

Engendering Health: A Social Constructionist Examination of Men's Health Beliefs and Behaviors*

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Abstract: Men in the United States suffer more severe conditions, have consistently higher death rates, and die nearly 7 years younger than women. Health-related beliefs and behaviors contribute significantly to these gender differences. To explain why women and men adopt the health beliefs and behaviors that they do, this article reviews research examining gender differences in social experiences, cultural representations of gender, and additional social and institutional structures, such as the media and the health care system. This review reveals that North Americans collectively work diligently to reinforce stereotypically feminine or masculine behavior in themselves and others, and that the beliefs and behaviors fostered in men and boys, the resources available to demonstrate masculinity, and the resources boys and men use to enact gender are largely unhealthy. It illuminates how cultural dictates, everyday interactions, and social and institutional structures help to sustain and reproduce men's risks, and how the health beliefs and behaviors that people adopt are means for demonstrating femininities and masculinities.

Men in the United States, on average, die nearly 7 years younger than women and have higher death rates for all 15 leading causes of death (U.S. 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 1.5 times higher (DHHS, 1996). Men are also more likely to suffer severe chronic conditions and fatal diseases (Verbrugge & Wingard, 1987). A variety of factors contribute to these gender differences and influence health and longevity, such as biology, economic status, and ethnicity. Many health scientists contend that health behaviors are the most important of these factors. The evidence supporting this belief is compelling. An independent scientific panel established by the U.S. government that has evaluated thousands of research studies recently estimated that half of all deaths could be prevented through changes in personal health practices (U.S. Preventive Services Task Force, 1996).

* Citation: Courtenay, W.H. (2000). Engendering health: A social constructionist examination of men's health beliefs and behaviors. *Psychology of Men and Masculinity*, 1(1), 4-15.

Although many sociocultural factors are associated with health behavior, gender is among the most important. Men have significantly less healthy lifestyles than women (Courtenay, 1998b, in press a), and being a woman may, in fact, be the strongest predictor of health-promoting behavior (Brown & McCreedy, 1986; Ratner, Bottorff, Johnson, & Hayduk, 1994). Few contemporary researchers or theorists have offered explanations for these gender differences and their implications for men's health (Courtenay, 1998a, 1998b, in press b; Sabo & Gordon, 1995). Feminist scholars were among the first to engender health, noting, for example, the absence of women as participants in health research and the use of men as the standard for health. The result, however, is that "gender and health" has now become synonymous with "women's health" (e.g., Bayne-Smith, 1995). Although health science of this century has frequently used males as study participants, the health risks associated with men's gender—or masculinity—have remained largely unproblematic and taken for granted. Little is understood about *why* men engage in riskier behaviors and adopt fewer health-promoting habits; nor have the social practices and institutional structures that influence these beliefs and behaviors been studied. The present review and analysis uses a social constructionist framework to examine these topics.

Evidence of Gender Differences in Health Beliefs and Behaviors

The possibility that poor health behavior on the part of men might account for gender differences in mortality had been raised as early as the mid-1970s (e.g., Goldberg, 1976; Harrison, 1978; Waldron, 1976). Since then, a growing body of research has provided strong evidence that men indeed have far less healthy lifestyles than women. A recent, extensive review summarizing this research systematically demonstrates that men are more likely than women to engage in more than 30 behaviors that increase the risk of disease, injury, and death (Courtenay, in press a). Although a thorough review of this evidence is beyond the scope of this article, a brief discussion serves to illustrate the point.

National health surveillance systems are providing increasing evidence of gender differences in behavior. Data from one such system indicate that the prevalence of behavioral risk factors in adults is more common among men than women for all but 3 of 16 (non-sex-specific) factors, including smoking, drinking and driving, safety belt use, and attending health screenings (Powell-Griner, Anderson, & Murphy, 1997). In comparison with men, women are making more beneficial changes in exercise (Caspersen & Merritt, 1995), are less likely to be overweight (National Institutes of Health, 1998; Powell-Griner et al., 1997), and are more likely to consume vitamin and mineral supplements (Slesinski, Subar, & Kahle, 1996).

Men are also less willing than women to seek support in situations in which they need help (e.g., Courtenay, 1998b; Rule & Gandy, 1994), including help for physical illnesses (Boehm et al., 1993). Men represent 65% of those who have not had a physician visit in 2 to 5 years and 70% of those who have not had a visit for more than 5 years (DHHS, 1998b). Among people with health problems, men are significantly more likely than women to have had no recent physician contacts regardless of income or ethnicity (DHHS, 1998a). Delays in obtaining timely health care can have profound consequences for men's health; early detection is often critical for preventing disease and death (DHHS, 1998a).

Similar gender differences are found in health beliefs. Even though men are at greater risk for all leading causes of death, they are consistently less likely than women to perceive themselves as being at risk for health problems (e.g., Boehm et al., 1993; Courtenay, 1998b; Flynn, Slovic, & Mertz, 1994; Savage, 1993). Seventy percent of U.S. men consider their health to be either “excellent” or “very good” (DHHS, 1998b). Men’s perceived invulnerability increases their risks and can prevent them from changing unhealthy behavior (e.g., Rosenstock, 1990). Men are also less responsive to or interested in obtaining health information than women and view it as less important than women do (e.g., Boehm et al., 1993; Hibbard & Pope, 1986; Spilman, 1988). Indeed, men are far less knowledgeable than women about health in general (Courtenay, 1998a, 1998b) and about specific diseases and their risk factors, such as cancer (Bostick, Sprafka, Virnig, & Potter, 1993), sexually transmitted diseases (EDK Associates, 1995), and heart disease (Ford & Jones, 1991). A lack of health knowledge has been associated with underuse of health care (Hibbard & Pope, 1986; Love, 1991) and with unhealthy behaviors, such as not using sun protection (see Courtenay, 1998b) and engaging in unsafe sex practices (EDK Associates, 1995).

Men’s beliefs about manhood also influence their health. A growing body of research provides evidence that men who endorse dominant norms of masculinity adopt poorer health behaviors and have greater health risks than their peers who endorse less traditional norms (e.g., Eisler, 1995; O’Neil, Good, & Holmes, 1995). In a recent longitudinal, national study of young men, traditional beliefs about manhood emerged as the strongest predictor of risk behaviors over time (Courtenay, 1998a). Although traditional masculinity is sometimes positively associated with men’s health (Courtenay 1996a; Eisler, 1995; Sabo & Gordon, 1995), the weight of the evidence suggests that men’s health risks increase with increasing endorsement of these norms.

Despite these consistent findings, few attempts have been made to explain why men are more likely than women to adopt unhealthy beliefs and behaviors. The following sections provide a social constructionist explanation for these findings.

The Social Construction of Gender and Health

Most previous explanations of men’s health risks have focused on the hazardous influences of “the male sex role” (Goldberg, 1976; Harrison, 1978). But men and boys are not passive victims of a socially prescribed role, nor do they construct only one role. Rather, they participate actively in sustaining and reproducing a variety of male “roles” and the social structures that foster them (for further discussion and critique of sex role theories, see Courtenay, 1998a, 1999a, in press b). According to social constructionist theory, women and men think and act in the ways 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. From this perspective, gender does not reside in the person; rather it resides in social transactions defined as gendered (Crawford, 1995). Furthermore, gender represents not two rigid or static categories (i.e., man or woman) but, rather, “a set of socially constructed relationships which are produced and reproduced through people’s actions” (Gerson & Peiss, 1985, p. 327). The daily 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. According to constructionist theorists, people are not simply “conditioned” or “socialized” by their cultures. Men and women are active agents in constructing and reconstructing dominant norms of femininity and masculinity. This concept of agency—the part individuals play in exerting power and producing effects in their lives—is central to constructionism (Courtenay, 1999a).

Previous authors have examined how a variety of activities are used as resources in constructing gender; these activities include language (Crawford, 1995), work (Connell, 1995), sports (Messner & Sabo, 1994), crime (Messerschmidt, 1993), and sex (Vance, 1995). The very manner in which women and men engage in these activities contributes both to the defining of oneself as gendered and to social conventions of gender. Similarly, the health beliefs and behaviors that an individual adopts simultaneously define and enact representations of gender and self. These beliefs and behaviors, like language, can be understood as “a set of strategies for negotiating the social landscape” (Crawford, 1995, p. 17) and as tools for constructing gender. 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”; “the doing of health is a form of doing gender” (Saltonstall, 1993, p. 12).

The sections to follow review evidence of gender differences in social experiences, cultural representations of gender, and social structural influences on gender. The review is limited to evidence that has implications for the health of women and men. Many of the studies reviewed examined gender stereotypes, characteristics that are generally believed to be “typical” either of women or of men. The theoretical bases for the studies vary widely and include research based on sex role theories that ignore agency or construct gender as one type. Nonetheless, this research offers a rich source of data that provides a basis for better understanding how women and men come to construct their beliefs about health, what resources are available to them for doing health, and how they learn to use health beliefs and behaviors to demonstrate gender.

These findings must be interpreted with caution. It is frequently claimed or implied that sex causes certain beliefs or behaviors simply because an association—which may be explained by other factors—has been found. Furthermore, contrasting two categorical notions of gender can reinforce binary distinctions of gender and can obscure the fact that women and men are more similar than dissimilar. It can also obscure the many differences among men. Despite these possible limitations, examination of gender differences in social experiences is a potentially valuable constructionist strategy (Crawford, 1995). It illuminates a process in which biological sex is transformed into gender.

Differential Treatment of Girls and Boys: The Early Makings of Gendered Health Behavior

Because there is high agreement in U.S. society about what are considered to be typically feminine and typically masculine characteristics (Williams & Best, 1990), it is not surprising that parents and other adults treat girls and boys differently from the very first day of life. In fact, regardless of an infant’s gender, parents and other adults interact with the infant on the basis of what they believe to be the infant’s gender. If adults believe that an infant is a boy, for example,

they will perceive it as stronger, firmer, or less fragile, than an infant who they believe is a girl (Golombok & Fivush, 1994).

Research indicates that parents provide less warmth and nurturance to their sons than to their daughters (Lytton & Romney, 1991). From infancy to adolescence, parents and other adults interact more emotionally with girls than with boys; they talk less about sadness and more about anger with boys; and they interpret the same emotional response as fear in girls but as anger in boys (Carli, 1997; Golombok & Fivush, 1994). Similarly, girls are encouraged to look inside themselves and notice their feelings, whereas boys are not (Block, 1984). Toys, games, and activities chosen by parents are consistently found to promote gender stereotypes (Carli, 1997; Lytton & Romney, 1991). Male infants and boys are also played with and handled more roughly than girls (Golombok & Fivush, 1994; Maccoby & Jacklin, 1974). Parents physically distance themselves more from boys than from girls, encourage boys in activities that limit proximity to others, encourage boys to be less dependent than girls, and express less concern about danger to their sons than to their daughters (Aries & Olver, 1985; Golombok & Fivush, 1994; Lytton & Romney, 1991). Furthermore, one study showed that boys were actively discouraged from seeking the help of their parents or other adults and were even punished when they did (Fagot, 1984). It is also well established that boys receive significantly more physical punishment than girls—both from adults and from their peers (Golombok & Fivush, 1994; Lytton & Romney, 1991; Maccoby & Jacklin, 1974). Moreover, boys are encouraged to fight. In fact, three of four Americans believe that it is important for a boy to have a few fistfights while he is growing up (Gelles & Straus, 1988).

From a social constructionist perspective, girls and boys are not blank slates that are written on or “socialized”; rather, they are active participants along with the world around them in the construction and reconstruction of gender. Peers provide boys and girls with important information about the responses they can expect for demonstrating behaviors considered appropriate or inappropriate for their gender. Girls and boys punish peers whose behavior crosses gender-stereotypic boundaries (Carter & McCloskey, 1984; Thorne, 1993). Not surprisingly, how girls and boys think their peers will act and respond to them greatly influences their gender-related preferences (Katz & Boswell, 1986).

Despite a popular assumption that gender stereotypes are loosening, research shows no evidence of any trend among parents to treat their daughters and sons in less sex-differentiated ways (Lytton & Romney, 1991). In fact, parents, peers, teachers, and other adults do everything they can to encourage gender-stereotypic behavior in boys and girls (Golombok & Fivush, 1994). Research consistently indicates, however, that more stringent demands to conform to gender-stereotypic behavior are placed on boys than on girls and that boys become subject to these demands at an earlier age (Golombok & Fivush, 1994). Boys have far less latitude in choosing what they can wear, what they can play, and whom they can play with, and they are seen far more negatively than girls when they engage in nonstereotypic behavior (Maccoby & Jacklin, 1974). Girls and boys themselves react more negatively toward male than toward female peers who display behaviors or preferences that cross gender stereotypes, and these reactions become increasingly negative as they grow older; boys, for example, are hit and ridiculed whereas girls are

ignored (Carter & McCloskey, 1984; Golombok & Fivush, 1994; Zucker, Wilson-Smith, Kurita, & Stern, 1995).

These gender differences in the early social experiences of girls and boys each have important implications for men's health. They may help to explain why, for example, men perceive themselves to be less vulnerable to physical harm than women do. These implications are addressed in greater detail subsequently.

Additional Social Transactions and Institutional Influences

Gender is not static; it is something that people construct and reconstruct. This dynamic process occurs in ongoing interaction with social and institutional structures. As noted by Connell (1993), "*masculinity is an aspect of institutions, and is produced in institutional life, as much as it is an aspect of personality*" (p. 602). Institutional structures provide both limits and opportunities to learn and display gender and can either foster or undermine people's attempts to adopt healthy habits. Therefore, health beliefs and behaviors are best understood when they are situated in the social transactions and structures that contribute to sustaining and reproducing them. This section focuses primarily on media and the health care system.

Engendered media and health. Clear distinctions are drawn in the media between the health behavior of women and that of men. In top-grossing U.S. films, smoking is done primarily by men, who are represented smoking 4 times more often than women (Hazan, Lipton, & Glantz, 1994). On prime-time television, 3 to 6.5 times more male than female characters smoke, and these characters rarely demonstrate the negative consequences of smoking (Gerbner, Gross, Morgan, & Signorielli, 1981; Signorielli, 1993). Linking the use of smokeless tobacco with virility and athletic performance is a common marketing strategy of tobacco companies, which target young men in particular (Connolly, Orleans, & Blum, 1992). *Sports Illustrated*, the magazine most often read by men, has more tobacco—as well as alcohol—advertisements than any other magazine (Klein et al., 1993). It is no coincidence that the most popular Madison Avenue icons of smoking—Joe Camel and the Marlboro Man—are male. Documents recently released by R.J. Reynolds Tobacco Company reveal that the "Joe Camel" advertising campaign was "designed to lure teenagers . . . especially boys" ("Joe Camel," 1998, p. A1).

Gendered media portrayals of alcohol consumption are similar. At least one character drinks alcohol in 60% of all prime-time television programs, and two thirds of these characters are men (Wallack, Breed, & Cruz, 1987). Research consistently reveals an unmistakable link between alcohol and masculinity in the various media, an association that is further strengthened by advertisers who "[interjoin] their products with athletic events" and who "strategically [place] ads in magazines and television programs with predominantly male audiences" (Lemle & Mishkind, 1989, p. 215). Beer commercials further link men's drinking with taking risks and facing danger without fear (Signorielli, 1993; Strate, 1992).

Body image and the relevance of diet are also gendered in the media. Women and girls are consistently portrayed as slimmer than men and boys in television, movies, and magazines (Signorielli, 1993; Silverstein, Peterson, & Kelley, 1986). In prime-time television, 3 times more male than female characters are obese (Gerbner et al., 1981). Women's magazines have far more messages about staying healthy and fit than men's magazines, which promote alcohol consumption almost exclusively (Signorielli, 1993).

Men and boys on television are also more likely than women and girls both to initiate violence and to get away with it (e.g., McGhee & Frueh, 1980; Signorielli, 1993). Violent and antisocial behaviors are often portrayed as effective means for male characters to meet their objectives; typically, these behaviors are rewarded and have no negative consequences (Heintz-Knowles, 1995; Sege & Dietz, 1994; Signorielli, 1993). Boys are 60% more likely than girls to be portrayed using physical aggression (Heintz-Knowles, 1995). Toy commercials demonstrate similar gender differences in aggressive behavior (Zuckerman, Singer, & Singer, 1980).

Despite these clear demonstrations of unhealthy behavior by men, it is women who are twice as likely to receive advice from physicians on television; it is also women who are most likely to die in daytime serials (Gerbner et al., 1981; Signorielli, 1993). For example, they are 4 times more likely than men to die from heart disease (Signorielli, 1993). Men currently represent 80% of those infected with HIV (Courtenay, in press a); on television, however, women and children account for 75% of characters suffering from the disease (Signorielli, 1993). This evidence suggests that, in the world of television, men and boys are invulnerable to the risks that their unhealthy behaviors pose. Indeed, invincible superheroes are characterized primarily as men (Pecora, 1992).

These media representations of gender have been found to contribute significantly to negative health effects (e.g., Hazan et al., 1994; Heintz-Knowles, 1995; Wallack et al., 1987). Research consistently reveals an association between the viewing of television violence and subsequent violent and aggressive behavior; there is also some evidence that this association is causal (e.g., Sege & Dietz, 1994; Signorielli, 1993). Boys who watch television 25 hours or more per week—as most do—are more likely than those who do not to adopt the unhealthy, “manly” behavior that is demonstrated (McGhee & Frueh, 1980). There is also some evidence that exposure to alcohol consumption on television is associated with increased favorable drinking attitudes (Signorielli, 1993).

Other social transactions and structural influences. One of the most important structural influences on gendered health behavior is work. “Women’s work”—work in which the vast majority of employees are female—includes such positions as secretary, receptionist, child care professional, nurse, and salesperson (Bureau of Labor Statistics, 1991). Timber cutting, fishing, mining, construction, truck driving, and farming are carried out almost exclusively by males and are considered “men’s work.” The work that men do is the most dangerous work (Bureau of Labor Statistics, 1993; National Institute for Occupational Safety and Health [NIOSH], 1993), and consequently—although they constitute only half (56%) of the workforce—men account for nearly all (94%) of the 16 fatal injuries that occur on the job each day (Centers for Disease Control and Prevention, 1998; NIOSH, 1993).

Cooking and nutrition are socially constructed as feminine. On television, far more women than men are homemakers and cooks (Peirce, 1989), and men’s magazines suggest that food choices are irrelevant to men (Signorielli, 1993). In the minds of both girls and boys, the enjoyment of cooking is associated with feminine behaviors (Golombok & Fivush, 1994). Not surprisingly, fewer than one third of men report that they like to cook (“Health Bulletin,” 1995); only one in five married American men does cook (Astrachan, 1988). Most men lack basic

knowledge about foods and nutritional risk factors, which are considered essential in improving dietary practices and reducing health risks (Courtenay, 1998a).

Playing sports is a major element in defining traditional masculinity (Connell, 1995; Kidd, 1987). On television, for example, male characters are more often portrayed as playing sports than are female characters (Peirce, 1989). Sport has long been a male preserve and has been consciously designed to make men out of males (Kidd, 1987). In many of men's sports, use of aggression and acceptance of health risks are rationalized and idealized (Messner & Sabo, 1994; White, Young, & McTeer, 1995); not surprisingly, men are more likely than women to engage in dangerous sports, and men sustain most of the 5 million sport injuries that occur each year (Courtenay, 1998a, in press a; Zuckerman 1994).

The institutional structure of prisons also contributes to constructions of masculinity, particularly violent and unhealthy forms of masculinity (Courtenay & Sabo, in press). Nine in 10 prisoners are men; nearly 1.5 million men are incarcerated in American jails and prisons (U.S. Department of Justice, 1994). Similarly, the military is both gendered and gender defining. Combat soldiers are almost exclusively men. In defending this standard, the U.S. military recently argued that the country is not culturally prepared to witness the things happening to women that happen to combat soldiers and to prisoners of war (Lieutenant Colonel Robert Maginnis, cited in Suarez, 1995). Consequently, in the Vietnam war, 58,000 American men and 8 American women were killed (Brende & Parson, 1985).

Health Care and the Social Construction of Gendered Risk

The health care system represents a particularly important institutional and structural influence in the construction of gender and health. The fact that women are less likely than men to be routinely tested or treated for symptoms of cardiovascular disease can foster unrealistic perceptions of risk among women (Wenger, 1994). But the ways in which health care contributes to social constructions of men's health have rarely been examined. In fact, several authors have recently argued that medical researchers, psychologists, and other health professionals have all contributed to cultural portrayals of men as healthy and women as the "sicker" gender and to the "invisibility" of men's poor health status (Annandale & Clark, 1996; Courtenay, in press b; Gijsbers van Wijk et al., 1991).

Gendered health messages. Historically, women but not men in the United States have been encouraged to pay attention to their health (Annandale & Clark, 1996; Oakley, 1994; Signorielli, 1993). Men also receive significantly less physician time in their health visits than women do (Blanchard et al., 1983; Waitzkin, 1984; Weisman & Teitelbaum, 1989), and they generally receive fewer services and dispositions than women (Verbrugge & Steiner, 1985). Men are provided with fewer and briefer explanations—both simple and technical—in medical encounters (Hall, Roter, & Katz, 1988; Waitzkin, 1984; Weisman & Teitelbaum, 1989). During checkups, they receive less advice from physicians about changing risk factors for disease than women do (Friedman, Brownson, Peterson, & Wilkerson, 1994). A recent review revealed that no study has ever shown that women receive less information from physicians, which led the authors to conclude that these encounters "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).

Gendered illness: The social construction of morbidity. It is popularly assumed that women are at a greater risk of illness or morbidity than men. This assumption was recently contested, along with data from two large studies that revealed few differences between the physical health of women and that of men (Macintyre, Hunt, & Sweeting, 1996). Less than thorough analyses of morbidity data, along with uncritical reiterations of “women’s excess illness” in the literature, contribute to medicine’s neglect of men’s poor health. As was noted recently, “The predominance of the ‘women’s higher morbidity’ paradigm . . . has tended to persist . . . taking on the characteristics of a dominant scientific paradigm with anomalous or inconsistent findings not being noticed or seriously discussed” (Macintyre et al., 1996, p. 623). This paradigm serves to define, construct, and reinforce strongly held cultural beliefs about gender and health.

Self-reported health status fosters assumptions of women’s greater morbidity. Self-reports, however, are not necessarily an accurate indicator of gendered risks. One large study of safety belt use that compared self-reports with actual use showed that among drivers who had been observed not wearing safety belts—more than three out of four of whom were men—one third had reported that they always wore safety belts (Preusser, Williams, & Lund, 1991). The validity of self-reported hypertension has also been found to be lower among men than women nationally (Vargas, Burt, Gillum, & Pamk, 1997). Morbidity statistics, often based on similarly unreliable self-reports, have greatly contributed to the cultural belief that women have poorer health than men. Although the evidence is not entirely consistent, reviews of research typically conclude that men report fewer physical or psychological symptoms and report illness less readily than women (Verbrugge, 1988). These findings may simply be reflecting the ability of women to perceive and report symptoms at a lower threshold than men rather than documenting real gender differences in the incidence of symptoms and disease (Gijsbers van Wijk et al., 1991).

Depression provides one example of how disease morbidity can be socially constructed. 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. A recent 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). In addition to failing to take into account men’s suicides in this age group which represent nearly seven of eight suicides (DHHS, 1996) this study disregarded decades of research that have consistently shown a lack of significant sex differences in diagnosable depression among college students (see 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 rely on themselves and to withdraw socially (Chino & Funabiki, 1984; O’Neil, Lancee, & Freeman, 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 (see Courtenay, in press b). One large study showed that clinicians were less likely to identify the presence of depression in men than in women and that they failed to diagnosis nearly two thirds of the depressed men (Potts, Burnam, & Wells, 1991).

Social construction of healthy and unhealthy bodies. Additional methodologic factors contribute to the social construction that men are healthy and women are not. Many reported

gender differences in health rely on findings that reflect differences in women's and men's approaches to health and in their respective responses to perceived illness. Behavioral indexes such as physician visits and days of bed rest are frequently used to measure the relative health of men and women. As others (Gijsbers van Wijk et al., 1991) have noted, these data confound our understanding of morbidity, because they actually represent how men and women *cope* with illness rather than representing their true health status; thus they obscure what may be greater illness among men (Kandrack, Grant, & Segall, 1991; Verbrugge, 1988, 1989).

One assumption underlying this research is that men's behavior is the normative referent. Consequently, researchers 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 behaviors—behaviors that can be considered health promoting—further pathologize women's health: “women's *excess* bed rest” and “women's *overutilization* of services.” These terms simultaneously transform curative actions into indicators of illness, make women's health problematic, and reinforce men's position in providing the gendered standard of health or health behavior. 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 health behavior are measured. If this were the case, we would be compelled instead to confront men's *inadequate* bed rest and men's *underutilization* of health care. However, the social forces that maintain women's health as problematic are strong. As noted by Oakley (1994), when morbidity statistics and women's greater propensity for illness are challenged as artifacts of research, the conventional reading of this challenge further pathologizes women's health by suggesting that women “aren't really ill at all, they're only inventing it” (p. 431). In contrast, the interpretation that “men really are ill, they're just denying it” is rarely proposed.

Medical and epidemiologic research further reinforces stereotypes by consistently failing to take into account gender, apart from biological sex. Men's risk taking and violence, for example, are simply taken for granted (Courtenay, 1999b). Although injury and death due to recreation, risk taking, and violence are consistently associated with being male, epidemiologic and medical findings are typically presented as if gender were of no particular relevance. This failure to question and study men's risk taking and violence perpetuates the false, yet widespread, cultural assumption that risk-taking and violent behaviors are natural to, or inherent in, men. Similarly, cultural assumptions that men simply do not (read: inherently) seek help prevent society from defining men's underuse of health services as problematic.

Manhood and Health

The preceding review demonstrates how North American life is distinctly divided by gender. The social practices required to enact gender differ categorically for women and men. Individuals are not required, per se, to adhere to these gender stereotypes. However, most individuals do so. From a constructionist perspective, differing social experiences and transactions do not cause demonstrated gender differences between women and men; rather, women and men learn to adopt different behaviors to enact or demonstrate gender as socially

prescribed. On the basis of the evidence presented thus far, what health-related beliefs and behaviors would one expect to be demonstrated by a man?

A man who enacts gender as socially prescribed would be relatively unconcerned about his health and well-being in general and would place little value on health knowledge. He would see himself as stronger, both physically and emotionally, than most women. He would think of himself as independent, not needing to be nurtured by others. He would not develop close friendships, and his social networks would be small. He would be unlikely to ask others for help. Work and employment would be central to his sense of self and essential for maintaining his self-esteem. The intense and active stimulation of his senses would be something he would come to depend on. He would face danger fearlessly, disregard his risks, and have little concern for his own safety. He would see himself as invulnerable to the risks commonly associated with unhealthy behavior. He would lack the vocabulary to describe physical sensations and would have difficulty identifying and expressing most of his emotions. However, he would consider anger to be acceptable, particularly when expressed physically. He would view physical violence as a sometimes necessary part of life. He would not be interested in learning about health, nutrition, or cooking, and he would be unconcerned about his weight, diet, or hygiene. Finally, he would adamantly reject doing anything that he or anyone else would consider feminine.

This gendered profile does not simply represent hypotheses about men's health beliefs and behaviors. There is abundant evidence that this is indeed how men typically think and behave and that the adoption of these beliefs and behaviors significantly influences men's health and longevity. It should be noted that some men do defy these social prescriptions and adopt healthy behaviors, such as getting annual physicals and eating healthy foods. But although these men are constructing a form of masculinity, it is not the dominant form. It should also be noted that women can and do adopt unhealthy beliefs and behaviors to demonstrate femininities, as in the case of unhealthy dieting to attain a culturally defined body ideal of slimness. However, as the preceding review indicates, the striving for cultural standards of femininity leads women to engage primarily in healthy, not unhealthy, behaviors.

Each embodied health practice that a man demonstrates simultaneously reinforces and reproduces gender (and gender as difference). Unhealthy behaviors often serve as cultural signifiers of "true" masculinity. A man who brags "I haven't been to a doctor in years" is simultaneously describing a health practice and situating himself in a masculine arena. Men demonstrate a form of masculinity when they refuse to take sick leave from work and when they insist that drinking does not impair their driving or that they need little sleep. Men often boast to others of these behaviors: "I haven't missed a day of work in my life!" or "I can drink *and* drive!" In these ways, many men and boys define their masculinity against positive health behaviors and beliefs. Men similarly construct masculinities by embracing risk. A man may define his degree of manliness, for example, by fighting physically or performing risky sports and displaying these behaviors like badges of honor or achievements of manhood.

Health care use and positive health beliefs or behaviors are socially constructed as forms of idealized femininity. They are, therefore, potentially feminizing influences that men must oppose with varying degrees of force, depending on what other resources are accessible or are being used in the construction of masculinities. Forgoing health care is a means of rejecting "sissy stuff." That men construct masculinity in opposition to the healthy beliefs and behaviors of

women—and less masculine (i.e., “feminized”) men—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, 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, for fear of being thought a sissy” (Korda, 1996, p. 148).

The carrying out of any one healthy behavior can require a man to dismiss multiple constructions of masculinity. Sun protection to prevent skin cancer may require the rejection of a variety of social constructions: Men are unconcerned about health matters; men are invulnerable to disease; the application of lotions to the body is a feminine pastime; men do not “pamper” or “fuss” over their bodies; and “rugged good looks” are produced with a tan. That 1.5 times more men than women nationally believe that one looks better with a tan, that men are significantly less likely to use sun protection, and that the skin cancer death rate is twice as high for men as for women (Courtenay, 1998b, in press a, in press b) may be a testament to the level of support among men for endorsing these constructions.

Men construct a variety of masculinities: ethnic, gay, professional, and rural masculinities, to name a few. The health-related beliefs and behaviors that men adopt vary depending on the type of masculinity they are constructing and their social class positioning (Courtenay, in press b). Demonstrating fearlessness may entail rock climbing for a middle-class man and street fighting for a poor urban man. Furthermore, gender and health are enacted differently in different contexts. A man may view the expression of emotional or physical pain to be unacceptable with other men but acceptable with a spouse or girlfriend. Elsewhere (Courtenay, 1998a, in press b), I have theorized that denial of risk and other unhealthy behaviors are used by men in the negotiation of social status and to enact idealized forms of masculinity that enable them to assume positions of social power relative to women or less powerful, marginalized men, such as gay and lower-class men. As they engage in the embodied social practice of everyday life, men are simultaneously creating the social structures that facilitate or limit constructions of gender and health. They are often, for example, the very researchers and scientists who have ignored men’s gendered health risks.

Conclusion

Research consistently demonstrates that women in the United States adopt healthier beliefs and behaviors 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 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 enact dominant ideals of manhood, they must adhere to cultural definitions of masculine beliefs and behaviors and actively reject what is feminine. The use of health beliefs and behaviors to define oneself as a woman or a man—unlike the presumably innocent effects of wearing lipstick or wearing a tie—has a profound impact on one’s health and longevity. The preceding analysis and review of research demonstrates that the resources

available for constructing masculinity are largely unhealthy and that men and boys do indeed use these resources and adopt unhealthy beliefs and behaviors to construct gender and signify manhood. It further demonstrates that social and institutional structures help to sustain and reproduce men's gendered health risks.

Several implications for future study can be drawn from the preceding discussion. Although researchers have long examined relationships between biological sex and health, very few attempts have been made to move beyond the use of biological sex as an independent or control variable and to explain what it is about gender, exactly, that influences health. Why do men adopt less healthy behaviors than women? One mediating factor may be men's beliefs about masculinity. Constructs and measures that assess these beliefs (e.g., Eisler, 1995) offer a promising method for future research. In addition, the influences of factors such as social class, ethnicity, sexual orientation, and education, and their interaction with masculinity, must be further examined. Research should also address the methodologic issues outlined earlier.

The differential health care experiences of women and men require further explanation, and new interventions for men are needed. Although many counseling and psychological interventions with men have been recommended in the past two decades (Courtenay, in press c), very rarely do these interventions address men's physical health (Courtenay, 1998c). Interdisciplinary approaches are especially needed (Courtenay, in press d). A clinical practice guideline was recently developed that provides evidence of biopsychosocial factors that affect the onset, progression, and management of men's health problems and outlines specific recommendations for clinicians working with men (Courtenay, 1996a). Also developed recently is a health risk assessment for men that includes items assessing men's health beliefs—including their beliefs about manhood (Courtenay, 1996b). Outcome research is needed to measure the effectiveness of these and other gender-specific interventions in promoting men's health and reducing their risks.

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