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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

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