Chapter 1
THEORISING MASCULINITY AND MEN’S HEALTH
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Introduction

Men in the United States, on average, die more than 5 years younger than women (Department of Health and Human Services [DHHS], 2007). For all 15 leading causes of death, except Alzheimer’s disease, and in every age group, men and boys have higher death rates than women and girls (Courtenay, 2003). Men’s age-adjusted death rate for heart disease and cancer are both 1.5 times higher than women’s (DHHS, 2007). Men are also more likely than women to suffer severe chronic conditions and fatal diseases (Verbrugge & Wingard, 1987), and to suffer them at an earlier age. Nearly three out of four persons who die from heart attacks before age 65 are men (American Heart Association, 1995). Similar patterns in morbidity and mortality have been observed in the UK, Canada and Australia (see Courtenay, 2002; and Chapters 3, 6 and 9).

A variety of factors influence and are associated with health and longevity, including economic status, ethnicity, and access to care (Laveist, 1993; Pappas et al., 1993; Doyal, 1995). However, these factors cannot explain gender differences in health and longevity. For instance, while lack of adequate healthcare, poor nutrition and substandard housing all contribute to the health problems of African Americans (Gibbs, 1988), they cannot account for cancer death rates that are nearly twice as high among African American men than among African American women (American Cancer Society, 2005). Health behaviours, however, do help to explain gender differences in health and longevity. An independent scientific panel established by the US government has evaluated thousands of research studies and estimated that half of all deaths in the US could be prevented through changes in personal health practices (US Preventive Services Task Force [USPSTF], 1996). Similar conclusions have been reached by other health experts reviewing hundreds of studies (Woolf et al., 1996).
Gender is one of the most important sociocultural factors associated with and influencing health-related behaviour. Women engage in far more health-promoting behaviours than men and have more healthy lifestyle patterns [see Courtenay, 2000a]. Being a woman may, in fact, be the strongest predictor of preventive and health-promoting behaviour [see Courtenay, 2000a]. A recent, extensive review of large studies, national data and metanalyses summarises evidence of sex differences in behaviours that significantly influence health and longevity [Courtenay, 2000a]. This review systematically demonstrates that males of all ages are more likely than females to engage in over 30 behaviours that increase the risk of disease, injury and death. This gender difference in health behaviours remains true across a variety of racial and ethnic groups [Courtenay et al., 2002].

Findings are generally similar for healthcare visits. Although gender differences in utilisation generally begin to disappear when the health problem is more serious [Verbrugge, 1985; Waldron, 1988; Mor et al., 1990], adult men make far fewer healthcare visits than women do, independent of reproductive healthcare visits [Verbrugge, 1985, 1988; Kandrack et al., 1991]. According to the US Department of Health and Human Services (1998), among persons with health problems, men are significantly more likely than women to have had no recent physician contacts, regardless of income or ethnicity; poor men are twice as likely as poor women to have had no recent contact, and high-income men are two and a half times as likely as high-income women.

Despite their enormous health effects, few researchers or theorists have offered explanations for these gender differences in behaviour, or for their implications for men’s health [Verbrugge, 1985; Sabo & Gordon, 1995; Courtenay, 1998a, 2000b, 2002; Courtenay & Keeling, 2000a, b]. Although health science of this century has frequently used males as study subjects, research typically neglects to examine men and the health risks associated with men’s gender. Little is known about why men engage in less healthy lifestyles and adopt fewer health-promoting beliefs and behaviours. The health risks associated with men’s gender or masculinity have remained largely unproblematic and taken for granted. The consistent, underlying presumption in medical literature is that what it means to be a man in America has no bearing on how men work, drink, drive, fight or take risks. Left unquestioned, men’s shorter lifespan is often presumed to be natural and inevitable.

This paper proposes a relational theory of men’s health from a social constructionist and feminist perspective. It provides an introduction to social constructionist perspectives on gender and a brief critique of gender
role theory before illustrating how health beliefs and behaviour are used in constructing gender in North America, and how masculinity and health are constructed within a relational context. It further examines how men construct various forms of masculinity – or masculinities – and how these different enactments of gender, as well as differing social structural influences, contribute to differential health risks among men in the US.

Health and the social construction of gender

Constructionist perspectives and theories of gender

Previous explanations of masculinity and men’s health have focused primarily on the hazardous influences of ‘the male sex role’ (Goldberg, 1976; Nathanson, 1977; Harrison, 1978; Verbrugge, 1985; Harrison et al., 1992). These explanations relied on theories of gender socialisation that have since been widely criticised (Deaux, 1984; Gerson & Peiss, 1985; Kimmel, 1986; Pleck, 1987; West & Zimmerman, 1987; Epstein, 1988; Messerschmidt, 1993; Connell, 1995). The sex role theory of socialisation, for example, has been criticised for implying that gender represents ‘two fixed, static, and mutually exclusive role containers’ (Kimmel, 1986, p.521) and for assuming that women and men have innate psychological needs for gender-stereotypic traits (Pleck, 1987). Sex role theory also fosters the notion of a singular female or male personality, a notion that has been effectively disputed, and obscures the various forms of femininity and masculinity that women and men can and do demonstrate (Connell, 1995).

From a constructionist perspective, women and men think and act in the ways that they do, not because of their role identities or psychological traits, but because of concepts about femininity and masculinity that they adopt from their culture (Pleck et al., 1994a). Gender is not two static categories, but rather ‘a set of socially constructed relationships which are produced and reproduced through people’s actions’ (Gerson & Peiss, 1985, p.327); it is constructed by dynamic, dialectic relationships (Connell, 1995). Gender is ‘something that one does, and does recurrently, in interaction with others’ (West & Zimmerman, 1987, p.140); it is achieved or demonstrated and is better understood as a verb than as a noun (Kaschak, 1992; Bohan, 1993; Crawford, 1995). Most importantly, gender does not reside in the person, but rather in social transactions defined as gendered (Bohan, 1993; Crawford, 1995). From this perspective, gender is viewed as a dynamic, social structure.
Gender stereotypes

Gender is constructed from cultural and subjective meanings that constantly shift and vary, depending on the time and place. Gender stereotypes are among the meanings used by society in the construction of gender, and are characteristics that are generally believed to be typical either of women or of men. There is very high agreement in our society about what are considered to be typically feminine and typically masculine characteristics [Williams & Best, 1990; Golombok & Fivush, 1994; Street et al., 1995]. These stereotypes provide collective, organised – and dichotomous – meanings of gender and often become widely shared beliefs about who women and men innately are [Pleck, 1987]. People are encouraged to conform to stereotypic beliefs and behaviours, and commonly do conform to and adopt dominant norms of femininity and masculinity [Eagly, 1983; Deaux, 1984; Bohan, 1993]. Conforming to what is expected of them further reinforces self-fulfilling prophecies of such behaviour [Geis, 1993; Crawford, 1995].

Research indicates that men and boys experience comparatively greater social pressure than women and girls to endorse gendered societal prescriptions – such as the strongly endorsed health-related beliefs that men are independent, self-reliant, strong, robust and tough [Williams & Best, 1990; Golombok & Fivush, 1994; Martin, 1995]. It is, therefore, not surprising that their behaviour and their beliefs about gender are more stereotypic than those of women and girls [Katz & Ksansnak, 1994; Rice & Coates, 1995; Street et al., 1995; Levant & Majors, 1998]. From a social constructionist perspective, however, men and boys are not passive victims of a socially prescribed role, nor are they simply conditioned or socialised by their cultural context. Men and boys are active agents in constructing and reconstructing dominant norms of masculinity. This concept of agency – the part individuals play in exerting power and producing effects in their lives – is central to constructionism [Courtenay, 2000b].

Health beliefs and behaviours: resources for constructing gender

The activities that men and women engage in, and their gendered cognitions, are a form of currency in transactions that are continually enacted in the demonstration of gender. Previous authors have examined how a variety of activities are used as resources in constructing and reconstructing gender; these activities include language [Perry et al., 1992; Crawford, 1995], work [Connell, 1995], sports [Connell, 1992; Messner & Sabo, 1994], crime [Messerschmidt, 1993] and sex [Vance, 1995]. The very manner in which women and men carry out these activities contributes both to the defining of one’s self as gendered and to social conventions of gender.
Health-related beliefs and behaviours can similarly be understood as a means of constructing or demonstrating gender (see Courtenay, 2000b). In this way, the health behaviours and beliefs that people adopt simultaneously define and enact representations of gender. Health beliefs and behaviours, like language, can be understood as ‘a set of strategies for negotiating the social landscape’ (Crawford, 1995, p.17), or tools for constructing gender. Like crime, health behaviour ‘may be invoked as a practice through which masculinities (and men and women) are differentiated from one another’ (Messerschmidt, 1993, p.85). The findings from one small study examining gender differences and health led the author to conclude that ‘the doing of health is a form of doing gender’ (Saltonstall, 1993, p.12). In this regard, ‘health actions are social acts’ and ‘can be seen as a form of practice which constructs . . . “the person” in the same way that other social and cultural activities do’ (Saltonstall, 1993, p.12).

The social experiences of women and men provide a template that guides their beliefs and behaviour. The various social transactions, institutional structures and contexts that women and men encounter elicit different demonstrations of health beliefs and behaviours, and provide different opportunities to conduct this particular form of demonstrating gender. If these social experiences and demonstrated beliefs or behaviours had no bearing on the health of women and men, they would be of no relevance here. This, however, is not the case. The social practices required for demonstrating femininity and masculinity are associated with very different health advantages and risks (Courtenay, 2000b). Unlike the presumably innocent effects of wearing lipstick or wearing a tie, the use of health-related beliefs and behaviours to define oneself as a woman or a man has a profound impact on one’s health and longevity.

**Theorising masculinity in the context of health**

The following sections provide a relational analysis of men’s gendered health behaviour based on constructionist and feminist theories, and examine how cultural dictates, everyday interactions and social and institutional structures help to sustain and reproduce men’s health risks.

**Gender, power, and the social construction of the ‘stronger’ sex**

A discussion of power and social inequality is necessary to understand the broader context of men’s adoption of unhealthy behaviour – as well as to address the social structures that both foster unhealthy behaviour among
men and undermine men’s attempts to adopt healthier habits. Gender is negotiated in part through relationships of power. Micro-level power practices (Pyke, 1996) contribute to structuring the social transactions of everyday life, transactions that help to sustain and reproduce broader structures of power and inequality. These power relationships are located in and constituted in, among other practices, the practice of health behaviour. The systematic subordination of women and lower-status men – or patriarchy – is made possible, in part, through these gendered demonstrations of health and health behaviour. In this way, males use health beliefs and behaviours to demonstrate dominant – and hegemonic – masculine ideals that clearly establish them as men. Hegemonic masculinity is the idealised form of masculinity at a given place and time (Connell, 1995). It is the socially dominant gender construction that subordinates femininities as well as other forms of masculinity, and reflects and shapes men’s social relationships with women and other men; it represents power and authority. Today in the US, hegemonic masculinity is embodied in heterosexual, highly educated, European American men of upper-class economic status.

The fact that there are a variety of health risks associated with being a man in no way implies that men do not hold power. Indeed, it is in the pursuit of power and privilege that men are often led to harm themselves (Clatterbaugh, 1997). The social practices that undermine men’s health are often the instruments men use in the structuring and acquisition of power. Men’s acquisition of power requires, for example, that men suppress their needs and refuse to admit to or acknowledge their pain (Kaufman, 1994). Additional health-related beliefs and behaviours that can be used in the demonstration of hegemonic masculinity include the denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, the display of aggressive behaviour, and physical dominance. These health-related demonstrations of gender and power represent forms of micro-level power practices, practices that are ‘part of a system that affirms and (re)constitutes broader relations of inequality’ (Pyke, 1996, p.546). In exhibiting or enacting hegemonic ideals with health behaviours, men reinforce strongly held cultural beliefs that men are more powerful and less vulnerable than women; that men’s bodies are structurally more efficient than and superior to women’s bodies; that asking for help and caring for one’s health are feminine; and that the most powerful men among men are those for whom health and safety are irrelevant.

It has been demonstrated elsewhere (Courtenay, 1998a, 1999, 2000b) that the resources available in the US for constructing masculinities are largely
unhealthy. Men and boys often use these resources and reject healthy beliefs and behaviours in order to demonstrate and achieve manhood. By dismissing their healthcare needs, men are constructing gender. When a man brags, ‘I haven’t been to a doctor in years,’ he is simultaneously describing a health practice and situating himself in a masculine arena. Similarly, men are demonstrating dominant norms of masculinity when they refuse to take sick leave from work, when they insist that they need little sleep, and when they boast that drinking does not impair their driving. Men also construct masculinities by embracing risk. A man may define the degree of his masculinity, for example, by driving dangerously or performing risky sports – and displaying these behaviours like badges of honour. In these ways, and as shown in the following chapters, masculinities are defined against positive health behaviours and beliefs.

To carry out any one positive health behaviour, a man may need to reject multiple constructions of masculinity. For example, the application of sunscreen to prevent skin cancer – the most rapidly increasing cancer in the US (Centers for Disease Control [CDC], 1995a) – may require the rejection of a variety of social constructions: masculine men are unconcerned about health matters; masculine men are invulnerable to disease; the application of lotions to the body is a feminine pastime; masculine men don’t ‘pamper’ or ‘fuss’ over their bodies; and ‘rugged good looks’ are produced with a tan. In not applying sunscreen, a man may be simultaneously demonstrating gender and an unhealthy practice. The facts that 1.5 times more men than women nationally believe that one looks better with a tan (American Academy of Dermatology, 1997), that men are significantly less likely to use sunscreen (Mermelstein & Riesenberg, 1992; Courtenay 1998a, b), and that the skin cancer death rate is twice as high for men as for women (CDC, 1995b), may be a testament to the level of support among men for endorsing these constructions.

When a man does experience an illness or disability, the gender ramifications are often great. Illness ‘can reduce a man’s status in masculine hierarchies, shift his power relations with women, and raise his self-doubts about masculinity’ (Charmaz, 1995, p.268). The friend of a US senator cautioned him against publicly discussing his diagnosis of prostate cancer, contending that ‘some men might see [his] willingness to go public with his private struggle as a sign of weakness’ (Jaffe, 1997, p.134). In efforts to preserve their masculinity, one researcher found that men with chronic illnesses often worked diligently to hide their disabilities: a man with diabetes, unable to manoeuvre both his wheelchair and a cafeteria tray, would skip lunch and risk a coma rather than request assistance; a middle-aged man declined offers of easier jobs to prove that he was still capable
of strenuous work; an executive concealed dialysis treatments by telling others that he was away attending meetings (Charmaz, 1995).

Feminities and men’s health

It is not only the endorsement of hegemonic ideals but also the rejection of feminine ideals that contributes to the construction of masculinities and to the systematic oppression of women and less powerful men. Rejecting what is constructed as feminine is essential for demonstrating hegemonic masculinity in a sexist and gender-dichotomous society. Men and boys who attempt to engage in social action that demonstrates feminine norms of gender, risk being relegated to the subordinated masculinity of ‘wimp’ or ‘sissy’. Healthcare utilisation and positive health beliefs or behaviours are also socially constructed as forms of idealised femininity (Courtenay, 1999, 2000b, 2004a, b). They are, therefore, potentially feminising influences that men must oppose with varying degrees of force, depending on what other resources are accessible or are being utilised in the construction of masculinities. Forgoing healthcare is a means of rejecting ‘girl stuff’.

Men’s risk-taking, and denial and disregard of physical discomfort and healthcare needs, are all means of demonstrating difference from women, who are presumed to embody these ‘feminine’ characteristics. These behaviours serve both as proof of men’s superiority over women and as proof of their ranking among ‘real’ men. A man’s success in adopting (socially feminised) health-promoting behaviour, like his failure to engage in (socially masculinised) physically risky behaviour, can undermine his ranking among men and relegate him to a subordinated status. That men and boys construct masculinities in opposition to the healthy beliefs and behaviours of women – and less masculine (i.e. ‘feminised’) men and boys – is clearly apparent in their discourse, as evidenced by the remarks of one firefighter: ‘When you go out to fires, you will work yourself into the ground. Just so nobody else thinks you’re a puss’ (Delsohn, 1996, p.95). In prison, men criticise fellow prisoners who ‘complain too much’ about sickness or pain or make frequent healthcare visits, as displaying signs of ‘softness’ (Courtenay & Sabo, 2001).

Differences among men

Contemporary feminist theorists are as concerned about differences among men (and among women) as they are about differences between women and men. As Messerschmidt (1993, p.87) notes, ‘“Boys will be boys”
differently, depending upon their position in social structures and, therefore, upon their access to power and resources. Although men may endorse similar masculine ideals, different men may enact these ideals in different ways. For example, although most young men in the US may agree that a man should be ‘tough’ (Courtenay, 1998a), how each man demonstrates being tough – and how demonstrating toughness affects him physically – will be influenced by his age, ethnicity, social class and sexuality. Depending upon these factors, a man may use a gun, his fists, his sexuality, a mountain bike, physical labour, a car or the relentless pursuit of financial strength to construct this particular aspect of masculinity.

Social class positioning ‘both constrains and enables certain forms of gendered social action’ (Messerschmidt, 1993, p.94) and influences which unhealthy behaviours are used to demonstrate masculinity. Demonstrating masculinities with fearless, high-risk behaviours may entail skydiving for an upper-class man, mountain climbing for a middle-class man, racing hot rods for a working-class man, and street fighting for a poor urban man. Many working-class masculinities that are constructed as exemplary – as in the case of firemen – require the dismissal of fear, and feats of physical endurance and strength, that often put these men at risk of injury and death. The avoidance of healthcare is another form of social action that allows some men to maintain their status and to avoid being relegated to a subordinated position in relation to physicians and health professionals, as well as other men. For an upper-middle-class business executive, refusing to see a physician can be a means of maintaining his position of power.

The construction of health and gender does not occur in isolation from other forms of social action that demonstrate differences among men. Health practices may be used simultaneously to enact multiple social constructions, such as ethnicity, class and sexuality. The use of health beliefs and behaviours to construct the interacting social structures of masculinity and ethnicity is illustrated in this passage by a Chicano novelist:

_A macho doesn’t show weakness. Grit your teeth, take the pain, bear it alone. Be tough. You feel like letting it out? Well, then let’s get drunk with our compadres . . . Drinking buddies who have a contest to see who can consume the most beer, or the most shots of tequila, are trying to prove their maleness._ [Anaya, 1996, p.63]

Too often, factors such as ethnicity, class, and sexuality are simply treated by health scientists as variables to be controlled for in statistical analyses. However, the social structuring of ethnicity, sexuality and class is intimately and systematically related to the social structuring of gender and
power (see Courtenay, 2001a, 2002). These various social structures are constructed concurrently and are intertwined. When European American working-class boys speed recklessly through a poor African American neighbourhood, not wearing safety belts and yelling epithets out their windows, they are using health risk behaviours – among other behaviours – in the simultaneous construction of gender, power, class and ethnicity; when they continue these behaviours in a nearby gay neighbourhood, they are further reproducing gender, power and normative heterosexuality. Similarly, poor health beliefs and behaviours are used by men and boys to construct masculinities in conjunction with the use of other behaviours such as crime (Messerschmidt, 1993), work (Pyke, 1996) and being ‘cool’ (Majors & Billson, 1992). Committing criminal acts may be insufficient to win a young man inclusion in a street gang; he may also be required to prove his manhood by demonstrating his willingness to ignore pain or to engage in physical fighting.

**Making a difference: the negotiation of power and status**

Just as men exercise varying degrees of power over women, so they exercise varying degrees of power among themselves. ‘Masculinities are configurations of social practices produced not only in relation to femininities but also in relation to one another’ (Pyke, 1996, p.531). Dominant masculinities subordinate lower-status, marginalised masculinities – such as those of gay, rural or lower-class men (Courtenay & Sabo, 2001; Courtenay, 2002, 2006). In negotiating this perilous landscape of masculinities, the male body is often used as a vehicle. The comments of one man in prison illustrate how the male body can be used in structuring gender and power:

> I have been shot and stabbed. Each time I wore bandages like a badge of honor . . . Each situation made me feel a little more tougher than the next guy . . . Being that I had survived, these things made me feel bigger because I could imagine that the average person couldn’t go through a shoot out or a knife fight, survive and get right back into the action like it was nothing. The perception that I had constructed in my mind was that most people were discouraged after almost facing death, but the really bad ones could look death in the eye with little or no compunction. (Courtenay & Sabo, 2001, p.161)

Physical dominance and violence are easily accessible resources for structuring, negotiating and sustaining masculinities, particularly among men who because of their social positioning lack less dangerous means.
The health risks associated with any form of masculinity will differ depending on whether a man is enacting a hegemonic, subordinated, marginalised, complicit or resistant form. When men and boys are denied access to the social power and resources necessary for constructing hegemonic masculinity, they must seek other resources for constructing gender that validate their masculinity (Messerschmidt, 1993). Disadvantages resulting from such factors as ethnicity, class, educational level and sexual orientation marginalise certain men and augment the relevance of enacting other forms of masculinity. Rejecting health behaviours that are socially constructed as feminine, embracing risk and demonstrating fearlessness are readily accessible means of enacting masculinity. As one young man reported, ‘If somebody picks on you or something, and you don’t fight back, they’ll call you a chicken. But . . . if you fight back . . . you’re cool’ (Majors & Billson 1992, p.26). Among some African American men and boys, ‘toughness, violence, and disregard of death and danger become the hallmark of survival in a world that does not respond to reasonable efforts to belong and achieve’ (Majors & Billson, 1992, p.34). The results of one small study suggest that toughness and aggression are indeed means for young inner-city African American men to gain status in communities where few other means of doing so are available: ‘If a young man is a “tough guy,” peers respect him . . . The highest value is placed on individuals who defend themselves swiftly, even if by doing so they place themselves in danger’ (Rich & Stone, 1996, p.81).

Marginalised men may also attempt to compensate for their subordinated status by defying hegemonic masculinity and constructing alternative forms of masculinity. As Pyke (1996, p.531) explains, men ‘with their masculine identity and self-esteem undermined by their subordinate order-taking position in relation to higher-status males’ can and do use other resources to ‘reconstruct their position as embodying true masculinity’ (emphasis added). Other authors have variously referred to these alternative enactments of gender as oppositional (Messerschmidt, 1993), compulsive (Majors & Billson, 1992), compensatory (Pyke, 1996), or protest (Connell, 1995) masculinities. These ‘hypermasculine’ constructions are frequently dangerous or self-destructive (Meinecke, 1981). Majors and Billson (1992, p.34) suggest that compulsive masculinity can ‘lead toward smoking, drug and alcohol abuse, fighting, sexual conquests, dominance, and crime’. Pyke (1996, p.538) describes lower-class men who ‘ostentatiously pursued drugs, alcohol, and sexual carousing . . . [to compensate] for their subordinated status in the hierarchy of their everyday work worlds’. Similarly, working-class men can and do ‘use the physical endurance and tolerance of discomfort required of their manual labor as
signifying true masculinity, [as] an alternative to the hegemonic form’ (Pyke, 1996, p.531). When the demonstration of the dominant heterosexual ideal is not an option – as among gay men – dismissing the risks associated with high numbers of sexual partners or unprotected anal intercourse can serve for some men as a means of demonstrating a protest masculinity. In describing coming out gay, one young man said, ‘Rage, rage, rage! Let’s do everything you’ve denied yourself for 25 years. Let’s get into it and have a good time sexually’ (Connell, 1995, p.153).

Like unhealthy behaviours, dominant or idealised beliefs or attitudes about manhood also provide the means for demonstrating gender. These signifiers of ‘true’ masculinity are readily accessible to men who may otherwise have limited social resources for constructing masculinity. In fact, among young men nationally, lower educational level, lower family income and African American ethnicity are all associated with traditional, dominant norms of masculinity (Courtenay, 1998a). The stronger endorsement of traditional masculine ideology among African American men than among non-African American men is a consistent finding (Pleck et al., 1994b; Levant & Majors, 1998; Levant et al., 1998). Among African American men, the endorsement of dominant norms of masculinity is stronger for both younger and non-professional men than it is for older, professional men (Hunter & Davis, 1992; Harris et al., 1994). Similarly, national data indicate that young men in the US who are not exclusively heterosexual hold more traditional or dominant beliefs about masculinity than young men who are exclusively heterosexual (Courtenay, 1998a). The endorsement of hypermasculine beliefs can be understood as a means for gay and bisexual men to prove to others that, despite their sexual preferences, they are still ‘real’ men.

A growing body of research provides evidence that men who endorse dominant norms of masculinity engage in poorer health behaviours and have greater health risks than their peers with less traditional beliefs (see Courtenay, 2003 for a review; Courtenay & McCreary, in press). One longitudinal study of 1,676 young men in the US, aged 15 to 23 years, is among the few nationally representative studies to examine the influence of masculinity on health behaviour over time. When a variety of psychosocial factors were controlled for, beliefs about masculinity emerged as the strongest predictor of risk-taking behaviour 2.5 years later (Courtenay, 1998a). Dominant norms of masculinity – the most traditional beliefs about manhood adopted by young men – predicted the highest level of risk-taking and of involvement in behaviours such as cigarette smoking, high-risk sexual activity and use of alcohol and other drugs.
Rethinking compulsive, oppositional, compensatory, and protest masculinities

The terms compulsive, oppositional, compensatory and protest masculinities can be somewhat misleading. Most men are compulsive in demonstrating masculinity, which, as Connell (1995) notes, is continually contested. Furthermore, most masculinities that men demonstrate in the US are oppositional or compensatory; relatively few men construct the hegemonic masculine ideal. This is not to suggest, however, that hegemonic masculinity is not profoundly influential. On the contrary, hegemonic masculinity is a ubiquitous aspect of North American life. Most men necessarily demonstrate alternative masculinities in relation to hegemonic masculinity that variously aspire to, conspire with, or attempt to resist, diminish or otherwise undermine hegemonic masculinity. They do this not only in relation to other men perceived to embody hegemonic ideals, but also in relation to institutionalised, hegemonic social structures – including the government and media, the judicial system, corporate and technological industries, and academia. However, to suggest that only certain men are compulsive in demonstrating dominant norms of masculinity is to risk further marginalising the subordinated masculinities of lower-class, non-European American, non-heterosexual men. Masculinity requires compulsive practice, because it can be contested and undermined at any moment.

Further contextualising men’s health

As Messerschmidt (1993, p.83) notes, ‘Although men attempt to express hegemonic masculinity through speech, dress, physical appearance, activities, and relations with others, these social signs of masculinity are associated with the specific context of one’s actions and are self-regulated within that context.’ Because masculinity is continually contested, it must be renegotiated in each context that a man encounters. A man or boy will enact gender and health differently in different contexts. On the football field, a college student may use exposure to injury and denial of pain to demonstrate masculinity, while at parties he may use excessive drinking to achieve the same end. A man may consider the expression of emotional or physical pain to be unacceptable with other men, but acceptable with a spouse or girlfriend. In some contexts, such as a prison setting (Courtenay & Sabo, 2001), the hierarchies of masculinities are unique to that particular context.
Farm life provides a context within which to examine the negotiation of one form of rural masculinity. Growing up on a farm, much of what boys learn to do to demonstrate hegemonic masculinity requires them to adopt risky or unhealthy behaviours, such as operating heavy equipment before they are old enough to do so safely (for an extensive discussion, see Courtenay, 2006). As two rural men said, ‘If you’re over ten, you’d better be out doing men’s work, driving a tractor and that kind of thing’ (Fellows, 1996, p.173); ‘My brother Tony and I started driving the pickup on the farm at age six, as soon as we could reach the pedals. We also learned how to drive a tractor’ (Fellows, 1996, p.305). The ways to enact masculinity are dictated in part by cultural norms, such as the belief held by most Pennsylvanians that ‘farmers embody the virtues of independence and self-sufficiency’ (Willits et al., 1990, p.572; emphasis added). Farmers who attempt to demonstrate this cultural ideal of masculinity undermine their health – and there are many such farmers (see Courtenay, 2006).

It has been emphasised elsewhere (Rich & Stone, 1996; Courtenay & Sabo, 2001) that the negotiation of masculinity in certain contexts can present men with unique health paradoxes, particularly in regard to physical dominance and the use of violence. The perception both among some men in prison (Courtenay & Sabo, 2001) and some inner-city African American men (Rich & Stone, 1996) is that failing to fight back makes a man vulnerable to even more extreme victimisation than does retaliating. This health paradox is reflected in the ‘protective, though violent, posture’ described by Rich and Stone (1996, p.81): ‘If you appear weak, others will try to victimise you . . . if you show yourself to be strong [by retaliating], then you are perceived as strong and you will be safe’ (pp.80–81). Although these men neither actively resist nor embrace hegemonic masculinity, they are complicit in its reconstruction.

**Institutional structures, masculinities, and men’s health**

The institutionalised social structures that men encounter elicit different demonstrations of health-related beliefs and behaviours, and provide different opportunities to conduct this particular means of demonstrating gender. These structures – including the government and the military, corporations, the technological and healthcare industries, the judicial system, academia and the media – help to sustain gendered health risks by cultivating stereotypic forms of gender enactments and by providing different resources for demonstrating gender to women than they provide to men. Institutional structures, by and large, foster unhealthy beliefs and behaviours among men, and undermine men’s attempts to adopt healthier
habits (Courtenay, 2000b, 2002, 2006). The workforce is one such structure. The work that men do is the most dangerous work (see Courtenay, 2000a, 2003). Consequently, although they comprise only 56% of the US workforce, men account for nearly all (94%) fatal injuries on the job (National Institute for Occupational Safety and Health, 1993).

Although they have a profound influence on men’s health, institutional structures are not simply imposed on men any more than a prescribed male sex role is simply imposed on men. ‘Social structures do not exist autonomously from humans; rather . . . as we engage in social action, we simultaneously help create the social structures that facilitate/limit social practice’ (Messerschmidt, 1993, p. 62). Men are agents of social practice. When men demonstrate gender ‘correctly’, in the ways that are socially prescribed, they ‘simultaneously sustain, reproduce, and render legitimate the institutional arrangements that are based on sex category’ (West & Zimmerman, 1987, p. 146). In a continuous cycle, definitions of gender influence social structures, which guide human interactions and social action, which in turn reinforce gendered social structures. This ongoing process results in a gender division and a differential exposure that inhibits both women and men from learning behaviours, skills and capacities considered characteristic of the ‘opposite’ gender (West & Zimmerman, 1987; Epstein, 1988). Men sustain and reproduce institutional structures in part for the privileges that they derive from preserving existing power structures. The businessman who works tirelessly, denies his stress, and dismisses his physical needs for sleep and a healthy diet often does so because he expects to be rewarded with money, power, position and prestige. Thus, although they are increasing their health risks, men who achieve these hegemonic ideals are compensated with social acceptance; with diminished anxiety about their manhood; and with the rewards that such normative, masculine demonstrations provide in a patriarchal society. In these regards, men also contribute to the construction of a healthcare system that ignores their gendered health concerns. Indeed, they are often the very researchers and scientists who have ignored men’s gendered health risks.

The medical institution and its constructions of gender and health

The healthcare system and its allied health fields represent a particularly important structural influence in the construction of gender and health. In the case of cardiovascular disease, for example, it is often noted that the fact that women are less likely than men to be routinely tested or treated for symptoms can foster unrealistic perceptions of risk among women
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(Steingart et al., 1991; Wenger, 1994). Rarely, however, have the ways in which healthcare contributes to social constructions of men’s health been examined. It has been argued that sociologists, medical researchers and other health professionals have all contributed to cultural portrayals of men as healthy and women as the ‘sicker’ gender (Gijsbers van Wijk et al., 1991), to strongly held beliefs that men’s bodies are structurally more efficient than and superior to women’s bodies (Courtenay, 2000b), and to the ‘invisibility’ of men’s poor health status (Annandale & Clark, 1996).

As Nathanson (1977, p.148) noted over three decades ago, sex differences in health and health-related behaviour arise ‘out of a medical model that has singled out women for special professional attention’: ‘women are encouraged and trained to define their life problems in medical terms and to seek professional help for them’ (p.149). While the personal practice of participating in healthcare is constructed as feminine, the institutional practice of conducting, researching or providing healthcare is constructed as masculine and defined as a domain of masculine power. Physicians, who are primarily men, maintain power and control over the bodies of men who are not physicians and the bodies of women – as well as over male and female health professionals in lesser positions of power, such as nurses and orderlies. In these ways, the healthcare system does not simply adapt to men’s ‘natural’ masculinity; rather, it actively constructs gendered health behaviour and negotiates among various forms of masculinity. Medical, sociological and feminist approaches to addressing gender and health have all contributed to the devaluing of women’s bodies and to the privileging of men’s bodies, as two feminist authors have noted (Annandale & Clark, 1996).

Historically, women but not men in the US have been encouraged to pay attention to their health (Nathanson, 1977; Lonquist et al., 1992; Signorielli, 1993; Oakley, 1994; Annandale & Clark, 1996; Reagan, 1997). Decades of cancer education efforts in the US have been directed primarily at women (Reagan, 1997). Very rarely are educational or counselling interventions designed to reduce men’s health risks (Courtenay, 2001b, 2004a, b; Stanton & Courtenay, 2003). Men also receive significantly less physician time in their health visits than women do, and generally receive fewer services and dispositions than women (see Courtenay, 2003). Men are provided with fewer and briefer explanations – both simple and technical – in medical encounters (see Courtenay, 2003). During checkups, for example, they receive less advice from physicians about changing risk factors for disease than women do. One review revealed that no study has ever found that women received less information from physicians than men, which led the authors to conclude that the findings ‘may reflect
sexism in medical encounters, but this may act to the advantage of female patients, who have a more informative and positive experience than is typical for male patients’ (Roter & Hall, 1997, p.44).

A variety of scientific methodological factors and research methods, developed and conducted primarily by men, have also contributed to the model of deficient women’s bodies (Courtenay, 2000b). For example, the use of behavioural indices of health, such as bed rest and healthcare utilisation, both pathologises women’s health and underestimates men’s health problems. These indices confound our understanding of morbidity, because they actually represent how men and women cope with illness rather than representing their true health status (Gijsbers van Wijk et al., 1991); thus they obscure what may be greater illness among men (Verbrugge, 1988; Kandrack et al., 1991). The assumption underlying these and other indices of health is that male behaviour is the normative or hidden referent; consequently, researchers and theorists alike presume that women are in poorer health because women get more bed rest than men do and see physicians more often. The terms applied to these behaviours – behaviours that can be considered health promoting – further pathologise women’s health: women’s excess bed rest and women’s over utilisation of health services. These terms simultaneously transform curative actions into indicators of illness, make women’s health problematic, and reinforce men’s position in providing the standard of health or health behaviour. It has been argued that a cultural perception of men’s health problems as nonexistent is required both to construct women’s bodies as deficient and to reinforce women’s disadvantaged social position [Annandale & Clark, 1996]. To maintain this construction, ‘women “cannot” be well and . . . men cannot be ill; they are “needed” to be well to construe women as sick’ (Annandale & Clark, 1996, p.32). By dismissing their health needs and taking physical risks, men are legitimising themselves as the ‘stronger’ sex.

The poor health beliefs and behaviours that men use to demonstrate gender remain largely invisible: a testament to the potency of the social construction of men’s resiliency and health. Medical and epidemiological examinations of health and health behaviour consistently fail to take into account gender, apart from biological sex. For example, while men’s greater use of substances is well known, the reasons why men are more likely to use substances are poorly understood and rarely addressed. Similarly, although injury and death due to recreation, risk-taking and violence are always associated with being male, epidemiological and medical findings are consistently presented as if gender were of no particular relevance. Instead, men’s risk-taking and violence are taken for granted. This failure
of medical and epidemiological researchers to study and explain men’s risk-taking and violence perpetuates the false, yet widespread, cultural assumption that risk-taking and violent behaviours are natural to, or inherent in, men.

**Conclusion**

Research consistently demonstrates that women in the United States adopt healthier beliefs and personal health practices than men. A wealth of scientific data suggests that this distinction accounts in no small part for the fact that women suffer less severe chronic conditions and live more than five years longer than men. From a social constructionist perspective, this distinction can be understood as being among the many differences that women and men are expected to demonstrate.

If men want to demonstrate dominant ideals of manhood as defined in North American society, they must adhere to cultural definitions of masculine beliefs and behaviours and actively reject what is feminine. The resources available in the US for constructing masculinities – and the signifiers of ‘true’ masculinity – are largely unhealthy. Men and boys do indeed use these resources and adopt unhealthy beliefs and behaviours in order to demonstrate manhood. Although nothing strictly prohibits a man from demonstrating masculinities differently, to do so would require that he cross over socially constructed gender boundaries, and risk reproach and sometimes physical danger for failing to demonstrate gender correctly. By successfully using unhealthy beliefs and behaviours to demonstrate idealised forms of masculinity, men are able to assume positions of power, relative to women and less powerful men, in a patriarchal society that rewards this accomplishment. By dismissing their health needs and taking risks, men legitimise themselves as the ‘stronger’ sex. In this way, men’s use of unhealthy beliefs and behaviours helps to sustain and reproduce social inequality and the social structures that, in turn, reinforce and reward men’s poor health habits.

It should be noted that some men do defy social prescriptions of masculinity and adopt healthy behaviours, such as getting annual physical check-ups and eating healthy foods. But although these men are constructing a form of masculinity, it is not among the dominant forms that are encouraged in men, nor is it among the forms adopted by most men. It should also be noted that women can and do adopt unhealthy beliefs and behaviours to demonstrate femininities, as in the case of unhealthy dieting to attain a culturally defined body ideal of slimness. However, as has been
demonstrated elsewhere (Courtenay, 1998a, 2000b), the striving for cultural standards of femininity leads women to engage primarily in healthy, not unhealthy, behaviours.

This theory of gender and men’s health will undoubtedly meet with resistance from many quarters. As a society, we all work diligently at maintaining constructions of women’s health as deficient, of the female body as inferior, of men’s health as ideal, and of the male body as structurally efficient and superior. From a feminist perspective, these constructions can be viewed as preserving existing power structures and the many privileges enjoyed by men in the US. Naming and confronting men’s poor health status and unhealthy beliefs and behaviours may well improve their physical wellbeing, but it will necessarily undermine men’s privileged position and threaten their power and authority in relation to women.

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References


