



## How do masculinity, paternity leave, and mortality associate? –A study of fathers in the Swedish parental & child cohort of 1988/89

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### ABSTRACT

One of the proposed causes for the gender gap in longevity is the attitudes and practices culturally prescribed for men, often conceptualised as ‘masculinity’. It has also been suggested that paternity leave, indicating a change from breadwinning to caring, could benefit men’s lifetime health. In this study, the objective was to examine associations between ‘masculinity’ (assessed at the age of 18–19 years), paternity leave (1988–1990), and mortality patterns (1991–2008) based on a population of Swedish men who had a child in 1988/89 ( $N = 72,569$ ). ‘Masculinity’ was measured during the compulsory military conscription process by a psychologist based on leisure and occupational interests, and paternity leave was measured in fulltime days by registry data. The main finding was that low ‘masculinity’ ranking increased the risk of all-cause mortality, and mortality from alcohol and violent causes, while taking paternity leave between 30 and 135 days decreased the risk of all-cause mortality. However, the weak association found between ‘masculinity’ and paternity leave indicates that entering a caring role as a father is not predicted by ‘masculinity’ assessed in late adolescence, and that the studied phenomena influence male mortality independently of each other.

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### Introduction

The question as to why men live shorter lives than women has been asked and examined many times. Yet, it is our belief that it deserves continued attention. Potential causes are still disregarded and strategies targeting them may well generate health and welfare gains among both sexes. In this paper, the focus is on two likely contributors to the gender gap in longevity. The first regards the fact that life-threatening attitudes and practices not only vary according to sex, but also are likely to vary according to *type of ‘masculinity’*. The second regards the changes brought about in the traditional division between male breadwinning and female caring resulting from *paternity leave*.

#### *‘Masculinity’ and health*

Freud was certainly right when stating that the concepts of ‘masculinity’ and ‘femininity’ are among the most confused in science (Connell, 1995). Yet, much research has been done in order to clarify and measure them for their possible impact on health and well-being (Connell, 1995; Constantinop1e, 1973). Among the early

tests of ‘masculinity’–‘femininity’ were the Strong Vocational Interest Blank based on men’s and women’s preferences for various careers (Strong, 1936), and the Minnesota Multiphase Personality Inventory (Hathaway & McKinley, 1943) based on interest patterns among soldiers. These measurements were basically bipolar, dichotomising ‘masculinity’ and ‘femininity’ into instrumentality and expressiveness on a uni-dimensional scale. The most utilised test in recent health-related research has been the Bem Sex Role Inventory (Bem, 1974) in which ‘masculinity’ and ‘femininity’ are defined as traits particularly desirable or acceptable in men and women, respectively; for men, this involves for example defending their own beliefs, strong personality, forcefulness, leadership abilities, willingness to take risks, and aggressiveness. This measurement introduces, not only a step away from essentialism, but also a two-dimensionality in its focus on culturally desirable-undesirable traits.

Several links have been proposed between ‘masculinity’–‘femininity’ and health. An early belief was that high scores of ‘masculinity’ would link to healthiness among men, while high scores of ‘femininity’ would link to healthiness among women (Holmlund, 2006). Yet, it has also been suggested that central to the very essence of ‘masculinity’ is choosing hazardous professions, taking risks in traffic, drinking alcohol in excess, refusing health care, etc., which generally makes ‘masculinity’ more life-threatening than ‘femininity’ (Courtenay, 2000; Sabo & Gordon, 1995).

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Further, Bem hypothesised when introducing her Sex Role Inventory, those individuals who scored high on both masculine and feminine traits (androgyny) were most likely to be flexible and thus healthy individuals.

Another role-related theory is that the risk of morbidity and mortality among men varies by the type of 'masculinity' they adopt (Courtenay, 2000; Person, 2006; Pyke, 1996). Connell (1995, 2002) has proposed three main categories: "hegemonic masculinity" refers to the situation where men achieve the mostly highly valued 'masculine' ideals at any given place and time, "complicit masculinity" refers to the situation where men do not achieve but support in principle the hegemonic ideals, and "subordinated masculinity" refers to the situation where men neither achieve nor support the hegemonic ideals. A potential hypothesis is that achieving the hegemonic 'masculinity' of strength, ambition, and self-reliance promotes healthiness through physical activity, educational aspiration, high incomes, etc. It could also be hypothesised that failing to achieve these ideals involves stress and mental ill-health as well as increased mortality through adopting risky behaviour patterns in order to compensate for a threatened social position (Messerschmidt, 1993).

Much of the critique against measurements of 'masculinity' and 'femininity' has concerned the validity of dichotomisation (Constantinople, 1973). Further, the concepts lack, as with all social constructions, essence and may be seen as non measurable properties; for example, concepts associated with sex change over time and it is not only men who behave in a 'masculine' way. The link between 'masculinity' and health is however not about the attribution (and idealisation) of good or bad practices, but about the consequences of actual practices. When relating any 'masculinity' measure to health, one must consider that 'masculinity' holds a plethora of aspects of 'masculinities'. With regard to health effects these can be conceptualised as either the "positive masculinity" of socially desirable traits like intellectual ambition and physical activity, or the "negative masculinity" of socially undesirable traits like aggression, egotism, and laziness (Helgesson, 1995).

The empirical evidence on 'masculinity' and mortality is not only limited, the adoption of different measures founded on different ideas of 'masculinity' makes comparisons between studies hard. From the United Kingdom it has been reported that those scoring high on 'masculinity' according to the Bem Sex Role Inventory had, relative to those scoring low or androgynously, an increased risk of coronary heart disease (Hunt, Lewars, Emslie, & Batty, 2007). A risk increase for the high 'masculinity' group was also found regarding consumption of alcohol and tobacco, which indicate subsequent gendered patterns of mortality (Emslie, Hunt, & Macintyre, 2002). However, the Bem Sex Role Inventory has also been used among the United Kingdom population to demonstrate that the higher the 'masculinity', the lower the risk of suicidal thoughts (Hunt, Sweeting, Keogh, & Platt, 2006). Studies using a uni-dimensional 'masculinity' scale have also found contrasting results. From the United States it has been reported that high 'masculinity' scores defined by the Strong Vocational Interest Blank are associated with increased risk of all-cause mortality (Lippa, Martin, & Friedman, 2000). In contrast, a study among Swedish men scored by a psychologist on the 'masculinity' of their vocational and leisure interests, found that low 'masculinity' ranks were associated with increased risks of all-cause mortality and suicide after adjustment for several risk factors (Månsson, Lundin, Falkstedt, & Hemmingsson, 2009).

#### *Paternity leave and health*

In 1974, Sweden was the first country in the world to offer fathers the chance to take paid parental leave. Since then, the

parental insurance system has undergone several revisions regarding the number of days, level of payments, and opportunity to allocate reserved days to the other parent (Social Insurance Agency). However, the main goal of greater gender equality persists, i.e. to enhance the potential for males in the sphere of caring work and for females in the sphere of paid work (Ferrarini, 2002). The reform's contribution to this is indicated by the development of men's share of parental leave: 4% in 1978, 6% in 1988, 10% in 1998, and 22% in 2008 (Statistics Sweden). However, the paternity leave reform was launched within a broader context of family and social policy (Korpi, 2000). Other fundamental gender equality reforms were a regulation strengthening the dual-earner norm by separate taxation for married people in 1971, and an extended and publicly financed day care system increasing the percentage of children in day care from 17% in 1975 to 57% in 1989 (National Agency for Education). In all, the opportunity for men to take parental leave was combined with strategies targeting opportunities for women in the labour market.

An increasingly common argument nowadays as to why men should adopt caring responsibilities is that this would benefit their health and well-being (Härenstam, Aronsson, & Hammarström, 2001), i.e. it is not only for the good of women and children (Jordan, 2007). The empirical basis is that a substantial part of the gender difference in premature mortality is caused by behaviours more socially encouraged in males than in females (Courtenay, 2000; Waldron, 1976). Further, it has been proposed that women are more averse to health risks, and live longer lives due to their prime and concrete caretaking of children, since, for example, heavy drinking may interfere with childcare duties, unhealthy food habits risk being adopted by the children, and risky behaviours threaten the children's security (Waldron, 1976). Fathers who take on caring practices may therefore develop more health-promoting attitudes and behaviours (Månsson, Lindholm, Lundberg, Öhman, & Winkvist, 2006).

Another reason why men could gain from alternating breadwinning with caring responsibilities is based on the concept of multiple roles (Biddle, 1986). The hypothesis of stress holds that individuals with many roles experience more stress, conflict, and ill-health since the primary life role, for men supporting duties and for women caring duties, is so hard that additional roles risk lifetime health (Goode, 1960). In contrast, the expansion hypothesis suggests that people with many roles have health advantages since they may compensate stress in one area with positive circumstances in other areas (Thoits, 1983). The conclusion from empirical research is that multiple roles benefit health among both sexes until the point of extreme stress (Barnett, 2004). In the Sweden of today, men could gain health from increased family involvement based on the expansion hypothesis, while women could gain health from decreased family involvement based on the stress hypothesis (Härenstam et al., 2001; Simon, 1995).

Included in the potential link between paternity leave and lifetime health, there are also other circumstances related to family and working life. It has for example been shown that those couples where the father takes parental leave are more stable than others (Oláh, 2001), and that moderately long paternity leave is associated with an increased chance of having a second and third child (Duvander & Andersson, 2006), both of which are associated with reduced risk of morbidity and mortality.

The research on how increased child-caring among fathers affects their health and longevity is scarce, and one evident reason is that this is still a rare phenomenon around the world. The premise in a Swedish study among men who had a child in 1978 was that the reform permitting fathers to take parental leave could have benefited men's health by encouraging less risky lifestyles and expanding life roles (Månsson, Lindholm, & Winkvist, 2007).

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