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Constructions of masculinity and their influence on men's well-being: a theory of gender and health

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Abstract

Men in the United States suffer more severe chronic conditions, have higher death rates for all 15 leading causes of death, and die nearly 7 yr younger than women. Health-related beliefs and behaviours are important contributors to these differences. Men in the United States are more likely than women to adopt beliefs and behaviours that increase their risks, and are less likely to engage in behaviours that are linked with health and longevity. In an attempt to explain these differences, this paper proposes a relational theory of men's health from a social constructionist and feminist perspective. It suggests that health-related beliefs and behaviours, like other social practices that women and men engage in, are a means for demonstrating femininities and masculinities. In examining constructions of masculinity and health within a relational context, this theory proposes that health behaviours are used in daily interactions in the social structuring of gender and power. It further proposes that the social practices that undermine men's health are often signifiers of masculinity and instruments that men use in the negotiation of social power and status. This paper explores how factors such as ethnicity, economic status, educational level, sexual orientation and social context influence the kind of masculinity that men construct and contribute to differential health risks among men in the United States. It also examines how masculinity and health are constructed in relation to femininities and to institutional structures, such as the health care system. Finally, it explores how social and institutional structures help to sustain and reproduce men's health risks and the social construction of men as the stronger sex. © 2000 Elsevier Science Ltd. All rights reserved.

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Men in the United States, on average, die nearly 7 yr younger than women and have higher death rates for all 15 leading causes of death (Department of Health and Human Services [DHHS], 1996). Men's age-adjusted death rate for heart disease, for example, is 2 times higher than women's, and men's cancer

death rate is 1½ times higher (DHHS, 1996). The incidence of 7 out of 10 of the most common infectious diseases is higher among men than women (CDC, 1997). Men are also more likely than women to suffer severe chronic conditions and fatal diseases (Verbrugge and 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). Furthermore, men's health shows few signs of improving — their cancer death rates have increased more than 20% over the past 35 yr; the

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rates for women have remained unchanged during the same period (American Cancer Society, 1994).

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 health care, 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 2 times higher among African American men than among African American women (National Institutes of Health [NIH], 1992). Health behaviours, however, do help to explain gender differences in health and longevity. Many health scientists contend that health behaviours are among the most important factors influencing health, and that modifying health behaviours is “the most effective way” to prevent disease (Woolf et al., 1996, p. xxxvii). Although not all health professionals and scholars would agree, the evidence supporting this belief is compelling. According to a former U.S. surgeon general, a wealth of scientific data have “confirmed the importance ... of health behaviours in preventing disease” and “suggest that efforts directed at improving these behaviours are more likely to reduce morbidity and mortality in the United States than anything else we do” (Koop, 1996, p. viii). An independent scientific panel established by the U.S. government that has evaluated thousands of research studies recently estimated that half of all deaths in the United States could be prevented through changes in personal health practices (U.S. Preventive Services Task Force [USPSTF], 1996). Similar conclusions have been reached by other health experts reviewing hundreds of studies (Woolf et al., 1996). These findings provide strong evidence of risk reduction through preventive practice; they are among the factors that have recently revolutionised the U.S. health care system, a system that increasingly emphasises interventions that can effectively contain health care costs through disease prevention (USPSTF, 1996). These findings also recently led the U.S. assistant secretary for health to claim that “it is particularly pertinent to highlight the health consequences of behaviour” (Lee, 1996, p. v).

Many sociocultural factors are associated with and influence health-related behaviour. Gender is one of the most important of these factors. Women engage in far more health-promoting behaviours than men and have more healthy lifestyle patterns (Walker et al., 1988; Kandrack et al., 1991; Lonquist et al., 1992; Rossi, 1992; Courtenay, 1998a,b, in press a). Being a woman may, in fact, be the strongest predictor of preventive and health-promoting behaviour (Mechanic and Cleary, 1980; Brown and McCreedy, 1986; Ratner et al., 1994). Government health surveillance systems

are providing increasing evidence of gender differences in specific behaviours associated with risk among nationally representative samples. Data from one such system indicate that the prevalence of risk behaviours among adults is more common among men than women for all but 3 of 14 (nonsex-specific) behaviours, including smoking, drinking and driving, using safety belts, getting health screenings, and awareness of medical conditions (Powell-Griner et al., 1997). Compared to men, women nationally are making the most beneficial changes in their exercise habits (Caspersen and Merritt, 1995), are less likely to be overweight (Powell-Griner et al., 1997; National Institutes of Health, 1998), and are more likely to consume vitamin and mineral supplements (Slesinski et al., 1996). Among adults in South Carolina, women are more likely than men to practice a cluster of healthy behaviours (Shi, 1998). Among California college students, men are more likely than women to engage in 20 of 26 specific high-risk behaviours (Patrick et al., 1997). A recent, extensive review of large studies, national data, and meta-analyses summarises evidence of sex differences in behaviours that significantly influence health and longevity (Courtenay, in press a). 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.

Findings are generally similar for health care 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 health care visits than women do, independent of reproductive health care visits (Verbrugge, 1985, 1988; Kandrack et al., 1991). According to the U.S. 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 $2\frac{1}{2}$ times as likely.

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 and Gordon, 1995; Courtenay, 1998a). Early feminist scholars were among the first to engender health, noting, for example, the absence of women as subjects in health research and the use of males as the standard for health. The result, however, has been an exclusive emphasis on women, and “gender and health” has become synonymous with “women's health” (e.g. Bayne-Smith, 1996). 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. Even in studies that address health risks more common to men than women, the discussion of men's greater risks and of the influence of men's gender is often conspicuously absent. Instead, the "gender" that is associated with greater risk remains unnamed (e.g., Donnermeyer and Park, 1995). Left unquestioned, men's shorter life span 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 United States.

Health and the social construction of gender

Constructionism 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 and Peiss, 1985; Kimmel, 1986; Pleck, 1987; West and Zimmerman 1987; Epstein, 1988; Messerschmidt, 1993; Connell, 1995). The sex role theory of socialisation, still commonly employed in analyses of gender, 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 and 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 and Zimmerman, 1987, p. 140; italics theirs); 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 (Kimmel, 1995). 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 and Best, 1990; Golombok and 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 and Best, 1990; Golombok and 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 and Ksanskak, 1994; Rice and Coates, 1995; Street et al., 1995; Levant and 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 cul-

tures. 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, 1999a).

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 and Sabo, 1994); crime (Messerschmidt, 1993); and sex (Vance, 1995). The very manner in which women and men do 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. 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 (Kimmel, 1995). 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, 1998a, in press b). 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

As Messerschmidt (1993, p. 62) notes in regard to the study of gender and crime, a comprehensive feminist theory of health must similarly include men “not by treating men as the normal subjects, but by articulating the gendered content of men's behaviour”. 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. Microlevel 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 United States, 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 microlevel 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, 1999a,b) that the resources available in the United States 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 health care 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 honor. In these ways, 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 United States (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 1½ 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 and 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 U.S. senator recently 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 maneuver 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).

Feminites 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". A gay man who grew up on Indiana farms said he would have been ridiculed as a "sissy" had he done the (risk-free) tasks of cooking, baking, and sewing that he preferred: "My uncle would have started it and it would have spread out from there. Even my grandfather would say, 'Oh, you don't want to do that. That's girl stuff'". (Fellows, 1996, p. 12). Health care utilisation and positive health beliefs or behaviours are also socially constructed as forms of idealised femininity (Courtenay, 1998a, 1999a,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 health care is a means of rejecting “girl stuff”.

Men’s denial and disregard of physical discomfort, risk and health care 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). Similarly, one author, the chief editor of a major publishing company, recently revealed his concern about disclosing his pain to others after a radical prostatectomy: “I was reluctant to complain further [to hospital staff], for fear of being thought a sissy” (Korda, 1996, p. 148). In prison, men criticise fellow prisoners who “complain too much” about sickness or pain or make frequent health care visits, as displaying signs of “softness” (Courtenay and Sabo, in press).

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 United States 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 labor, 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 health care 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. Prisoners can similarly maintain their status by disregarding their health care needs: “When you got stabbed you usually banded yourself up... To go to the doctor would appear that you are soft” (Courtenay and Sabo, in press).

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, social 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, economic status 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 economic status is intimately and systematically related to the social structuring of gender and power. These various social structures are constructed concurrently and are intertwined. When European American working-class boys speed recklessly through a poor African American neighborhood, 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 neighborhood, 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 and 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. As Connell (1995, p. 76) notes, “To recognise more than one kind of masculinity is only a first step”; “we must also recognise the relations between the different kinds of masculinity: relations of alliance, dominance and subordination. These relationships are constructed through practices that exclude and include, that intimidate, exploit, and so on” (Connell, 1995, p. 37). 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 and Sabo, in press).

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, economic status, 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. Messerschmidt (1993, p. 110) notes that “participation in street violence, a more frequent practice when other hegemonic masculine ideals are unavailable (e.g., a job in the paid-labor market), demonstrates to closest friends that one is ‘a man’” — or 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 and 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 and 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 and Stone, 1996, p. 81). Gay and bisexual men or boys may also attempt to compensate by endangering themselves or by adopting physically dominant behaviours rather than being relegated to a lower-status position. As one man put it, “I really hated football, but I tried to play because it would make me more of a man” (Fellows, 1996, p. 40). Gay men may also refuse to engage in behaviour that reduces the risk of contracting AIDS when that behaviour contradicts dominant norms of masculinity: “Real men ignore precautions for AIDS risk reduction, seek many sexual partners, and reject depleasuring the penis. Abstinence, safer sex, and safer drug use compromise manhood” (Levine, 1998; pp. 146–147).

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 and 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 yr. Let’s get into it and have a good time sexually” (Connell, 1995, p. 153).

It is important to note that although these hyper-masculinities may aspire to or be complicit in the reconstruction of an idealised form of masculinity, they are not hegemonic. The fact that some inner-city African American men are successful in being “tough” or “cool,” and that some gay men refuse to have protected sex, does not mean that these men are enacting hegemonic masculinity. On the contrary, for marginalised men, “the claim to power that is central in hegemonic masculinity is constantly negated” (Connell, 1995, p. 116).

Like unhealthy behaviours, dominant or idealised beliefs 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 nonAfrican American men is a consistent finding (Pleck et al., 1994b; Levant and Majors, 1998; Levant et al., 1998). Among African American men, the endorsement of dominant norms of masculinity is stronger for both younger and nonprofessional men than it is for older, professional men (Hunter and Davis, 1992; Harris et al., 1994).

Gay and bisexual men may also adopt culturally sanctioned beliefs about masculinity to compensate for their subordinated and less privileged social position. National data indicate that young men in the United States who are not exclusively heterosexual hold more traditional or dominant beliefs about masculinity than

young men who are exclusively heterosexual (Courtenay, 1998a). Although this finding may at first glance appear counterintuitive, it is consistent with a constructionist and relational theory of men’s health. 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. Diaz (1998) also maintains that gay Latino men are more compelled to demonstrate dominant norms of masculinity than nongay Latino 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 (Neff et al., 1991; Pleck et al., 1994a; Eisler, 1995; O’Neil et al., 1995). One recent longitudinal study of 1676 young men in the United States, aged 15 to 23 yr, 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 2½ yr later. 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.

This feminist structural framework for understanding men’s health may help to explain the many health differences found among men, based on their ethnicity, socioeconomic status and education (DHHS, 1998). It may help to explain, for example, why men with the least education are twice as likely to smoke cigarettes as the most highly educated men, and nearly 3 times more likely to report frequent heavy alcohol use; and why their death rate for injuries is nearly 3½ times higher and (among those 25 to 44 yr of age) their death rate for homicide is 7 times higher (DHHS, 1998).

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 United States 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, nonheterosexual men. Masculinity *requires* compulsive practice, because it can be contested and undermined at any moment.

Whichever term one chooses to use to describe masculinities that resist (or undermine) hegemonic masculinity, it is critical to distinguish among various forms of resistant masculinity. In terms of men's health, the risks associated with enacting gender can differ greatly among different forms of resistant masculinity. Gay men who identify as *radical fairies* (Rose, 1997) and pacifists provide two examples of men who actively undermine hegemonic masculinity. These men are enacting very different resistant masculinities than those enacted by inner-city gang members, who are constructing an alternate *yet still authoritative and dominant* form of masculinity. Indeed, when lower-class men who lack access to cultural or economic resources attempt to demonstrate power and authority through the use of physical violence, it could be argued that they are not enacting a "compensatory" form of masculinity, but rather a form of *situational or interpersonal hegemony*. Furthermore, the resistant masculinities demonstrated by pacifists, radical fairies and inner-city gang members lead to very different levels and categories of health risk; the masculinities enacted by radical fairies and pacifists may in fact reduce their risks, unlike those forms requiring the use of physical dominance or violence.

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 and Sabo, in press), 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. 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); and, "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). Another rural man describes similar expectations: "if you were a guy ... you were born to be a total, typical, straight male — to play sports, to hunt, to do everything a guy was supposed to do" (Fellows, 1996, p. 307). 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. Among Wisconsin residents who had suffered agricultural injuries — most of whom were men — farmers were the most likely to delay seeking health care; half of them waited for over 2 hr and one in four waited 24 hr (Stueland et al., 1995). Long (1993) described a farmer who caught his finger in equipment while harvesting his wheat field; he pulled his finger out — severing it — wrapped his hand in a handkerchief, and finished his work for the day before seeking medical care.

It has been emphasised elsewhere (Courtenay and Sabo, in press; Rich and Stone, 1996) 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 and Sabo, in press) and some inner city African American men Rich and 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 may 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, technological industries, the judicial system, academia, health care system 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, 1998a, in press a).

The workforce is one such structure. The work that men do is the most dangerous work. Mining, construction, timber cutting and fishing have the highest injury death rates in the United States, while the largest number of total injury deaths occur in construction, transportation, agriculture, farming, foresting and fishing — all of which are jobs held primarily by men (Bureau of Labor Statistics, 1993; National Institute for Occupational Safety and Health [NIOSH], 1993). Consequently — although they comprise only half (56%) of the U.S. workforce — men account for nearly all (94%) fatal injuries on the job (NIOSH, 1993). Furthermore, as one small study found, positive health-related activities often conflict with the work activities expected of men — and work is typically given precedence, as evidenced by one man’s comments: “I’d do more [to be healthy], but I can’t with my job hours. My boss at the lab would kill me” (Saltonstall, 1993, p. 11). When a corporate law firm requires its employees to work 12- to 14-hr days, it is limiting access to health care for its (primarily male) attorneys.

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 and Zimmerman, 1987, p. 146). In a con-

tinuous 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 and 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 health care system that ignores their gendered health concerns. Indeed, they are often the very researchers and scientists who have ignored men’s gendered health risks. As Assistant Surgeon General Susan Blumenthal, who directs the Office on Women’s Health at the U.S. Public Health Service, noted recently, “Men need to become advocates and speak passionately about their health, but they may be concerned that speaking out will reveal weakness, not strength” (Jaffe, 1997, p. 136). As Coward (1984, p. 229) notes, men have kept their bodies from being the subjects of analysis: “Men’s bodies and sexuality are taken for granted, exempted from scrutiny, whereas women’s are extensively defined and overexposed. Sexual and social meanings are imposed on women’s bodies, not men’s ... men have left themselves out of the picture because a body defined is a body controlled”.

The medical institution and its constructions of gender and health

Connell (1993) identifies three institutions that are particularly relevant in the contemporary organisation of gender: the state, the workplace/labor market and the family. The health care 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 (Steingart et al., 1991; Wenger, 1994). Rarely, however, have the ways in which health care contrib-

utes to social constructions of men's health been examined. Recently, 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, 1998a); and to the "invisibility" of men's poor health status (Annandale and Clark, 1996).

As Nathanson (1977, p. 148) noted two 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 health care is constructed as feminine, the institutional practice of conducting, researching or providing health care 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 health care 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 recently (Annandale and Clark, 1996).

Historically, women but not men in the United States have been encouraged to pay attention to their health (Nathanson, 1977; Lonnquist et al., 1992; Signorielli, 1993; Oakley, 1994; Annandale and Clark, 1996; Reagan, 1997). According to Reagan (1997), who recently analysed decades of cancer education in the United States, these educational efforts have been directed primarily at women. Although many counseling and psychological interventions with men have been recommended in the past two decades (Courtenay, in press c), very rarely are these interventions designed to reduce men's health risks (Courtenay, 1998c). Men also receive significantly less physician time in their health visits than women do (Blanchard et al., 1983; Waitzkin, 1984; Weisman and Teitelbaum, 1989), and generally receive fewer services and dispositions than women (Verbrugge and Steiner, 1985). Men are provided with fewer and briefer explanations — both simple and technical — in medical encounters (Waitzkin, 1984; Hall et al., 1988; Weisman and Teitelbaum, 1989). During checkups, they receive less advice from physicians about changing risk factors for disease

than women do (Friedman et al., 1994). Only 29% of physicians routinely provide age-appropriate instruction on performing self-examinations for testicular cancer, compared to the 86% who provide instruction to women on performing breast examinations (Misener and Fuller, 1995). A recent 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 and Hall, 1997, p. 44).

A variety of scientific methodologic factors and research methods — developed and conducted primarily by men — have also contributed to the model of deficient women's bodies (Courtenay, 1998a, in press b). For example, the use of behavioural indices of health — such as bed rest and health care utilisation — both pathologises women's health and underestimates the significance of 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 *overutilisation* 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.

Given that women are unquestionably less susceptible to serious illness and live longer than men, it would seem that women should provide the standard against which men's health and men's health behaviour are measured. If this were the case, we would be compelled instead to confront men's *inadequate* bed rest and men's *underutilisation* of health care. However, the social forces that maintain women's health as problematic are strong. When morbidity statistics and women's greater propensity for illness are challenged as an artifact of research, for example, the conventional reading of this challenge further pathologises women's health by suggesting that women "aren't really ill at all, they're only inventing it" (Oakley, 1994, p. 431). In contrast, the interpretation that men really *are* ill and they are simply denying it is rarely

proposed. It was recently 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 and 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 and Clark, 1996, p. 32). By dismissing their health needs and taking physical risks, men are legitimising themselves as the "stronger" sex.

Despite countless examples in research, literature and daily life, 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 epidemiologic examinations of health and health behaviour consistently fail to take into account gender, apart from biologic 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, epidemiologic and medical findings are consistently presented as if *gender* were of no particular relevance (Courtenay, 1999b). Few health scientists, sociologists and theorists identify masculinities — and rarely even male sex — as a risk factor; fewer still have attempted to identify what it is about men, exactly, that leads them to engage in behaviours that seriously threaten their health. Instead, men's risk taking and violence are taken for granted.

The failure of medical and epidemiologic 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. Similarly, cultural assumptions that men simply don't (read inherently) seek help prevent society from defining men's underutilisation of health services as a problem. Although it too is taken for granted, there is nothing natural about the fact that men make fewer health visits than women. Early in their lives, most adolescent girls in the United States are *taught* the importance of regular physical exams and are introduced to them as a part of being a woman; adolescent boys are not taught that physical exams are part of being a man. Furthermore, for many men, it is their wives, girlfriends and mothers who monitor their health and schedule any medical appointments that they have. Men who want to take greater responsibility for their health will need not only to cross gendered boundaries, but also to learn new skills. Gendered health perspectives that address social structural issues and masculinity are similarly absent from health science research and literature.

Such perspectives could, for example, utilise a gendered approach to examining men's work and their far greater exposure to industrial carcinogens as a possible explanation for their greater risk of cancer as compared to women.

The social construction of disease

Depression provides one example of how the health care system contributes to the social construction of disease. Despite suicide rates that are 4 to 12 times higher for men than for women (DHHS, 1994), according to Warren (1983), early documentation on the prevalence of depression among women based on self-reporting has resulted in an emphasis on treating women for depression and suggested an immunity to depression among men. Although young men account for nearly seven of eight suicides among those 15 to 24 yr old (DHHS, 1996) — an age group in which suicide is the third leading cause of death — a recent large study based exclusively on self-report data concluded that depression is a "more critical" health problem for college women than for college men (Sax, 1997, p. 261). This study fails to take into account men's suicides in this age group. It also disregards decades of research that have consistently found a lack of significant sex differences in *diagnosable* depression among college students (Nolen-Hoeksema, 1987; Courtenay, 1998b).

Treatment rates are also used as indicators of morbidity. However, because depressed men have been found to be more likely than depressed women to not seek help (Chino and Funabiki, 1984; O'Neil et al., 1985), treatment rates are likewise an inaccurate measure of depression. Gender-biased diagnostic decisions of mental health clinicians also contribute to inaccuracies in morbidity statistics (Waisberg and Page, 1988; Ford and Widiger, 1989; Fernbach et al., 1989; Adler et al., 1990). One recent large and well-constructed study found that clinicians were less likely to identify the presence of depression in men than in women, and that they failed to diagnose nearly two thirds of the depressed men (Potts et al., 1991).

Although the failure among clinicians to diagnose depression in men contributes to men's low treatment rates, men's own unwillingness to seek help contributes to the social construction of their invulnerability to depression. Indeed, in response to depression, men are more likely than women to rely on themselves, to withdraw socially, to try to talk themselves out of depression, or to convince themselves that depression is "stupid" (Warren, 1983; Chino and Funabiki, 1984; O'Neil et al., 1985). Nearly half of men over age 49 nationally who reported experiencing an extended depression did not discuss it with anyone (American

Medical Association, 1991). Instead, men tend to engage in private activities, including drinking and drug use, designed to distract themselves or to alleviate their depression (Chino and Funabiki, 1984; Nolen-Hoeksema, 1987). Denial of depression is one of the means men use to demonstrate masculinities and to avoid assignment to a lower-status position relative to women and other men. As Warren (1983, p. 151) notes, “The linkage between depression and femininity may provide men with the strongest motivation to hide their depression from others,” and, “Because depression is frequently accompanied by feelings of powerlessness and diminished control, men may construe depression as a sign of failure”.

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 nearly 7 yr 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 United States 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 physicals 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, in press b), the striving for cultural standards of femininity leads women to engage primarily in healthy, not unhealthy, behaviours.

This relational 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 United States. Naming and confronting men’s poor health status and unhealthy beliefs and behaviours may well improve their physical well-being, but it will necessarily undermine men’s privileged position and threaten their power and authority in relation to women.

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