives" [31]. Crenshaw later coined the term intersectionality, arguing that Black women were excluded from the feminist and antiracist discourses and that sex and race discrimination literature tended to focus on privileged group members: Black men and White women, respectively. Intersectionality recognizes the insufficiency of a "single-axis framework" and asserts that forms of social stratification do not exist separately from each other but are complexly interwoven [32].

Drawing on these themes, we review recent evidence regarding sex differences in the type and experience of racial discrimination, as well as differences in the association of racial discrimination with mental health outcomes among Black American men and women. Further, we explore literature examining potential mechanisms, which may partially account for sex differences in this association (i.e., gendered-stereotypes and differences in coping/emotion regulation), and review research examining the association between racial discrimination and biomarkers of stress reactivity and psychopathology risk. We close with a discussion of considerations for future research and clinical intervention, including the importance of realizing a more "intersectional" approach in mental healthcare, more broadly.

Sex Differences in the Experience of Racial Discrimination

Some studies suggest that Black men report more racial discrimination than Black women [26, 33]. For example, a 2006 meta-analysis reported that Black American and other minority males generally reported a higher frequency of racial discrimination, while only a few studies observed this pattern among Black and/or other minority females [25]. Other studies have suggested there are no sex differences in the frequency of experiencing racial discrimination across racial/ethnic groups [34, 35].

As others have noted, sex differences in the experience and impact of discriminatory treatment may hinge not only on the *level* but also on the *type* of racial discrimination encountered [36]. For instance, recent research examining sex differences in the type of discrimination exposure suggests that Black women report less lifetime racial discrimination, relative to Black men [37]. Also, while there were no apparent sex differences in daily experiences of racial discrimination, qualitative differences were observed. In particular, Black women endorsed a greater likelihood of experiencing interpersonal racial discrimination in educational, domestic, and public domains, while Black men were more likely to experience discrimination in employment and medical settings, as well as in interactions with law enforcement [37]. Other research employing mixed methodology observed no apparent sex differences in the endorsement of peer- and adult-perpetrated racial discrimination experiences among Black adolescents [38]. However, qualitative data further revealed that Black female adolescents' subjectively defined experiences of discriminatory treatment (i.e., inappropriate comments, unwelcome hair touching, and limited opportunities for interracial dating) were clearly distinct from that of Black male adolescents.

Still, another study found that while Black women reported higher levels of individual and cultural racism, Black men reported higher levels of institutional racism [39]. This latter observation is further consistent with findings from an earlier study which also found Black men to endorse significantly greater institutional and collective (i.e., a sense of organized

or concentrated racial hostility from an outside group) discrimination, relative to Black women [40].

Sex Differences in the Association Between Racial Discrimination and Mental Health

Past studies have found that depression [41] and anxiety [42] scores were higher in Black women than Black men. Consistent with the aforementioned, research has indicated that sex moderated the link between individual racism and mental health, such that women reported poorer mental health outcomes (i.e., depression, obsessive-compulsive symptoms, somatization, and interpersonal sensitivity) than men [39]. However, sex did not moderate the link between cultural or institutional racism and mental health outcomes. Contrary to these findings, recent work has shown that Black males may be *more* susceptible than females to the negative psychological impact (i.e., depression and anxiety) caused by an *increase* in racial discrimination, over time [43•]. Adding further nuance, one previous study reported that restrictive emotionality, which assessed traditional masculinity ideology around the disclosure of vulnerabilities (i.e., sex role norm conformity), moderated the link between racial discrimination and depressive symptoms. Specifically, racial discrimination was associated with greater negative affect among Black men endorsing higher levels of restrictive emotionality [44]. As this observation highlights, both one's sex, and the extent to which an individual *subscribes* to socially-constructed sex norms, appear to *matter* in connecting experiences of racial discrimination to poorer mental health in Black Americans.

Potential Sources of Sex Differences in Discrimination and Mental Health

Below, we review evidence documenting sex differences in the stereotypes typically ascribed to Black Americans, as these views may relate to both type and frequency of racial discrimination exposure. Further, we discuss research examining both adaptive and maladaptive emotion regulation strategies that have been linked to both racial discrimination and poorer mental health among Black Americans. Lastly, we explore evidence linking racial discrimination to biomarkers of both chronic stress reactivity and global psychopathology risk.

Sex Differences in Stereotypes

Sex differences in prevailing stereotypes regarding Black individuals may impact the type of discrimination they experience [39, 45]. For instance, although Black Americans have been "generally" stereotyped as unintelligent, Black American women are often regarded as more intelligent than Black men [46–49]. Additionally, evidence suggests that Black men are more likely to be viewed as threatening, aggressive, and prone to violence and criminal behavior than Black women [49–53]. These gendered stereotypes may increase overt, aggressive types of discrimination. In contrast, Black women may experience more subtle and persistent forms of racial discrimination. For example, a recent report found that compared with Black men and other women of color, Black women are more likely to experience microaggressions, or personal slights, insults, and invalidations that are potentially less intense but more frequent than more overt/direct forms of racial discrimination [54]. Further, the impact of these subtle acts of racial discrimination may be intensified at the intersection of racism and sexism [55]. In this way, Black women experience a type of multiplicative discrimination based on their sex and race, as both sex and racial stereotypes are cued simultaneously [56]. Importantly, researchers have noted that because Black women and men experience racial discrimination differently, existing measures of racial discrimination may fail to adequately capture experiences unique to Black women [57•]. Thus, it is feasible that previously observed sex differences between Black men and women may reflect some degree of measurement bias favoring the former over the latter.

Sex Differences in Emotion Regulation and Coping Strategies

Extensive evidence indicates that there are sex differences in emotion regulation and coping strategies, particularly in response to racial discrimination [58, 59]. In general, sex role theories research suggests that women tend to ruminate, or focus repetitively on the sources, indicators, and consequences of their negative emotions, more than men [60]; while men may be more prone to use suppression, distraction, and other avoidant strategies [61–64]. Yet, emerging evidence indicates that there may be some overlap in certain strategies that Black men and women employ to cope with racial discrimination, and likely psychological distress, more broadly. For example, emotional eating may be a salient coping strategy for both Black men and women [65, 66]. Notably, one study recently found that racial discrimination was positively associated with greater depressive symptomatology and emotional eating among young Black men and women. Specifically, racial discrimination was associated with depressive symptomatology only among young Black adults endorsing moderate and high levels of emotional eating [33]. Still, other research suggests that racial discrimination may be more generally associated with poorer dietary habits among middle-aged and older Black Americans [67].

Previous research further notes that Black women endorse seeking social support and turning to religion more than Black men [68]. Among Black women, prayer is often employed to cope with stressful situations, including experiences of racial discrimination. Notably, Cooper and colleagues [69] found that Black women who reported greater usage of prayer coping also reported lower subjective stress following a discrimination recall task. Growing evidence also indicates that greater mindfulness, defined by Kabat-Zinn [70] as "curious and nonjudgmental attention to present-oriented thoughts, emotions, and physical sensations", may buffer the impact of racial discrimination on mental health, particularly among Black American emerging adults [71, 72]. Notably, one study reported that trait mindfulness significantly moderated the association between past year racial discrimination and anxiety symptoms [73]. In a 2018 study, mindfulness significantly moderated the positive association between racial discrimination with symptoms of both depression and anxiety, such that the effect for discrimination was weaker at higher levels of mindfulness [71]. In a recent partial replication, Watson-Singleton and colleagues [72] also found that mindfulness significantly moderated the association between racial discrimination and depressive symptoms in a sample of emerging adult Black men and women. In this study, both everyday experiences, as well as the anticipation of future racial discrimination, were more strongly associated with depression symptoms among individuals endorsing low and average, but not the highest levels of mindfulness [72].

Relatedly, there has been increasing research focus on the concept of vigilance, and particularly, race-related vigilance, which has been characterized as a distinct *preparatory* response to frequent racial discrimination, with significant implications for both mental and physical health among Black Americans [72, 74–78]. Previous research has suggested that Black men may specifically cope with racial discrimination by developing a sense of heightened vigilance, in anticipation of expected racial hostility [79]. Moreover, greater race-related vigilance has been associated with sleep impairment [29, 74, 80, 81] and greater depressive symptoms among young adult Black women [77], as well as among Black Americans overall [72, 82]. Recent findings further suggest that race-related vigilance is positively correlated with rumination [77]. Rumination is a well-established risk factor for depression onset and recurrence, and sex differences in lifetime depression risk favoring women may be partially accounted for by coincident sex differences in rumination [83–87]. Importantly, sex differences regarding both depression risk and the use of rumination as an emotion regulation strategy appear to be consistent among Black Americans as well as among other cultural groups [88].

Nearly 20 years ago, researchers hypothesized that increased rumination was one of several likely responses to chronic racial discrimination [89]; and recent data provide consistent support for this early assertion [3, 28, 77, 90–95]. For example, correlational findings indicate that rumination is positively associated with greater racial discrimination, and particularly, discrimination involving threats and/or actual physical harm [92, 94]. Moreover, compared with other groups, Black Americans face substantial disparities across a range of sleep outcomes [96–98]. Rumination has been shown to partially mediate the relationship between racial discrimination and subjective sleep quality in Black young adults [93].

Rumination has further been characterized as one component of a broader pattern of "perseverative" negative, repetitive (i.e., worry) thinking believed to underlie global psychopathology risk [99–105]. Consistent cross-sectional and longitudinal evidence further indicates that rumination significantly mediates the relationship between racial discrimination and depressive symptoms among Black young adults [77, 106], a pattern which also appears to extend to Hispanic/Latino emerging adults [107] as well as to young adults identifying as gay, lesbian, and/or bisexual [108].

Interestingly, there is some indication that active coping, commonly conceptualized as the mental and physical effort deployed to directly address a given stressor (i.e., [109, 110]), may moderate the association between racial discrimination and rumination [77]. Research on active coping has revealed sex differences in the use of these strategies, as well as in their impact on mental health outcomes for Black men and women [35, 111–121]. For instance, the Superwoman Schema Conceptual Framework [122] suggests that Black women may exhibit a specific type of active coping. Notably, this framework suggests that Black women specifically show (1) an obligation to manifest strength, (2) an obligation to suppress emotions, (3) resistance to being vulnerable or dependent, (4) determination to succeed, even in the face of limited resources, and (5) an obligation to help others. Endorsement of the Superwoman Schema has been associated with physiological reactivity and elevated emotional distress among Black women [123].

Similarly, John Henryism, characterized as a form of persistent effortful coping in the face of excessive barriers and demands, also has been studied extensively in Black Americans. The term, first coined by Sherman James, was initially defined as an individual's perceived ability to overcome challenges in their environment through sheer hard work and determination [124–126]. Some research indicates that John Henryism may be globally associated with risk for depression in both Black men and women [127]; however, other findings suggest John Henryism is associated with lower levels of depressive symptoms among Black women [128]. Further, the association between John Henryism and mental health risk may be more complex among Black men. Notably, while Matthews and colleagues [114] initially observed an

inverse association between John Henryism and depressive symptoms among Black men in their study, further analyses revealed that John Henryism was positively associated with depression symptoms among men endorsing greater masculine self-reliance [114]. Consequently, higher John Henryism also has been linked to lower levels of happiness in Black men [129].

Sex Differences in Physiological Markers of Discrimination Stress

There is increasing interest in characterizing the *psychophysiological cost* of chronic racial discrimination exposure [76, 90–93, 95, 130–133]. The negative mental and physical health consequences of racial discrimination are theorized to accumulate over the life course, eventually resulting in the dysregulation of multiple body systems (i.e., cardiovascular, neuroendocrine, immune) and disease onset, as well as in increased risk for anxiety and mood disorders among Black Americans [89]. Allostatic load—reflecting the cumulative "wear and tear" of frequent and/or incomplete activation of the body's integrated stress responses [134]—is one conceptualization that is increasingly used to demonstrate the *biopsychosocial* impact of racial discrimination. Recent evidence indicates that allostatic load may be a particularly salient risk marker for numerous chronic diseases, poorer mental health outcomes, and even all-cause mortality among Black women in the USA [135•]. Researchers have previously suggested that allostatic load or "weathering" observed among Black women may be induced by greater lifetime exposure to stressors such as sex and racial discrimination [33, 77, 95, 136–138]. In this way, experiences of social marginalization are possibly incorporated biologically, or embodied, and differentially impact Black women [139]. Consequently, higher allostatic load among Black women may further exacerbate the already deleterious impact of racial discrimination on mental health.

In addition to the allostatic load framework, cardiovascular reactivity has been advanced as a useful model for understanding the connection between stress responsivity, broadly, and increased risk for poorer mental and physical health [140–149]. Indeed, the autonomic nervous system has long been characterized as an important pathway linking racial discrimination to increased risk for poorer mental and overall health among Black Americans [89, 143, 150–152]. Under the cardiovascular reactivity framework, greater stress-related changes in blood pressure (as well as other cardiovascular parameters) in response to myriad laboratory stressors are thought to, at least partially, reflect "real world" cardiovascular responses to stress [153–156]. An established literature has examined the association between racial discrimination and blood pressure in Black Americans and sex may play an important role in this association (for review, see [7, 157]). Indeed, meta-analytic evidence suggests that racial discrimination may be associated with a greater risk for hypertension among Black men, relative to Black women; however, this relation does not appear to rely solely on elevated blood pressure [157]. This finding underscores the importance of research which has focused on more specific markers of acute and chronic stress reactivity in relation to racial discrimination. For example, greater racial discrimination has been linked to increased catecholamine (i.e., norepinephrine and epinephrine) activity in both Black men and women [78, 158]. Further, cortisol is a primary stress hormone of the hypothalamic-pituitary-adrenal (HPA) axis, and there is some evidence that greater racial discrimination is associated with greater overall cortisol output (i.e., both acute stress-related and diurnal changes), particularly under stressful conditions [159, 160]. Further, there is some indication that the link between racial discrimination and alterations in HPA axis activity may begin in childhood among Black Americans [161].

With respect to sex differences, there is some evidence that naturally occurring stressors may have a differential impact on cortisol reactivity among Black men and women. For instance, following the Duke Lacrosse scandal, in which a Black woman accused several White lacrosse players of rape at an off-campus party, researchers compared stress-related changes in salivary cortisol among Black American men and women engaging in a laboratory study, before and after the incident. Notably, while there was a general trend toward elevated cortisol levels among all participants recruited *after* the scandal, Black women in this group exhibited the highest overall cortisol levels. Interestingly, Black women completing the study *before* the scandal exhibited the lowest overall levels [162]. Still, other research has shown that associations among racial discrimination, anxiety symptoms, and overall cortisol concentrations do not appear to differ among emerging adult Black men and women [163]. Further factors including religious engagement and neighborhood composition also may impact the association between racial discrimination and cortisol among Black Americans [164, 165].

Whereas previous research has focused on measures reflecting, primarily, sympathetic nervous system activity (i.e., blood pressure, heart rate), recent findings indicate that functioning of the parasympathetic nervous system may be especially relevant in discerning the impact of racial discrimination on both mental and physical health in Black Americans [76, 92, 130, 132, 166]. Notably, heart rate variability (HRV), broadly defined here as measures derived from the variability in time between consecutive heartbeats, is a robust index of the vagus nerve (i.e., parasympathetic) influence on cardiac function. Researchers have further characterized resting state (i.e., baseline) HRV, as a stable trait-like index of an individual's capacity for appropriate and efficient self-regulation [167–172]. Lower HRV is associated with symptoms of anxiety and depression as well as with

psychological distress, more generally, in non-clinical samples [168, 173–179].

Diminished HRV also has been consistently observed across a variety of clinical presentations (i.e., major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder, borderline personality disorder, and bulimia), contributing to its characterization as a "transdiagnostic" biomarker of psychopathology (for overview, see [180–182]). In contrast, higher levels of HRV are generally associated with better overall mental health and well-being [173]. Meta-analytic findings indicate that HRV is positively, though weakly, correlated with a variety of measures of self-regulation [170]. Moreover, neuroimaging research has shown reliable associations between resting HRV and both resting-state and task-related activation in brain regions associated with emotional processing (for review, see [183–193]).

Notably, consistent research examining links among HRV, racial discrimination, and mental health outcomes has only emerged fairly recently [166]. One impetus for this work has been the curious observation that Black Americans tend to exhibit *higher* resting HRV relative to White Americans [130]. Importantly, this pattern contrasts with previous assertions that low HRV among Black Americans might represent a significant pathway linking greater social and economic stress to poorer physical health [194]. In partial congruence with this early view, our group and others have shown that racial discrimination is inversely associated with HRV in Black American young adults [92]. However, factors such as individual differences in coping (i.e., rumination, prayer | [69, 92, 94]), and variations in racial identity [137, 195] may further moderate this relation.

Moreover, while resting HRV has been associated with self-reported difficulties in emotion regulation in one study with a mixed minority sample [196], the extent to which HRV may consistently capture self- and emotion regulation processes in Black Americans, particularly in the context of racial discrimination, remains largely unexplored. At least one prior study has examined the role of HRV as a "psychophysiological" moderator in the link between racial discrimination and negative mental health. Notably, Utsey and Hook [197] observed a positive association between institutional racial discrimination and psychological distress in a sample of young adult Black men and women; however, this relationship was significantly attenuated among men with higher resting HRV. More recently, Hill and Hoggard [77] examined the moderating roles of both John Henryism and resting HRV (conceptualized in this study as a biomarker of active coping) in the association between everyday racial discrimination and race-related vigilance, with rumination in a sample of young adult Black women. These researchers observed that greater everyday discrimination and race-related vigilance were significantly associated with rumination, but only among women endorsing high John Henryism, and/or exhibiting higher resting HRV. These results provide some initial support for the working hypothesis that higher HRV among Black Americans may reflect a type of psychophysiological compensation. Notably, as HRV is broadly regarded as a marker of self-regulatory capacity [170–172, 191, 198–201], we have previously proposed that the higher HRV observed among Black Americans might indicate a greater coping demand and/or a greater frequency of self-regulation in response to chronic discrimination stress [76, 130, 132].

While it is clear that additional research, including replication of these past findings, is needed, some evidence indicates that ethnic/racial differences in HRV may originate in utero [202] and may be reliably apparent in Black and White American newborns within the first year of life [203]. Further, there is accumulating evidence that African-origin groups outside of the USA also may exhibit higher HRV relative to individuals of predominantly White descent [204]. This notion is further bolstered by research showing that Brazilians identifying as either "Black" or "Brown" exhibited higher HRV relative to Brazilians identifying as "White". Moreover, in this study, when racial discrimination was taken into account, "ethnic" differences in HRV were diminished [205].

Research Recommendations and Clinical Implications

Measurement Issues

Oversight in the design and focus of previous measures, as well as under- and over-reporting biases common to self-report assessment are some of the potential sources argued to, at least partially, account for the relatively incongruent findings regarding sex differences in the racial discrimination-mental health link among Black Americans [206•]. Of particular note, the type of discrimination unique to Black women may not be captured by existing measures of racial discrimination, given that the nuances of their experience of gendered racism may not fit under more singular understandings of racial discrimination. For instance, Ifatunji and Harnois [204] found that common measurements of discrimination were found to be biased toward Black male experiences of discrimination, thus, presenting an inaccurate view, whereby observed sex differences in perceived discrimination favoring Black men may be inflated, if not wholly created, by the gendered nature of survey questions. As an illustration, one of the items on the Racism and Life Experiences Scale [207] asks how often a person experiences, "Others reacting to you as if they were afraid or intimidated." This item may be more likely to reflect Black male experiences of discrimination, given their greater likelihood of being seen as threatening [51]. Researchers should take into account these measurement issues when exploring sex differences in discrimination and its role as a determinant of mental health.

Recruitment and Retention

Black individuals are believed to be less willing to participate in research, which contributes to their being underrepresented in the literature. Lower rates of participation may be indicative of greater concern regarding research participation rather than lower desire to participate [208]. With respect to recruitment, researchers should employ targeted approaches that run parallel to general recruitment efforts. In terms of retention and combating barriers of mistrust and fear, research teams should display a sincere interest in participants by having a caring attitude and being responsive to participant needs. Importantly, Black males continue to be more underrepresented in research studies and clinical trials than Black females [209]. As a result, studies may not have sufficient power to assess sex differences when they are lacking Black males in comparison with Black females in their sample. Given this challenge, researchers should consider utilizing strategies that specifically target the recruitment of Black males [209, 210]. In particular, barbershops have been increasingly identified as trusted congregating spaces for Black men and have been successfully targeted in research studies and interventions focusing on Black men [211].

Clinical Implications: Intersectionality Theory in Practice

It is critical in clinical practice to more carefully consider the numerous overlapping sources and systems of oppression, present across relational contexts, which may be actively and perhaps interactively influencing clients of any background who present for therapy. It has been argued that an intersectional framework facilitates a greater appreciation for subjectivity and daily experiences, especially as they relate to the role of discrimination on mental health outcomes. Notably, Crenshaw wrote: "discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars traveling from any number of directions and, sometimes, from all of them." In this way, using a strong intersectional framework in clinical practice emphasizes that clients' distress may result from and/or be exacerbated by experiences of oppression and discrimination resulting from different sources, which may vary by context [212]. Overlooking the ways in which both clients and therapists are influenced by their multiple positionality (race, sex, sexual orientation, etc.) may negatively impact the utility of clinical interventions. Researchers have suggested that "psychotherapists explicitly integrate a strong intersectionality framework into their practice by (a) creating opportunities to discuss social inequities and power in psychotherapy, (b) using language that emphasizes how external structural systems of oppression impact individuals, and (c) keeping in mind that context contributes to the form of oppression that becomes salient at a given time" [212].

Conclusion

Extensive evidence documents an association between racial discrimination and negative mental health outcomes among Black Americans. However, there is a dearth of literature on the role of sex differences in this relation. Collectively, the research briefly discussed here indicates that sex differences exist in the experience of racial discrimination among Black Americans. In particular, Black men may be more susceptible to both structural and communal forms of racial discrimination, and also, may be more likely to develop a greater sense of preparatory vigilance as a consequence. In contrast, Black women may face both a wider range of potential sources, as well as greater variability in the subjective experience of racial discrimination. For both Black men and women, growing evidence confirms early assertions that rumination is a common, maladaptive correlate of racial discrimination; while emerging findings suggest that greater mindfulness among Black Americans may be a relevant protective factor against the deleterious effects of chronic race-related stress. Further, evidence supports that racial discrimination is associated with psychophysiological markers of stress reactivity and increased risk for psychopathology; and despite previous notions that discrimination may be more strongly related to physical health among Black men compared with Black women, recent data suggests that Black women may face a similar allostatic burden.

Previous findings suggest that Black Americans may minimize their experiences of racial discrimination as a means of maintaining a sense of control or mastery [213]. A greater sense of mastery has been described as an important social determinant of mental health among Black men [214] and previous research has shown positive associations between John Henryism and perceived control [117]. As the original John Henryism Hypothesis suggests, a strong sense of self-reliance and determination in the face of insurmountable challenges (i.e., frequent multi-domain racial discrimination) may be adaptive, so long as an individual also has additional resources and supports (i.e., income, education, healthcare access) available [126]. In contrast to this classic view, there is growing evidence that even with greater socioeconomic resources, Blacks in the USA tend to derive less benefit, with respect to both mental and physical health, relative to White Americans [9]. Moreover, Black men may be particularly vulnerable, as they are more likely to have fewer socioeconomic resources relative to Black women [215]. Previous findings also indicate that mood disorders appear to be associated with greater risk for cardiometabolic and other chronic disorders among Black men [216]. Also, higher socioeconomic status has further been shown not to account for the link between

racial discrimination and increased depression risk among Black men [217].

Across developmental spectra, the overlapping relations among sex, racial discrimination, and mental health remain woefully understudied. Moreover, there is a substantial need for research examining how sex differences in discrimination-related coping might further account for some of the heterogeneity in past research. Overall, Black men and women face distinctive cultural norms and structural constraints, and may thus, embody and respond to experiences of racial discrimination in both similar and distinct ways. Tellingly, it also seems apparent that their shared sociocultural context may mean arriving at a similar destination (i.e., increased risk for poorer mental and physical) despite different developmental and experiential pathways.

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Compliance with Ethical Standards

Conflict of Interest Briana N. Brownlow, Effua E. Sosoo, Risa N. Long, Lori S. Hoggard, and Tanisha I. Burford each declares no potential conflicts of interest.

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