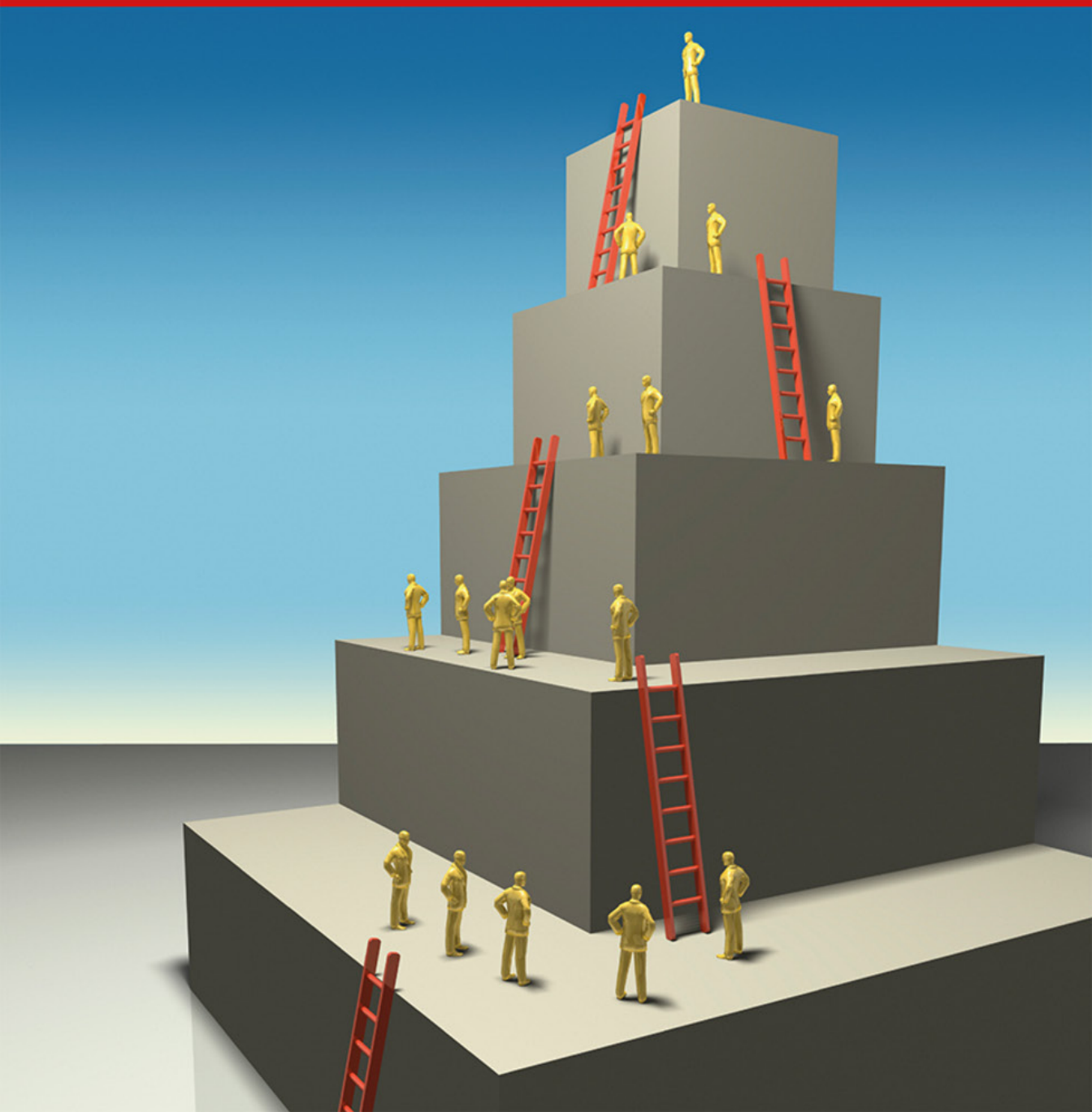
Men's Health Equity

A Handbook

Edited by Derek. M. Griffith, Marino A. Bruce, and Roland J. Thorpe, Jr.



MEN'S HEALTH EQUITY

Worldwide, men have more opportunities, privileges, and power, yet they also have shorter life expectancies than women. Why is this? Why are there stark differences in the burden of disease, quality of life, and length of life amongst men, by race, ethnicity, (dis)ability status, sexual orientation, gender identity, rurality, and national context? Why is this a largely unexplored area of research? *Men's Health Equity* is the first volume to describe men's health equity as a field of study that emerged from gaps in and between research on men's health and health inequities.

This handbook provides a comprehensive review of foundations of the field; summarizes the issues unique to different populations; discusses key frameworks for studying and exploring issues that cut across populations in the United States, Australia, Canada, the United Kingdom, Central America, and South America; and offers strategies for improving the health of key population groups and achieving men's health equity overall. This book systematically explores the underlying causes of these differences, describes the specific challenges faced by particular groups of men, and offers policy and programmatic strategies to improve the health and well-being of men and pursue men's health equity. *Men's Health Equity* will be the first collection to present the state of the science in this field, its progress, its breadth, and its future.

This book is an invaluable resource for scholars, researchers, students, and professionals interested in men's health equity, men's health, psychology of men's health, gender studies, public health, and global health.

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FOREWORD

Men's Health Equity: A Handbook is a testament to just how far the men's health field has developed in the 30 years or so since it began to be identified as a discrete issue.

In the 1990s, men's health was virtually synonymous with urology, and there was a significant focus on testicular cancer, prostate disease, and erectile dysfunction. Even when the area of interest widened, clinical issues tended to dominate with sexually transmitted infections, suicide, and cardiovascular disease among the topics added to the list.

Women's health and men's health were seen as largely separate spheres. Some advocates even felt that they were in some way in competition and sought to highlight the significant differences in research funding between prostate and breast cancers. There was also an assumption that all men were pretty much the same and that they could be effectively engaged through a one-size-fits-all approach, especially if interventions were linked to sport or motor cars.

The state of men's health work could not now be more different. Advocates are now interested in the widest possible range of health problems affecting men—physical, mental, and social—and not just those that are exclusively male or where the burden on men is greatest.

There is now much more interest in the social determinants of men's health—the so-called "causes of the causes" of health problems, meaning the factors that lead many men to smoke, drink alcohol at risky levels, or drive dangerously. These underlying factors include racism, homophobia, socioeconomic deprivation, limited educational opportunities, and the constraints of male gender role norms.

Men are no longer seen as a homogeneous group. As this book demonstrates so well, the differences between men are now seen by many in the field as being just as, if not more, relevant than the differences between men and women. A far greater awareness of the need to address "intersectionality" is leading to a greater focus on those groups with the worst outcomes, including gay, bisexual, and transgender men; men from some ethnic minority groups (not least Indigenous populations); men living on low incomes or who are unemployed; homeless men; disabled men; migrant men; and prisoners. Geographic differences in men's outcomes within individual countries as well as between countries are also being recognized.

Importantly, and increasingly, men are not seen as beings simply trapped within a negative one-dimensional paradigm of masculinity. Yes, men who conform to "traditional" masculine norms do seem more likely to experience poor health. But aspects of masculinity can also be beneficial to men's health, such as an interest in physical fitness and strength, being goal focused, and providing for a family and being a good father. Masculinity can no longer be viewed as essentially "pathological" or

"toxic," and an approach to health that builds on men's strengths is now widely believed to be more effective.

The men's health field is now much more interdisciplinary, as this book very clearly demonstrates. Clinicians, scientists, public health specialists, psychologists, sociologists, advocates, and policymakers are now engaged much more collaboratively. There is a growing body of high-quality research and evidence on which more effective policy and practice can be based. This evidence is also more widely available through several specialist men's health journals as well as a range of other publications.

Men's health and women's health are viewed as interdependent and interrelational. Better health for one sex translates into better health for the other, most obviously in the field of sexual and reproductive health, but also much more widely. More importantly, it has become clear that both men and women would benefit from an approach to health policy and practice that is gender sensitive and responsive to the needs and sensibilities of both sexes. Men's health and women's health cannot any longer be seen as being engaged in some sort of zero-sum game.

The development of national men's health policies in Australia, Brazil, Iran, and Ireland has helped to highlight the importance of policy work alongside research and practice. It is clear that policy can have a significant catalytic effect on the practices of organizations in the health and related fields. In Ireland, for example, the men's health policy has led to the development of a wide range of effective community-based health promotion initiatives as well as a men's health training program for professionals from a wide range of professional backgrounds (including education and social work as well as health).

Men's health has, in recent years, become a global concern of interest to an increasing number of major organizations, including the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Human rights-based approaches to health clearly embrace both sexes, and health economic analyses have highlighted the significant cost of male morbidity and mortality. The UN's Strategic Development Goals (SDGs) on health, including the target of a one-third reduction in premature mortality by 2030, have a clear relevance to men's health and have prompted WHO-Europe to develop a men's health strategy for the 53 countries in its region. WHO-Europe has recognized the importance of working with men to achieve their goal of greater gender equality and to reduce the inequalities in health seen across the region and within countries. Similar action is now required at the global level.

The work of the men's health "movement," which includes those organizations working at the international, national, and local levels on men's health as a generic issue (or on one specific issue, such as prostate cancer), combined with increasing media interest, has created a new public awareness of the physical and emotional health needs of men. There may not have been the radical and political mobilization generated by the women's health movement, but men's health advocates are now beginning to achieve at least some of their goals. More men are becoming more actively engaged in their health and more receptive to the changes needed to promote a happier and healthier life.

Global Action on Men's Health has recently emerged as a nongovernmental organization that is bringing together organizations and individuals active in the field with the aim of raising the need for global action to address the huge disparities in men's health within countries and between them. Obvious concerns include the 30-year male life expectancy gap between the worst- and best-performing countries and the global pattern of excess male mortality from cancer, suicide, interpersonal violence, cardiovascular disease, road traffic accidents, and occupational hazards. This growing voice is also starting to be heard by politicians and policymakers across the world.

Men's health is no longer a marginal issue, but it remains far from a mainstream one. No countries have allocated resources that are proportionate to the problems. Most global health organizations do not yet address gender, or they continue to equate gender with women alone. Nonetheless, this is without doubt an exciting and propitious time to be actively involved in men's

health work. The field is rapidly developing in terms of both theory and practice, and this book makes a major contribution that will help all those involved to leap to the next level.

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PREFACE

More than a century after W.E.B. Du Bois called for the elimination of factors that create health disparities (Du Bois & Eaton, 1899), differences in health remain that are not only unnecessary and avoidable but are also considered unfair and unjust (Whitehead, 1991). Although differences in health outcomes between men and women emerged in only the last century (Beltrán-Sánchez, Finch, & Crimmins, 2015), differences in health outcomes between groups distinguished by race, ethnicity, and other socially and politically meaningful factors have a longer history, existing as long as we have had data in the United States and across the globe (Byrd & Clayton, 2000; De Maio, 2014; Krieger, 1987; Woodward & Kawachi, 2000). Although billions of dollars have been spent and an entire "health disparities industry" (Shaw-Ridley & Ridley, 2010) has been born and nurtured, racial and other disparities persist (Bruce, Griffith, & Thorpe, Jr., 2015; Thorpe, Richard, Bowie, LaVeist, & Gaskin, 2013). Despite the recognition that the mortality gap between Blacks and Whites is driven by the poor health of men (Satcher et al., 2005), many are reluctant to consider men's poor health relative to women's health as a health "disparity" because non-Hispanic White men are not socially or economically disadvantaged in our society. Braveman (2006) says that "the gender disparity in life expectancy is, albeit an important public health issue, not an appropriate health disparities issue, because in this particular case it is the a priori disadvantaged group—women—who experiences better health" (p. 186). Unfortunately, as a result, adequate resources and attention are not devoted to the health of men who are marginalized by race, ethnicity, immigration status, sexual orientation, and other socially meaningful factors that account for much of the sex difference in mortality globally (Young, 2009; Young, Meryn, & Treadwell, 2008).

The field of men's health equity has emerged from gaps in knowledge that exist between health inequities and men's health research. Scholarship on men's health and scholarship on health inequities have grown largely in parallel, although a need remains to examine where these fields intersect. While the scholarly literature in each area has grown exponentially in recent decades, the science of understanding and improving the health of men who are at the margins of each field—yet lie at the nexus of these literatures—has not kept pace with the development of either field (Griffith, 2018). Improvements in population health and achieving health equity require an accelerated development of an area of specialization that can explicate how and why inequities among men exist and that can present evidence that informs efforts to improve the health of men and reduce inequities among them (Griffith, 2018). This emergent field is that of men's health equity.

Why the Term "Men's Health Equity"

The term *men's health equity* is new. It is an effort to reflect the increasing attention that is being paid to men's health and gender health equity across the globe by the World Health Organization (WHO, 2018) and others (e.g., Global Action on Men's Health, Promundo, etc.) (Ragonese, Shand, & Barker, 2018). Historically, systematic differences in health outcomes by gender where men fare worse than women (e.g., life-threatening chronic diseases) (Rieker & Bird, 2005), and systematic differences among men that are rooted in social disadvantage (Griffith, Metzl, & Gunter, 2011) have not fit definitions of health disparities, health inequalities, or health inequities (Braveman, 2014) because these terms have been reserved for differences in health that are due to differences that are thought to be rooted in inequities in underlying social position in society (Braveman, 2003; Carter-Pokras & Baquet, 2002). And yet, while men may be advantaged socially, politically, and economically in most if not all parts of the world, subgroups of men (e.g., particular racial, ethnic, sexual identities) are not. Men's health outcomes, relative to women who share the same socially meaningful characteristics except gender, and males who share a sex and gender identity but are different by one or more socially meaningful characteristics often have worse health that is rooted in their underlying social position in society. Men's health equity is an area of research, practice, and policy that seeks to understand and address the needs of these men in ways that are sensitive to and congruent with the socially meaningful identities that have implications for health because their meaning is rooted in inequitable societal structures. The global burden of premature mortality and gender differences in mortality within countries and regions of the world is embodied in these populations of men but little scholarship has focused on their unique challenges or needs and more research, policies, and programs should be informed by a richer understanding of these men.

Why a Handbook on Men's Health Equity?

Although there are books on men's health (Broom & Tovey, 2009; Courtenay, 2011; Gough & Robertson, 2009; Lee & Owens, 2002; Robertson, 2007), Latino men's health (Aguirre-Molina, Borrell, & Vega, 2010), and social determinants of African American men's health (Treadwell, Xanthos, & Holden, 2012), there is no book dedicated to men's health equity. The current class of edited volumes tends to focus on specific racial and ethnic groups of men, the psychology of men and masculinities, racial disparities without considering the role of gender, or men's health without discussing race and ethnicity and the heterogeneity among men along other key dimensions (e.g., sexual orientation, gender identity, [dis]ability status). *Men's Health Equity* is the first volume to present the state of the science in this field, its progress, its breadth, and its future.

While the editors of the handbook are based in the United States, we are honored to be joined by international scholars in this effort to discuss the complex health issues facing men in Australia, Canada, the United Kingdom, and various countries in Central and South America. Although not representative of the entire world, *Men's Health Equity* is by far the most comprehensive volume to date on the diversity among men across the globe. Moreover, rather than limit diversity to race, ethnicity, or national context, we are also fortunate to have contributions that discuss critically understudied populations such as rural men, gay and bisexual men, transgender and intersex men, and men with disabilities and functional limitations. This handbook (a) provides a comprehensive review of foundations of the field, (b) summarizes the issues unique to different populations, (c) discusses key frameworks for studying and exploring issues that cut across populations, and (d) offers strategies for improving the health of key population groups and reducing men's health inequities overall. Beyond simply describing patterns of illness and disease between men and women and among men, those in the field of men's health equity have sought to use a critical lens to systematically explore the root causes of these patterns, the specific needs of groups of men, and what can be done to improve the health and well-being of groups of men.

The Organization of *Men's Health Equity*

In addition to this preface, we are fortunate to have a foreword by Peter Baker, who is the Director of Global Action on Men's Health, and Alan White, who is Emeritus Professor of Men's Health and Founder and Co-director of the Centre for Men's Health at Leeds Beckett University in Leeds, England to place this volume in the context of the larger field of men's health. The book is organized in six parts. Part I: *Psychosocial and Developmental Foundations of Men's Health Equity* includes the introduction to the book and highlights some of the critical social science roots of men's health equity by leading scholars who discuss the challenges and benefits of framing men's health and men's health disparities in the context of masculinity, manhood, fatherhood, and key phases of life (young adulthood, middle age, older adulthood). Part II: *Environmental, Social, and Policy Determinants of Men's Health Inequities* describes three key contextual determinants of men's health inequities: environments (rural and urban); social determinants (incarceration and domestic violence); and policy (global policies and United States health, public, and social policies). Part III: *Health Behaviors and Health Outcomes* examines patterns and causes of several leading causes of death among men, including health behaviors; seeking help for mental health concerns; depression, trauma, and suicide in young adult men and across the adult life course of men; diabetes; and cancer. Part IV: *Men's Health Inequities in the United States* provides population-specific context to understanding the unique challenges, history, and strengths that men of diverse groups face in the United States. This section includes chapters that provide insight into the patterns and determinants of the health of gay and bisexual men, transgender and intersex men, men with disabilities and functional limitations, and men of each main racial and ethnic group in the United States (Asian men, Black men, European [White] men, Hispanic/Latino men; Native American men; and Pacific Islander and Native Hawaiian men). Part V: *Men's Health Inequities Across the Globe* examines the health profiles and the unique determinants of health for men from Australia, Canada, Central America, and South America, including a separate chapter on men's health in Brazil. Part VI: *Final Thoughts and Future Directions* includes three contributions: (a) a *Life Course Perspective: Implications for Men's Health Equity* by handbook co-editor Roland Thorpe, Associate Professor of Health, Behavior, and Society at Johns Hopkins Bloomberg School of Public Health and Paul Archibald, Assistant Professor of Social Work at Morgan State University; (b) an *Afterword* by Lisa Bowleg, Professor of Applied Social Psychology at George Washington University; and (c) a *Conclusion* by the editors, which includes our comments, reflections, recommendations, and wishes for the future of men's health equity. While we realize this book does not include many health issues (e.g., sexually transmitted infections; heart disease), countries (e.g., Russia), regions of the world (i.e., Africa, Asia, West Indies) that we hoped and initially envisioned, we are delighted that the book is as comprehensive of a treatment of men's health equity as it is. We hope this handbook helps to educate, inspire, and stimulate new collaborations and research that "center the margins" of populations and health issues that comprise the burgeoning field of men's health equity.

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PART I

Psychosocial and Developmental Foundations of Men's Health Equity

1
INTRODUCTION

Derek M. Griffith, Marino A. Bruce, and Roland J. Thorpe Jr.

In most industrialized societies across the globe, men tend to have more opportunities, privileges, and power yet shorter life expectancies than women (Baker et al., 2014; Thorpe, Griffith, Gilbert, Elder, & Bruce, 2016). Although this difference is now seen as normal, it is a relatively recent phenomenon that emerged in the late 1800s (Beltrán-Sánchez, Finch, & Crimmins, 2015) and grew throughout the 20th century and into the new millennium. The Industrial Revolution, the advent of public health as a discipline, advances in medicine, and myriad social, economic, and health policy changes led to dramatic improvements in health across the world. Simultaneously, these technological advances also led to the emergence and persistence of sex differences in life expectancy and premature mortality. The recent emergence of sex differences in life expectancy is a fundamental conundrum underlying calls for the recognition of men's health as an area of specialization (Meryn & Shabsigh, 2009; Porche, 2007). While there has been little sustained effort by policymakers or practitioners to improve men's health in the United States or across the globe (Baker et al., 2014), there have been a number of milestones achieved in the effort to raise attention of men's health as a global issue.

In recent years, there has been a dramatic increase in the number of professional organizations (e.g., the Global Action on Men's Health, the International Society of Men's Health, the American Society of Men's Health, the European Men's Health Forum), professional journals (e.g., the *American Journal of Men's Health*, the *International Journal of Men's Health*, the *Journal of Men's Health*, the *International Journal of Men's Social and Community Health*), and reports (e.g., the American Psychological Association's *Health Disparities in Racial/Ethnic and Sexual Minority Boys and Men,* The European Commission's *The State of Men's Health in Europe,* Promundo's *Masculine Norms and Men's Health: Making the Connections*) that has raised awareness of and attention to men's health. Even in journals that are not focused on men's health, there have been several special issues on the topic. For example, special issues have been dedicated to men's health (Crawshaw & Smith, 2009; Gough, 2013; Robertson & White, 2011), biopsychosocial determinants of the health of boys and men (Thorpe, & Halkitis, 2016), diabetes and men's health issues (Jack, 2004), and patterns and causes of men's health outcomes (Graham & Gracia, 2012; Treadwell & Ro, 2003; Treadwell, Young, & Rosenberg, 2012). In different ways, these issues have helped to highlight the heterogeneity among determinants of men's health outcomes, and refine how researchers, practitioners, and policy makers approach efforts to conceptualize and improve men's health. In addition to these scholarly efforts, important policy initiatives have focused explicitly on improving men's health in Australia, Brazil, Ireland, and elsewhere. Although men's health is emerging as a field across the

globe, little of this work systematically examines or addresses the heterogeneity among men. While efforts continue to raise the profile and understanding of men's health as a field of research, policy, and practice, there also is a need to build an area of study that focuses on men whose determinants and patterns of health may not exactly align with a singular notion of men's health.

How Do We Define the Field of Men's Health Equity?

Health equity has been defined as the absence of systematic disparities in health and the determinants of health (Minority Health & Health Disparities Research & Education Act, 2000), and the principle underlying a commitment to eliminate social determinants of health and disparities in health (Braveman, 2014). Braveman (2014) argues that social justice is at the heart of the concept of health equity but it is unclear what data are driving a focus on health equity when men, across the globe, live shorter and often sicker lives than women. Whether measured by rates of premature mortality (World Health Organization, 2014), age standardized death rates in leading causes of death (e.g., cardiovascular diseases, cancers, diabetes, chronic respiratory diseases) (World Health Organization, 2014), life expectancy (National Center for Health Statistics, 2018), or mortality (Bilal & Diez-Roux, 2018), the finding that men fare worse on many health outcomes than women has been a persistent pattern across the world but this difference is not considered a health disparity or inequity.

Braveman (2006) argues that "the gender disparity in life expectancy is, albeit an important public health issue, not an appropriate health disparities issue, because in this particular case it is the a priori disadvantaged group—women—who experiences better health" (p. 186). Recent definitions of health disparities from Healthy People 2020 and others have explicitly included the notion that disparities refer to populations whose health are worse based on some social disadvantage or characteristics historically linked to discrimination (Braveman, 2014). The fundamental problem with this notion is that it does not consider that groups can be advantaged based on one characteristic (e.g., gender) but disadvantaged based on another (e.g., sexual orientation, race, ethnicity, gender identity, educational attainment). This has been a particular problem in garnering attention and resources to focus on the health of men who improve the health of men who account for much of the sex difference in mortality globally (Young, 2009; Young, Meryn, & Treadwell, 2008): men who are advantaged by their sex or gender but marginalized by race, ethnicity, immigration status, sexual orientation, and other socially meaningful factors. Moreover, this highlights how central an intersectional approach is to men's health equity.

Intersectionality is an analytic and theoretical approach that considers the meaning and consequences of socially defined constructs and that offers new ways of understanding the complex causality of social phenomena; thus, it is a useful framework for examining the complexity of men's health and men's health equity (Griffith, 2012). Grounding men's health equity in an intersectional approach illuminates the heterogeneity among men's experiences, which are based on their unique, subjective identities and structural positions within systems of inequality and structural impediments. An intersectional approach has been a critical strategy that many scholars (including several contributors to this handbook) have used to demonstrate the complex web of conditions that shape the lives and health of men. These conditions either create opportunities for health equity or health inequities, and the institutional arrangements that create and maintain them (Griffith, Johnson, Ellis, & Schulz, 2010). Thus, the goal of men's health equity is to shed light on the lives of men that remain invisible when we use the generic terms "men" or "men's health," and to move beyond a focus on "what" differences exist between men and women or among men to "why," "how," or "under what conditions" such differences (or similarities) illuminate modifiable determinants to improve the health and well-being of men without adversely affecting women's health (Addis, 2008; Bruce, Griffith, & Thorpe, 2015a; Griffith, 2018). Men's health equity includes a strong commitment to encouraging and promoting scholarship, policies, and programs to improve

women's health and achieve gender equity, and highlights the need for each of these areas to consider the realities of the daily lives of women, men, and those who do not readily fit or choose not to be limited by the sex/gender binary.

Men's health equity is an intersectionality-based health equity lens that highlights that each group of men's experiences are fundamentally different from that of others, based on their unique identity and structural position within systems of inequality and structural impediments (Griffith, 2018; National Academies of Sciences, Engineering, and Medicine, 2017). Using an intersectional lens to study men's health requires researchers to recognize and contextualize the ways that race, class, sexual orientation, disability, and other structures and axes of inequity constitute intersecting systems of oppression and yet take on new meaning when combined with biopsychosocial constructs that are applied to men (e.g., sex, gender, masculinities, manhood) (Griffith, 2018).

Men's health equity is a field of research, practice, and policy that seeks to understand and address the needs of men whose poor health is rooted in their underlying social position in society in ways that are sensitive to and congruent with the socially meaningful identities and structures that have implications for individual-level and population-level solutions to health inequities (Srinivasan & Williams, 2014). Men's health equity includes two lines of research: (a) a population-specific approach that focuses on identifying, examining, and developing interventions from the unique biopsychosocial factors that affect the health of socially defined populations (Bediako & Griffith, 2007; Jack & Griffith, 2013); and (b) a comparative approach that is useful for identifying and monitoring gaps between men and women and among groups of men that are unnecessary, avoidable, considered unfair and unjust, and yet are modifiable (Carter-Pokras & Baquet, 2002). The National Institute on Minority Health and Health Disparities provides a useful set of definitions of minority health and health disparities that we use to elaborate further on the lines of research that characterize men's health equity (National Institute on Minority Health and Health Disparities, 2018a).

The population-specific approach to men's health equity is consistent with the National Institute on Minority Health and Health Disparities definition of minority health. According to the National Institute on Minority Health and Health Disparities, (2018a):

> Minority health is the distinctive health characteristics and attributes of racial/ethnic minority groups in the U.S. Minority health research is the scientific investigation of these distinctive health characteristics and attributes of the minority racial and/or ethnic groups. The research questions may focus on protective factors for conditions where outcomes may be better than expected including projects that evaluate mechanisms and interventions to sustain or improve a health advantage. The research questions may also address mechanisms and develop and evaluate interventions to reduce health disparities within a race/ethnic group(s). (Part 2)

As one can see from this definition, the goal of this line of work is to recognize and consider not only unique risk factors that may exacerbate or lead to worse health outcomes, but the goal of this population-specific approach also is to identify protective factors that may be important foundations for building policy and programmatic interventions at any or across biopsychosocial levels and factors. For specific examples, it would be useful to refer to special issues that have been published on minority men's health (Thorpe, Duru, & Hill, 2015), HIV/AIDS among sexual minority men (Jia, Aliyu, & Huang, 2014; Wolf, Cheng, Kapesa, & Castor, 2013), and African American men's health (Jack & Griffith, 2013; Thorpe et al., 2015; Thorpe, & Whitfield, 2018; Treadwell, Xanthos, & Holden, 2012; Wade & Rochlen, 2013). In addition to the population-specific approach to men's health equity, it also is important to consider the comparative approach to men's health equity.

The comparative approach to men's health equity is congruent with the National Institute on Minority Health and Health Disparities and Healthy People 2020 definitions of health dis-

parities. The National Institute on Minority Health and Health Disparities (2018b) argues that health disparities research "is a multidisciplinary field of study devoted to gaining greater scientific knowledge about the influence of health determinants and defining mechanisms that lead to disparities and how this knowledge is translated into interventions to reduce or eliminate adverse health differences" (National Institute on Minority Health and Health Disparities, 2018b, p. NIMHD–9). Also, Healthy People 2020 argues that "Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." The National Institute on Minority Health and Health Disparities definition of health disparities highlights the multidisciplinary nature of the field of study, the critical need to address determinants of health in addition to health outcomes, and that the goal of this field of study is to develop interventions to reduce or eliminate adverse health differences. Further, as de Melo-Martin and Intemann (2007) so concisely note,

> the aim of research on health disparities is not to just accurately describe health differences or determine their cause, but to do so in a way that will be useful to making predictions, preventing greater health disparities, and improving human health.
>
> *(p. 218)*

In the context of men's health, there have been special issues on the science of men's health disparities (Watkins & Griffith, 2013) and social determinants of men's health disparities (Bruce, Griffith, & Thorpe, 2015a). Although special issues of journals have provided important insights into aspects of men's health, particularly within groups of men, the science has been limited on addressing how men's health outcomes are not only shaped by gender but also by other socially meaningful demographic characteristics that represent proxies for understanding stress and other factors that affect health patterns and outcomes (Bruce, Griffith, & Thorpe, 2015b).

Griffith, Metzl, and Gunter (2011) defined men's health disparities as "research that considers how the individual or population-level health behaviors and health outcomes of men are determined by cultural, environmental and economic factors associated with their socially defined identities and group memberships" (p. 418). In this paper, Griffith and colleagues also offered a research agenda that suggested that men's health disparities examine three key areas:

> (a) how masculinities are related to health; (b) how gender is constructed and embedded in social, economic, and political contexts and institutions; and (c) how culture and subcultures influence how men develop their masculinities and how they respond to health issues.
>
> *(p. 418)*

More recently, Griffith (2018) defined men's health disparities as research and practice that "may focus on protective factors for conditions where outcomes may be better than expected including projects that evaluate mechanisms and interventions to sustain or improve a health advantage … The research questions may address mechanisms and develop and evaluate interventions to reduce health disparities among men and between men and women" (Griffith, 2018, p. 1319). Men's health equity builds from all of this work.

Men's health equity is a multidisciplinary field of study devoted to gaining greater scientific knowledge about the influence of health determinants and defining mechanisms that lead to inequities among men and between men and women and about how this knowledge is translated into interventions to reduce or eliminate adverse health differences. The goal of men's health equity

research and practice is to highlight, inform, and address the distinctive and common determinants of health that shape the health of men whose health outcomes are poorer than those of women and other groups of men whose positions in the social hierarchy are also important for understanding their health (Griffith, 2018).

Men's health equity is transdisciplinary: research conducted by investigators from different disciplines working jointly to create new conceptual, theoretical, methodological, and translational innovations that integrate and move beyond discipline-specific approaches to address a common problem (Hall et al., 2012; Stokols, 2006). The field of men's health equity is an effort to move beyond the narrow boundaries and silos of men's health, specific medical specialties, health inequities (and related synonyms), public health, population health, and various social science disciplines, and to be an umbrella that includes all who are interested in using scientific methods to inform, address, and eliminate avoidable yet unjust differences in health outcomes among men.

Beyond the epidemiologic argument about differences in life expectancy and other outcomes or the moral argument that often underlies the desire to achieve health equity, men's health equity highlights real economic and social costs of not focusing on differences among men. In their seminal, sobering work, "Economic Burden of Men's Health Disparities in the United States," Thorpe, Richard, Bowie, LaVeist, and Gaskin (2013) estimated the potential cost savings from eliminating differences in health disparities among men of color in the United States. Using national data from 2006 to 2009, Thorpe, and colleagues found that the total direct medical care expenditures for African American men equaled $447.6 billion, of which $24.2 billion was for excess healthcare expenditures. With regard to indirect costs to the economy from wages lost because of lower productivity and premature death, African American and Hispanic men were associated with $317.6 and $115 billion, respectively.

Conclusion

The breadth and depth of literature focusing on men's health equity has grown in recent years; however, there is considerable room for conceptual and empirical expansion and extension. The chapters in this volume represent the state of the science associated with men's health equity and establish a solid foundation for interdisciplinary discourse. Critical thought and discussion across disciplines can usher in an era of transdisciplinary approaches to men's health equity needed to address limitations in the current literature. We believe that this handbook is a useful resource for scholars, health practitioners, and policymakers who are seeking a better understanding of factors and mechanisms that contribute to health inequities among men across the globe.

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2

MASCULINITY AND MEN'S HEALTH DISPARITIES

Conceptual and Theoretical Challenges

Steve Robertson and Lynne Kilvington-Dowd

Introduction

In the field of men's health, including the important emerging area of men's health disparities, conceptual and theoretical assumptions and challenges are omnipresent. These assumptions and challenges come from a range of disciplinary backgrounds. Biological, sociobiological, psychological, and sociological explanations are all found as either implicit or explicit explanations for understanding men's health practices and outcomes. At the forefront of many of these assumptions and challenges have been discussions around how masculinities—differing ways of being a man—influence men's practices and subsequent health outcomes. Many of these discussions have also included exchanges on how masculinities interact with other identity issues—including class, ethnicity, sexuality, disability, and age—to influence men's varied health and social practices.

In this chapter, we examine differing conceptual and theoretical ideas around gender and masculinities and consider how they are related (either implicitly or explicitly) to understanding men's health practices and, specifically, men's health disparities. In having this focus, we recognize that we are not also encompassing the important work that has been undertaken on theorizing health disparities (or *health inequalities* as they are often also referred to). (For an excellent overview on theorizing health inequalities, see the double special issue on this topic edited by Smith and Schrecker [2015].)

In this chapter, then, we begin by briefly considering biological, sociobiological, and early psychological explanations of gender and masculinities before spending considerably more time exploring a range of nuanced sociological understandings. This latter section not only includes seminal work around hegemonic masculinities but also contemporary, "third wave" men and masculinities literature, which has not, as yet, been fully considered by researchers in the fields of men's health or men's health disparities. Having completed our review of this work on masculinities and men's health, we then consider some of the conceptual thinking around intersectionality. Here, we reflect on how acknowledging mutually constituting structures of power can make possible more nuanced and multilayered insights into men's health disparities. Throughout the chapter, we refer to empirical work when appropriate to highlight or illuminate the conceptual or theoretical ideas being discussed.

Biology, Sociobiology, and Men's Health Disparities

One of the difficulties faced in the men's health field, especially when considering disparities, is accounting for, differentiating, and simultaneously integrating notions of "sex" and "gender."

Although multiple definitional distinctions between these two notions are available (though, as we will consider shortly, some use them interchangeably), and vary a little, across the literature they are mainly consistent with each other in considering *sex* to be related to the classification of people as male or female at birth—based on physical characteristics such as chromosomes, hormones, internal reproductive organs, etc.—and *gender* to refer to the socially constructed roles, activities, and attributes that society considers appropriate for men and women (and the personal sense of identity linked to this). Although researchers in the social sciences often distinguish between the two (with the notable exception of poststructural and/or postmodern accounts that tend to reject such binary thinking and conceptualizing and see sex/gender as consisting of a multifaceted nexus of discursive signs and signifiers), researchers in the biological sciences often conflate the two, with many papers supposedly examining gender actually being papers that focus on biological male/female (sex) differences.

Two main concerns stem from collapsing sex/gender in this way. The first is that men's (and women's) health outcomes become essentialized; that is, health outcomes, and the sex disparities within them, are understood as arising as a direct result of the influence of the *Y* chromosome, testosterone, or other sex-specific physiological differences. Our second concern about failing to distinguish between sex and gender is about the possibility of overemphasizing sex differences.

There is certainly evidence that some health outcomes are directly linked, or strongly influenced, by genetic and hormonal factors. For example, Kraemer (2000) highlights that the male fetus is at greater risk of death or damage from many obstetric catastrophes that can happen before birth, with perinatal brain damage, cerebral palsy, congenital deformities of the genitalia and limbs, premature birth, and stillbirth all being more common in boys. Similarly, in terms of sex-based differences, Baker et al. (2003) have shown that before menopause, women have a considerably lower rate of heart disease than men and that this difference is primarily related to the effects of the hormone estrogen on the prevention of atherosclerosis (the build-up of fatty material inside the arteries); after menopause, when estrogen levels decrease, rates of cardiovascular disease become similar for both women and men. Understanding the role that genetics and physiology play in generating sex-based differences in health outcomes is clearly important. Recognition of these factors creates opportunities for more accurate diagnosis and treatment possibilities, as suggested by Baker et al. (2003) who highlights what an understanding of the relationship between estrogen and heart disease might mean for therapeutic interventions.

As for our second concern about the overemphasis of sex differences possibly leading to bias in light of the conflation of sex and gender, such bias has been reported in research. For instance, Arber et al. (2006) highlight the possible role of diagnostic bias in recognizing heart disease in men and women, therefore suggesting it is not only biological sex (hormonal) influences that might determine disparities in rates of diagnoses of heart disease but also the influence of gender. In addition, Kraemer (2000) states that genetic, hormonal, and physiological differences are strongly socially mediated, pointing to the importance of gender as well as sex.

Social science research funding lags behind funding in the physical sciences (Bastow, Dunleavy, & Tinkler, 2014), and biomedical funding dominates the health research agenda. It is no surprise, then, that there has been far more research undertaken that comments on sex differences than on recognizing and considering gender within the health research environment. It has also been suggested that within research studies considering sex differences, those that quantitatively show significant difference are more likely to get published than those that do not demonstrate such difference (Connell et al., 1999). Within work on sex differences in health practices or outcomes, this can obviously create a strong impression that such differences are common when most published research appears to demonstrate the presence of such differences. However, as Connell et al. (1999) also show, there is a small but important body of published research that demonstrates no sex differences across a range of health practices and outcomes. In addition, as Walsh (1997) notes, this overemphasis on sex difference obscures within-sex differences (disparities) related to other aspects

of identity such as social class, ethnicity, sexuality, and other matters—that is to say, it fails to note aspects of difference along lines of identity other than sex and gender. (We return to this important issue later in the chapter in our discussion of intersectionality.) Of course, this does not mean that research on sex differences is not important in how we understand health disparities, but rather that it is often overemphasized compared to health research in which gender is considered.

Closely linked to notions of biological sex in explaining health practices and outcomes are ideas found in the field of sociobiology. This can be understood as the role that evolutionary imperatives play in determining social behavior; evolutionary mechanisms, mediated through genetics (and epigenetics), are seen to influence men's (and women's) behaviors in ways that best benefit the continuation of the species. For example, the drive for men to be the provider—the breadwinner—is crudely linked within a sociobiological framework to making oneself more attractive as a partner and, therefore, more likely to get opportunities to reproduce. Those men least able to provide become less likely to reproduce, and the gene pool is thus strengthened. Within such a framework, higher male suicide rates when being made redundant (laid off) from work or otherwise unemployed (Robertson, Gough, & Robinson, 2017) could be explained by a lesser ability, perhaps a lesser genetic ability, to be resilient and to sustain a provider role in a fragile economy, leading to a sense of failure and ultimately suicide. Furthermore, for reproductive potential to be fulfilled, according to sociobiological thought, there is an evolutionary necessity for men to have as many sexual partners as possible and for women to find the best man with the best seed (Plummer, 2005), and this arrangement has obvious implications for its implied heteronormativity and for how sexual health programs and interventions are considered. In the most extreme view, as Plummer (2005) points out, sociobiologists can even be seen as apologists for sexual violence, including rape.

Of course, biological and sociobiological conceptualizations have also been said to account for some health disparities linked to race and ethnicity. As Braun (2002) notes, genetic explanations for health differences between ethnic groups are common both in the scientific literature and in popular media accounts of biomedical research. However, such naïve accounts fail to take into account the influence of social context. For example, socioeconomic differences between ethnic groups have been shown to account for a substantial portion of the racial disparity in health outcomes (Institute of Medicine, 2000).

As one of the co-authors has pointed out elsewhere (Robertson, 2007), although strict adherence to such genetically deterministic explanations for behavior (at least as a sole explanation) are rare, sociobiology continues to be a widely taught theory and to have appeal within media representations, and thereby exerts influence in explaining how (men's) health practices and outcomes emerge. Thus, sociobiology should not be ignored in considerations of theoretical and conceptual approaches to men's health disparities.

Sex Role Theory and a Psychology of Men's Health Disparities

As we have seen, naïve forms of biological and sociobiological approaches can act to neglect the importance of gender through their overemphasis on sex. Many within the field of psychology have attempted to rectify this omission when trying to understand the relationship between men (or women) and their health. To do so, they have specifically operationalized gender through concepts of "masculinity" and "femininity" as variables that can then be correlated to health outcomes or health-related practices. This has predominantly been done through the development, testing, and application of psychological scales (Levant & Pollack, 1995). One of the earliest was Bem's Sex Role Inventory (BSRI; Bem, 1974, 1981) that asks people to assess how true 60 personality characteristics (predetermined as being "masculine" or "feminine") are for them on a seven-point scale. In the United Kingdom, Annandale and Hunt (1990) used the BSRI and correlated it with physical measures of health (height, blood pressure, and self-assessment), indicators of mental health (using

a recognized psychological scale), self-assessed general health status, and health service utilization (number of general practitioner visits in the last year). The results showed that those who scored as "highly masculine" (these could be men or women) had better self-reported measures of mental and physical health and lower rates of health service utilization.

Pleck (1995) has reviewed research in which psychometric scales were used to measure how much men have internalized, or adhered to, traditional notions of masculinity. Although the orientation of these psychometric scales varies, Pleck's review of their use shows that masculinity can be linked to lower levels of social support, reduced instances of help-seeking for psychological problems, lower levels of same-sex intimacy, higher rates of homophobia, increased alcohol and drug use, less consistent use of condoms, increased cardiovascular stressors, more sexual partners, and a belief that relationships between men and women are inherently adversarial.

In studies in which psychometric scales are used, the studies have conflicting results about whether masculinity confers advantages or disadvantages in terms of health practices and outcomes. As Robertson (2007) notes, this is possibly because of the different ways that masculinity is conceptualized and operationalized in psychometric studies. In terms of theory, such studies rely heavily on role theory and differentiating sex roles in order to formulate the scales, usually Likert-type scales, used to measure masculinity or its characteristics.

The basic assumption in role theory is that social expectations about a person's status in society produces conformity to given roles and their related sets of functions (e.g., neighbor, father, doctor; Robertson, 2007). Fulfillment of these roles is encouraged through a range of implicit or explicit rewards and sanctions that are brought to bear in order to facilitate conformity (see chapter 5 of Parsons, 1964). Many of these roles are culturally considered as gendered—more suitable or acceptable for men or for women. Historically, roles have also been considered more or less suitable along lines of religion, ethnicity, and sexuality. However, difficulties emerge when particular social roles will not or cannot be fulfilled. For example, society may expect one of men's roles to be that of breadwinner and economic provider for his family and, even in this era of the "new man," the relationship between paid employment and male identity remains strong (Oliffe & Han, 2014). If this view becomes internalized by an individual man who cannot earn sufficiently (through low pay, being made redundant, or being otherwise unemployed), the result can be what Pleck terms Sex Role Strain (Pleck, 1981) or Male Gender Role Strain (MGRS; Pleck, 1995). Thus, the greater the internalization of cultural norms of masculinity roles for an individual, the greater the role strain experienced when these norms cannot be lived up to. The ultimate outcome of MGRS provides a possible alternative explanation for the higher rates of male suicide (compared with rates among females) after unemployment or redundancy, which we noted previously in the section on sociobiology. As also mentioned previously, however, these anticipated roles, and the strain(s) attached to them, are not just gender specific but can be anticipated in relation to other aspects of identity such as ethnicity, sexuality, and disability.

Theorizing gender and masculinity through sex role theory in the ways noted in the previous paragraph and developing psychological scales to operationalize and measure masculinity have come under a great deal of criticism, mainly from sociologists. The point here, expanded at length by Hearn (1996), is that the concept of masculinity has been hijacked, mainly by the "psy" sciences. Specifically, masculinity often becomes associated with sets of characteristics that are individually "possessed" and/or "internalized," to greater or lesser degrees, by men through processes of sex role socialization that form part of a "deep center" psychological essence of men (Robertson, Williams, & Oliffe, 2016, p. 55). As one of the co-authors of this chapter notes elsewhere (Robertson, 2007), criticisms of such conceptualization are threefold.

First, role theory is said to lack sufficient historical perspective and, therefore, understanding of change (Carrigan, Connell, & Lee, 1985). From the psychological perspective, people are seemingly understood as empty vessels at birth who are socialized, or not, into particular ways of being (such as masculine). Within this framework, "Change is always something that *happens to* sex roles,

that impinges on them. … Sex role theory cannot grasp change as a dialectic arising within gender relations themselves" (Carrigan et al., 1985, p. 578).

Second, linked to this lack of historical perspective and understanding of change, role theory also fails to sufficiently address issues of power relations between men and women (and similarly between ethnic groups, differing sexualities, etc.) as demonstrated by Segal (1997): "The complex dynamics of gender identity, at both the social and the individual level, disappear in sex role theory, as abstract opinions about 'difference' replace the concrete, changing power relations between men and women" (p. 69).

A third criticism often raised against sex role theorizing is that it fails to adequately separate biological sex and gender. In this sense, as with the sociobiological explanations discussed previously, it remains an essentialist way of thinking, one that creates and reinforces rigid and dichotomized views about sex/gender differences. As Connell (1995) states, "Sex roles are defined as reciprocal; polarization is a necessary part of the concept" (p. 26). Within sex role theorizing, there are, therefore, no opportunities for nuanced considerations of men's and women's practices as diverse, wide-ranging, and often overlapping. This being the case, the difficulty of exploring the complexity of gender relations (and within-sex differences) becomes clear when they are presented as opposite ends of a continuum; that is, as sex differences. This focus on differences rather than congruency also helps to obscure other important issues of identity such as class, ethnicity, and sexuality (Connell, 1995) and thereby offers only a limited conceptual tool for understanding the breadth of health disparities.

Relational Models of Gender and Masculinities

Having considered biological approaches to men's health disparities, sociobiological approaches, and psychologically operationalized sex role theory conceptualizations, we now turn to relational model explanations for understanding gender and how these may be of use in understanding men's health disparities. Such relational theorizing on gender and masculinities is primarily informed by Connell (1987, 1995) and Connell and Messerschmidt (2005). Here, gender is seen as being about sets of relations between men and women, but also about relations *among* men and *among* women; masculinities are a part of, and not distinct from, the larger system of relations that Connell (1987, 1995) terms the *gender order*[1] Such conceptualization thereby avoids the polarizing tendencies found within biological and sex role theorizing and also opens opportunities for seeing power relations within the gender order as a nexus that operates along other identity axes such as sexuality, ethnicity, and disability.

The key aspects of relational models have been discussed elsewhere (Robertson et al., 2016) and are reiterated here. Rather than being viewed as singular and consisting of character types or attributes held by individuals, in relational models, masculinities are recognized as diverse processes of arranging and doing social practices that operate in individual and collective settings—that is, masculinities operate as what Connell (1995) terms *configurations of practice*. Masculinities, then, are not essential aspects of the (male) self but are conceptualized as being generated through, and as impacting upon, sets of social relations as part of a wider dynamic of gender relations. That is, they occur and/or are performed in intersubjective encounters, rather than existing within an individual's psyche. Such conceptualization helps explain how men can be involved in changing, and often contradictory, practices in different times and places. O'Brien, Hunt, and Hart's (2005) research offers an example from a study participant that shows how men's previous practices of not seeking help shift for men who have experienced various aspects of ill health:

> Before I'd say, "Alright, I'll just go on and not see anyone." … You didn't tend to go to the doctors, you know. Well, I didn't. It was only when I got the pains in my heart that

> made me go to the doctor. I wouldn't hesitate now if I had to go to the doctor's if I felt anything was wrong.
>
> *(p. 510)*

However, for those men seeking help for depression, depression did seem to pose a threat to their gendered identity because it was discursively constructed by them as a "feminine" complaint:

> The very idea of going to the doctor if I feel, you know from personal experience, if I feel in any way down or in a depressed mood. … If I was a woman, I'd probably go to the doctor and get some … antidepressants. … But as a man, you just pull your socks up.
>
> *(p. 511)*

In a similar way, Galdas, Cheater, and Marshall's (2007) research exploring help-seeking for cardiac concerns of White British and South Asian men highlights important cultural differences. Stoicism in relation to pain and discomfort was a valued, gendered attribute for the White British men in the study, whereas the South Asian men emphasized wisdom, education, and responsibility for the family as core gendered attributes. This led to a reluctance to disclose symptoms and to seek help among the White British men but a greater willingness to seek help among the South Asian men when experiencing chest pain.

Evident here—as shown in the O'Brien et al. (2005) study and in the Galdas et al. (2007) study—are the differing contexts within which help-seeking configurations of practice can be normalized or avoided. Gender, the "doing" of masculinity, is at play in all the previous accounts of men's practices but with quite differing results in terms of health help-seeking practices. It is also clear that other aspects of identity (e.g., in the previous ethnicity example in Galdas et al. [2007]) intersect with gender to produce different configurations of practice that impact health outcomes and that may generate or prevent disparities.

Some configurations of practice are more dominant than others; that is, some are considered to be of greater status or are held in higher value than others. Thus, although variable, power still remains more embedded in some masculinity practices (some gendered arrangements and processes) than in others. In considering these practices, Connell (1995) suggests that certain configurations of masculinity practices can be considered hegemonic in that they are predominant and influential. Other configurations become subordinated to, marginalized from, or complicit with hegemonic configurations of practice. Understanding configurations as hierarchical in this way allows us to consider the contradictory nature of individual men's health practices, to explore differences within and between groups of men (rather than just between men and women), and to understand how the subordinating and marginalizing of some configurations of practice can create diverse health practices and outcomes. In addition, the interplay of gender with other structures—such as social class, ethnicity, sexuality, and disability—creates particular relationships to masculinities. For example, previous research by one of the authors of this chapter (Robertson, 2006) shows the identity disruption and related impact on mental well-being that can occur when men cannot live up to (hierarchically) hegemonic configurations of masculinities because of physical impairment:

> *Interviewer*: Has that [becoming physically impaired] changed the way you think of yourself as a man?
>
> *Vernon*: Yeah, 'cause though you know you're still a man, I've ended up in a chair, and I don't feel like a red-blooded man. I don't feel I can handle 10 pints and get a woman and just do the business with them and forget it, like most young people do. You feel compromised and still sort of feeling like "will I be able to satisfy my partner?" Not just sexually—other ways, like DIY jobs round the house and all sorts.
>
> *(p. 445)*

The quote draws on aspects of what is expected, what is normative, in terms of male bodies and behavior (e.g., drinking, sexual prowess, and skilled labor) to explain how increasing physical impairment impacted Vernon's sense of male self. He also references these masculine ideals as those that women want in a man, thereby implying that heterosexual gender relations are contingent on the able-bodied man fulfilling his role(s) in order to sustain the relationship. Although this example has obvious resonance with sex role theories outlined previously, the relational model allows for more nuance and complexity. The (power) dynamics (both present and implied) within this short narrative are not just those between Vernon and his wife (man/woman dynamics) but are also those at play between Vernon and other (able-bodied) men and the disparities (perceived or real) that these dynamics create.

Through emergent and often subtle processes, hegemonic configurations of practice become embedded within social institutions (structures) and thereby act to replicate and maintain an existing gender order. In this way, gender (masculinities) can be conceptualized as a structuring force. Recognizing that hegemonic configurations of gendered practice are embedded in social structures allows us to understand the role that structural power plays in influencing men's health practices. It helps to avoid viewing differences, including health disparities, as something internal, something biologically and/or psychologically fixed, and somehow the result of an essential part of a person's core. For example, seeing hegemonic configurations of gendered practice as embedded in social structures allows us to understand the overrepresentation and harsher treatment (e.g., secure "lock-down" mental health facilities, more physical treatment like electro-convulsive therapy, the use of neuroleptics, seclusion) of African, African American, and African Caribbean men in U.S. and U.K. mental health services not as a result of biological or psychological make-up but as an example of the historical, hierarchical subordination of particular configurations of gendered practice within these institutions (McKeown, Robertson, Habte-Mariam, & Stowell-Smith, 2008). As Griffith (2012) poignantly reminds us, men's health is rooted in structures shaped by race and ethnicity—which, in turn, have important social, political, economic, and cultural meaning. (We return to this in "Intersectionality: Identity, Power, Resources, and Health," a later section in this chapter.)

The embedding of hegemonic configurations within social structures, described in the previous paragraph, acts to constrain the options—including options related to health practices—that are available to men and to specific groups of men in particular. That is not to say that there is no resistance or challenge to these structural influences, but any challenge is always carried out in relation and with reference to hegemonic (and therefore culturally expected) gendered practices (Connell & Messerschmidt, 2005; de Visser & Smith, 2006). The embedding of hegemonic configurations within social structures helps us to understand that although men's health (and other) practices are diverse they are not a matter of "free choice." Power embedded in social structures does not determine action in a simplistic sense. Individual men's conceptualizations of gender roles and norms clearly impact their health priorities, but social structures do limit and constrain the choices available; that is, they act to encourage particular configurations of gendered practice and restrict others.

Dolan's (2007, 2011) research on health and working-class masculinities provides useful examples of how social structures can constrain health choices. Although all the men in one of the studies (Dolan, 2011) portray their relationship with their family as that of "provider," many experienced high levels of unemployment and a related "depth of hardship":

> *Bob*: Christmas wasn't what I liked it to be. … We managed to get the children a couple of presents. The rest came from secondhand places. And the church donated some. … If any father turns round and likes that idea, no. … We were struggling, just getting the food and this, that and the other.
>
> *(p. 591)*

Although Bob clearly wishes to comply with hegemonic configurations as provider for his family, he is constrained from doing so through the situation within his socioeconomically deprived locality. This pressure to meet expected gender norms, yet being constrained from doing so, is clearly a source of personal strain for Bob that might impact his health and well-being. To this extent, relational models can link to sex role theory with both recognizing the influence of social norms on individual behavior. However, also demonstrated in this quote is the point made previously about sex role theories neglecting the importance of power dynamics; it is structural power issues, the national and local social employment context outside Bob's control, and the material consequences of Bob's circumstances that create the strain that he experiences. One of the co-authors of this chapter has explored these issues in more detail elsewhere (Robertson et al., 2017), considering the links between masculinities and health inequalities within neoliberal economies and highlighting the relationship between structure and agency for men's health practices and outcomes under neoliberalism. Within that work, neoliberal policies are explained as precursors to precarious employment, low pay, and unrewarding service sector work that is often seen as feminized, especially by men from lower working classes and socioeconomically deprived locations where secure manufacturing employment has previously been the historical norm.

We have further shown how neoliberal policies are linked to stress and ill health, especially for particular groups of men marginalized from hegemonic advantage (again, those from lower social classes, but also men of color and men with impairments or disabilities; Robertson et al., 2017). Such issues are reinforced by increasingly quasiprivatized and privatized health service delivery models that emphasize neoliberal messages of self-care, autonomy, and self-blame. Masculinities are formed within such contexts but also act to produce and replicate them. In this sense, in relational models, masculinities, when understood as the gendered nature of intersubjective encounters, can be recognized as both the producer and product of both structure and agency.

Third Wave Conceptualizations of Gender and Masculinities

Connell's (1995) original formulation of masculinities has been much critiqued—in particular, hegemonic masculinity has been a focus of much consideration. It is not our intention to repeat and/or review all such critiques here, and, indeed, Connell and Messerschmidt (2005) themselves provide an excellent examination and consideration of many of these early critiques. This section will, instead, consider what some (Hearn et al., 2012)[2] have called a third wave conceptualization of gender and masculinities that is said to move beyond the early formulation of hegemonic masculinity. Specifically, we provide a brief overview of postmodern or poststructural conceptualizations, inclusive masculinity theory (IMT), hybrid masculinities, and the "masculine bloc," making links with each to health disparities.

Research on postmodern or poststructural conceptualizations of masculinity is diverse. Here, we summarize what Robertson et al. (2016) have written about such approaches previously, focusing on the key common ideas found in the writing of authors such as Alan Petersen (1998, 2003) and John MacInnes (1998). An initial consideration for postmodernists when thinking about gender is that even to talk about masculinity and femininity creates a false notion that all men (and all women) share certain natural, innate characteristics; this notion has obvious links to the criticisms of sociobiological and sex role theorizing discussed previously in this chapter. To understand gender in this binary way, these authors suggest, creates tendencies for both homogenizing (i.e., all men are the same, and all women are the same) and polarizing (i.e., men and women are fundamentally different). Petersen (1998, 2003) suggests that it is important to recognize how gender dualisms can obscure connections and similarities. For example, such dualisms help to obscure the fact that men and women from lower socioeconomic groups are likely to have more in common in terms of health practices and outcomes than men from high and low socioeconomic groups (Griffith, 2012).

In addition, within postmodern thinking is a strong emphasis on the role of discourse in constructing the social world and a concomitant minimizing of the importance (or even existence) of materiality. Although they might still have a strong emphasis on sets of relations and intersubjectivity, some researchers (Hearn et al., 2012) consider the view of masculinities as a fluid, contradictory assemblage of discourses to be more fruitful than Connell's (1995) approach. Within such theorizing, not only masculinities but even (male) bodies are to be understood *only* as products of discourse: "Rather than seeing bodies as biologically given, or prediscursive, bodies have come to be seen as fabricated through discourse as an effect of power/knowledge" (Petersen, 1998, p. 66). This postmodern focus on fluidity and discourse facilitates excellent interrogations of when, why, and how concepts are deployed and used for particular ends. Examples of such critical examination in the health arena are provided in an edited text by Rosenfeld and Faircloth (2006). Several contributors explore how and why—for whose benefit and through what processes—masculinities have become medicalized in a range of contexts, including erectile dysfunction, posttraumatic stress disorder, and male aging (the "andropause").

However, such (over)emphasis on discourse obscures, denies even, any focus on materiality and corporeality that is also significant in relation to men and their health. Gender relations are about more than discourse, and intersubjective encounters are physical in nature as well as representational. As Connell (1995) points out, to consider masculinities in social analysis means considering the materiality of gendered relations in production and consumption, in institutions, and in places of social struggle; the possibility for maintaining hegemonic configurations of practice requires subordination of other forms "by an array of quite material practices" (Connell, 1995, p. 78). In addition, it is important not to get drawn into the extreme relativism that postmodern theorizing demands. As Hearn (1996) suggests, although differences exist among men in terms of power relations with women, men are also bound together as a gendered social group. Considering male identity as too multiple, too fluid, and too fragmented runs the risk of creating a case for antifoundationalism, which, in turn, can suggest a concomitant diminution of recognition of men's power and domination.

Others, informed by postmodern and queer theory insights, have also tried to theorize gender and masculinities in ways that recognize the importance of difference (thus avoiding homogenizing notions) while avoiding essentialist notions and an overemphasis on discourse. Such approaches also challenge the way hegemonic masculinity has previously been formulated. Inclusive masculinity theory (IMT; Anderson, 2009; Anderson & McGuire, 2010) provides one such conceptualization. As its originator explains (Anderson & McCormack, 2016), IMT is an inductively derived theory based on empirical work initially with young men in college sports settings—although it has been significantly expanded and refined since its initial definition. The theory was conceived after the consideration of empirical data showing that an increasing number of young straight men were rejecting homophobia and that they were more emotionally open, more physically tactile, and more open to gay peer friendships and to recognizing a range of sexualities as legitimate (Anderson & McCormack, 2016). However, in explaining changes in gendered practices, Anderson (2009) was reluctant to explain this simply as a cultural shift in decreasing homophobia, given that many of these open expressions of masculinity practices also exist in cultures where homophobia is still very much present. Instead, to account for these changes in men's gendered practices, Anderson (2009) introduced the concept of homohysteria (i.e., the fear of being socially perceived as gay) and the assertion that the trend of the rejection of homophobia could be explained by the absence or decreased instance of homohysteria. Within cultures that meet the criteria for demonstrating homohysteria (see Anderson & McCormack, 2016), homophobia persists (even when emotionally open masculinity practices exist) and functions as a tool to police gender.

IMT can apply to considerations of men's health and health disparities. For example, reviewing research on men and suicide (a persistent and highly sex-differentiated issue), Robertson, Bagnall,

and Walker (2014) have demonstrated strong empirical evidence that an adherence to masculinity is not problematic per se. Rather, both quantitative and qualitative evidence show that gendered practices of stoicism, difficulties in being emotionally expressive, are the practices most linked to negative mental health help-seeking, endorsement of mental health stigma, and likelihood of suicide among men. If the IMT conceptualization is correct, and modern changes in masculinity practices are more than just stylistic (we return to this shortly), then there is real hope for future reductions in mental health stigma and related suicide among men as masculinity practices continue to become more emotionally open in cultures with reduced homohysteria.

An additional key aspect of IMT is the view that it proffers on the hierarchical nature of masculinities. Drawn from postmodern and poststructural suggestions that masculinity and femininity are becoming increasingly fluid and blurred, IMT is further infused with the concept that within cultures with reduced homohysteria, Connell's (1995) theorizing begins to collapse regarding the view of masculinities as hierarchical with certain practices being hegemonic. Instead, diverse forms of masculinity practices—for example, what Connell (1995) would term *subordinated* and *marginalized* practices—become more evenly esteemed and valued and femininity in men less stigmatized (Anderson, 2009). Again, if such theorizing is correct, there is hope that many of the health disparities currently experienced by gay men that are said to result from societal stigma, discrimination, stress, and denial of civil rights (Jackson, Agénor, Johnson, Austin, & Kawachi, 2016) will reduce as homohysteria and homophobia decline.

As Johansson and Ottemo (2015) suggest, researchers who work within IMT are optimistic about the changes in masculinities and gender practices, seeing them very much as a trend likely to continue.[3] In addition, as masculinities become more permissive and inclusive, IMT researchers, such as Anderson and McCormack (2016), note that there will be less need and use for the concept of hegemony. Others criticizing the original formulation of hegemonic masculinity take a different view. Considerable change—a radical rupture in gender and masculinity practices—is suggested by IMT researchers such as Anderson (2009). Authors such as Demetriou (2001) and Bridges and Pascoe (2014) agree that a degree of change has taken place and is taking place. However, their thinking diverges from IMT in terms of the extent to which they think this has happened and the reasons for it. They suggest that changes toward "softer," more emotionally open and inclusive masculinity practices are more a reconfiguration than a radical rupture.

Demetriou (2001) argues for a move away from the dualism between hegemonic and nonhegemonic masculinities found in Connell's (1995) work. Instead, Demetriou (2001) proposes the concept of a "hegemonic masculine bloc," in which masculinity practices, including subordinated, marginalized, and complicit practices, are recognized as being in a constant process of negotiation, translation, hybridization, and reconfiguration.[4] As with IMT, this suggests that masculinity practices previously appearing to be passive within Connell's framework (most notably subordinated and marginalized practices) actually play a more active role in the (re)production of the gender order. Rather than masculine power being "a closed, coherent, and unified totality" (Connell, 1995, p. 355) that stands in clear and obvious opposition to women's rights and homosexuality, in the hegemonic masculine bloc, aspects of these are incorporated so that the concept appears less threatening and more egalitarian. In hybridizing traditional, hegemonic practices with marginalized or subordinated practices—such as demonstrating health self-care and libertarian views within the international business culture (Connell & Wood, 2005) or supporting gender justice and dressing stylishly while identifying as straight (Bridges, 2014)—the hegemonic masculine bloc masks and obfuscates the way that patriarchal power and privilege are maintained.

To this extent, as Bridges and Pascoe (2014) note, privilege works best when it goes unrecognized and, as Demetriou (2001) highlights, it is through its hybrid and contradictory nature that hegemonic masculinity can subtly reproduce itself to maintain the current gender order. Thus, although agreeing with IMT theorists Anderson and McCormack (2016) that the assimilation of previously marginalized or subordinated masculinity practices that blur social and symbolic bound-

aries is now widespread, those conceptualizing masculinities more as a "hegemonic masculinities bloc" (Demetriou, 2001) or as "hybridized" (Bridges & Pascoe, 2014) would challenge the reasons for this, the extent of this in terms of material rather than stylistic change, and whether such change represents a genuine challenge to existing systems of power and inequality.

Conceptualizing masculinity practices as hybridized is important in relation to understanding and thinking about ways to address men's health disparities. Such a framework is useful in understanding the relationship among masculinities, work, and health within the neoliberal economic context as it is best placed to explain the links between agency and structure within a time of change in working conditions and continuity (in terms of where power and privilege reside and in terms of associated inequalities; Robertson et al., 2017). Further suggested in previous work (Robertson et al., 2017), and also connected with our discussion on neoliberalism and masculinities previously in this chapter, is that the focus of men's health promotion at the level of the individual and individual behavior change is misplaced in neoliberal working (and under/unemployment) contexts that directly act against the ability of men to make or sustain such changes. In addition, those outlining the importance of conceptualizing masculinities as hybrid practices (Bridges & Pascoe, 2014) have also highlighted how such practices are both more available and more acceptable for certain men—namely young, white, straight, socially privileged men. This observation raises an important issue that is threaded through this chapter but that has, so far, mainly been alluded to and not fully addressed: the issue of how gender and masculinities intersect with other aspects of identity and the importance of this intersection for understanding men's health disparities.

Intersectionality: Identity, Power, Resources, and Health

Although this text has another chapter on intersectionality, we would, nevertheless, be remiss if we did not give some attention to this important issue in a chapter on the conceptual and theoretical challenges to understanding masculinities and men's health disparities.

Intersectionality is rooted in emancipatory black feminism (Crenshaw, 1995; Hill Collins, 2000; Hooks, 1990) with an emphasis on exploring how power invested in macrostructural forces and experienced through individual social locations gives rise to systems of inequality (Hill Collins & Bilge, 2016), including health inequalities and disparities (Griffith, 2012; Hankivsky & Christoffersen, 2008). At its core is a focus on multiple intersecting social categories such as gender, race, ethnicity, class, sexuality, and disability, which are mutually constitutive and, therefore, give meaning to each other (Cole, 2009; Smooth, 2013). Thus, power is understood through "a lens of mutual construction" (Hill Collins & Bilge, 2016, p. 28). Intersectionality focuses on the intersecting processes that produce, reproduce, and resist power, leading to social and material inequality between groups and within them (Hankivsky, 2014). The association between power, resources, and health is clearly documented (Marmot & Allen, 2014; Marmot & Wilkinson, 2006); those with the least power and access to material resources have poorer health outcomes. In an intersectional framework, power is perceived as relational and contextually derived (Hill Collins & Bilge, 2016; Smooth, 2013). As a consequence, men's configurations of practice are concomitantly influenced by multiple structures and individual social locations that intersect and inform men's identities, both enabling and restricting men's agency and their health. We posit, therefore, that intersectionality demonstrates not only how differing social contexts lead to disparities in the way men experience health but also identifies the processes that engender health inequity or disparities more broadly (Hankivsky & Christoffersen, 2008). These processes are demonstrated later in this section using three key principles, which underpin intersectionality: privilege and marginalization, an emphasis on heterogeneity and anti-essentialism, and recognition that social identities and power shift over time. For each of these, we draw on empirical examples to support the discussion.

Privilege and Marginalization

In the field of men's health, a tendency exists to conceptualize privilege and marginalization as mutually exclusive. Certain groups of men, based on shared characteristics, such as aboriginality, disability, gay or transgender identity, or African American heritage, are generally identified as marginalized or subordinated vis-à-vis other men, and evidence shows that men within such groups generally have poor health outcomes (Griffith, 2012; Macdonald & Brown, 2011; Robertson, 2007; Robertson & Monaghan, 2012). However, power is rarely either absolute or nonexistent (Smooth, 2013). Intersectionality posits that social structures, which shape aspects of identity, are constitutive, and, therefore, one can be privileged by one axis—such as class, race, sexuality, ability—yet marginalized by another (Hankivsky, 2012; Hill Collins & Bilge, 2016; Smooth, 2013). Conceptualizing the coexistence of privilege and marginalization shifts the focus from identifying groups of marginalized men at risk of poor health outcomes, to an emphasis on understanding how privilege and marginalization occur within the context and practices of men's daily lives. Privileged, elderly, white middle-class men, for example, encounter marginalization in accessing emotional support in the feminized context of family caregiving. Models of emotional support in caregiving broadly mirror those of mental health services, which are predominantly provided by, and consequently respond to, the needs of women (Adamson, 2015; Bondi, 2009; Kingerlee, Precious, Sullivan, & Barry, 2014; Morison, Trigeorgis, & John, 2014) with strong emphasis on help-seeking and emotional disclosure (Cleary, 2011; Kingerlee et al., 2014; Morison et al., 2014). There is resonance here with the "hegemonic masculine bloc"—discussed in the previous section—in understanding marginalization and subordination as more active (rather than simply passive) social practices.

Heterogeneity and Anti-Essentialism

As intersectionality encompasses the multiple ways in which social categories such as gender, race, class, sexuality, and ability are linked and the ways in which they inform each other, there exists an array of possible subject positions in how men experience them. By way of example, the marginalization experienced by aboriginal men or the privilege enjoyed by white middle-class men is not uniformly experienced by these two contrasting groups of men all the time (Smooth, 2013). On the contrary, power and privilege, or powerlessness and marginalization, are differentially experienced between groups but also, more significantly, within them (Smooth, 2013). Within the men's health field, there has been a tendency to emphasize oppositional notions—men's power and privilege or, conversely, powerlessness and marginalization, as respectively either protective of, or detrimental to, health. Such essentialist notions, however, fail to acknowledge the heterogeneity within such categories (Cole, 2009).

In their examination of the sources of stress among middle-aged African American men, Griffith, Ellis, and Allen (2013) illustrate such within-group diversity. Racism is identified as a significant and concomitant cause of stress for most African American men. It is experienced by these men in the context of their daily lives, employment, unemployment, and lost opportunities, and it permeates the sense of family responsibility some men feel as family providers, leading to a perceived failure to meet with society's expectations. However, beyond the scope of this study is the extent to which these confounding drivers of stress result in disparate health outcomes for different men within the largely homogeneous sample of middle-aged African American men. Stress is likely to be differentially experienced by men within this category, dependent on other determinants such as education, income, class or social status, age, and how these factors play out within the context of family life. Therefore, it is the combination of the intersection of macrostructural factors, individually experienced in and through a wide range of contexts, that jointly enables and constrains the agency of African American men to cope with and circumvent the chronic stress known to be detrimental to health.

The work by Griffith et al. (2013) hints at the diverse experiences and sources of stress experienced by middle-aged African American men. Shared characteristics such as African American heritage, gender, and age do not imply a uniform experience of stress. For example, some African American men are deemed by others to have "brought stress on themselves by not taking care of responsibilities" (p. 25). This indicates that we need to ensure that diversity within marginalized groups is broadly represented in research studies, or we risk secondary marginalization. Secondary marginalization occurs when an understanding of vulnerability is formed based on the experiences of the most privileged within any one category, thereby failing to recognize how diversity within such categories can lead to divergent experiences and health outcomes (Cole, 2009; Smooth, 2013).

Social Identities and Power Shift Over Time

Intersectionality, as a theoretical framework, focuses on defining and making visible power relations; however, power is not entirely constant or static. Power changes, shifts, and fluctuates, in ways analogous with the sociopolitical and economic environment (Hill Collins & Bilge, 2016; Smooth, 2013). Therefore, power operates in different ways across time and locational contexts. Social and political meanings are, thus, historically and/or geographically bound and are contested and restructured at both the level of the individual and more broadly by society (Smooth, 2013). Although changes in power systems occur gradually and are, therefore, often framed in long and multigenerational time spans, temporary fluctuations and shifts in the shorter term can also occur and have significant effects on social identities.

Changes in working-class male power, fought for and won after World War II (most notably through collective action), exemplify the kinds of shifts that can occur in power systems over a relatively short span of time (from a historical perspective). In recent years, the power of the working-class male has been eroded by confounding factors. Technology has replaced many skilled, semiskilled, and manual blue-collar jobs; globalization processes have heralded the outsourcing of production and manufacturing jobs to cheaper overseas labor markets; and neoliberal policies have curbed union power and have undermined worker protections (Standing, 2012). The result, as we suggested previously in the chapter, is a transition in many Western-world economies—from production and manufacturing to female-dominated service sector employment—characterized by low pay, part-time and irregular hours, and instability, rendering working-class men vulnerable to underemployment and unemployment (Robertson et al., 2017; Standing, 2012). The impact of unemployment on men's health is demonstrated by Artazcoz, Benach, Borrell, and Cortès (2004), who suggest that unemployed men from manual labor backgrounds with family responsibilities are more vulnerable to mental health problems than their female counterparts, illustrating the intersections of gender, class, and life stage (i.e., men with families) regarding men's health (see also Robertson et al., 2017). Other groups of currently privileged men, however, may be equally vulnerable in the future, as technology and globalization—underpinned by neoliberal deregulation—replace stable, well-paid, and professional jobs and act to constrain the agency of these groups of men to maintain health.

On the basis of these three key principles (i.e., privilege and marginalization, an emphasis on heterogeneity and anti-essentialism, and recognition that social identities and power shift over time), it is possible to see how intersectionality avoids the essentialist notions found within biomedical, sociobiological, and many psychological conceptualizations of gender and masculinities. With equal weight given to aspects of identity other than sex or gender, the resulting emphasis on heterogeneity within intersectionality helps facilitate exploration of health disparities among men themselves (rather than just focusing on those between men and women) while avoiding postmodern notions of total fluidity. That these multiple identities are developed relationally, within historically driven sociopolitical and economic contexts, also allows us to understand the primacy of power dynamics in generating men's health disparities.

Conclusions

A myriad of ways exist for theorizing and conceptualizing gender and masculinities, and we have attempted here to outline the main works in the field and to show how these can help us in recognizing and understanding men's health disparities. Biomedical work that focuses mainly on sex rather than gender is vital in helping us to see where patterns of difference and inequalities exist between men and women—although this approach is limited in its application for helping us to understand how and why these disparities arise and is deficient of a needed emphasis on sex similarities rather than just sex differences. Psychological research, especially that operationalizes masculinity as sets of personality traits, has value, particularly in helping us to consider differences (i.e., disparities) relating to men's mental health and well-being outcomes. However, because of the emphasis in psychological research on the individual and on implicit essentialism, such conceptualization is limited in its ability to consider how men's health disparities are embedded within social contexts. In response to this, relational and third wave thinking about gender and masculinities moves away from essentialist thinking, recognizes the importance of social context and associated power dynamics, and thereby facilitates an understanding of the complex and contradictory nature of men's health practices and outcomes, including disparities. Some still argue, though, that even these approaches overemphasize gender and, in doing so, neglect the importance of other aspects of identity and how these crosscut and intersect with gender to generate an array of health inequalities. Theorizing along lines of intersectionality addresses this by maintaining a focus on sets of relations (rather than essential characteristics) but gives equal weight to other aspects of identity (such as ethnicity, sexuality, social class, etc.) to help explore how health disparities are produced and sustained.

However much we have sought to achieve our goal of including the main texts on gender, masculinity, and health disparities, we recognize that there is much we have not covered. For example, the concept of health inequalities or disparities itself is the subject of much conceptual contestation (Smith & Schrecker, 2015), and we have not attempted to address this issue or to contribute to this debate within this chapter. Similarly, the gender and masculinities conceptual field is now quite broad and, in focusing on what we see as the major conceptual works, we have no doubt failed to pay attention to some newer texts that may prove to be very influential over time.

This chapter arose partly through ongoing discussion and debate between the two co-authors about the explanatory power of relational conceptual models that retain a primary focus on gender and masculinities versus those that maintain that the intersectionality of identity is the issue of primary importance. This is not a new debate, and Christensen and Jensen (2014) have done excellent work outlining and discussing this contention. It is fair to say that we have not fully reached consensus about whether primary emphasis should be placed on conceptualizing gender and masculinities or whether this should be seen as one aspect of identity among others (i.e., intersectional), when trying to understand men's health disparities. Nevertheless, it is also true to say that we have moved much closer to reaching this consensus through co-writing this current piece and are certainly in agreement about the advantages of relational models in aiding this understanding. As Lohan (2007) points out, academic work, both empirical and theoretical, that conceptually links the masculinities and health inequalities fields has been slow to emerge, and we hope that this chapter has helped to move this work at least a little further.

Notes

1 It is in this sense, in these important links to the larger structural ordering of sets of relations, that gender relational models differ somewhat from other models (such as symbolic interactionism) that focus more on the micro aspects of intersubjective relations.
2 Although Hearn et al. (2012) discuss this in relation to masculinities theorizing in Sweden, at a broad level we see clear similarities in masculinities theorizing across the global north.

3 While being optimistic about these changes in masculinities, researchers of IMT also recognize that such changes are not evenly distributed and that both homohysteria and homophobia continue to exist in both local and national contexts (Anderson & McCormack, 2016).
4 While recognizing this constant state of flux and fluidity within the "masculine bloc," Demetriou (2001) would not see this as postmodern conceptualizations would: that is, as only being present in discourse and devoid of materiality or material structure.

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3

PRECARIOUS MANHOOD AND MEN'S HEALTH DISPARITIES

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Introduction

Of all the societal advantages men have over women, longevity is not one. Across the globe, most women outlive most men (World Health Organization, 2017). Consider the leading causes of death in the United States shown in Table 3.1.

As shown in the right column of Table 3.1, men die at higher rates than women for nearly every major cause of death, with one exception: Women die of Alzheimer's disease at higher rates than men. However, this reversal of the typical pattern likely reflects the fact that women outnumber men among the elderly, which is when Alzheimer's disease usually strikes (Tejada-Vera, 2013). In other words, women's lower mortality rate at every age ensures that more women than men live long enough to develop Alzheimer's disease.

Although the causes of illness and death are complex and multiply determined, behavior plays a significant role in people's health and longevity. Diet, exercise, and smoking influence the two leading causes of death (i.e., heart disease and cancer), whereas diet, alcohol, and drug use can influence rates of diabetes and kidney diseases. Similarly, accidental deaths, suicides, and homicides have obvious behavioral causes. In fact, the more that behavior contributes to a given cause of death, the larger is the sex difference in rates of death from that cause (Kruger & Nesse, 2006). For example, boys and men are 2.15 times more likely than girls and women to die from unintentional injuries and 3.91 times more likely to die from violence-related injuries (Sorenson, 2011).

In this chapter, we consider men's health through the lens of men's gender role behaviors. Specifically, we evaluate gender differences in health from the perspective of precarious manhood theory (Bosson & Vandello, 2011; Vandello & Bosson, 2013; Vandello, Bosson, Cohen, Burnaford, & Weaver, 2008). This theory argues that cultures often conceptualize manhood, relative to womanhood, as a precarious social status, and this has implications for men's functioning across multiple domains. Here, we propose that the precariousness of the male gender role influences men's behavioral choices—the things that they choose to do and not to do—in ways that contribute to their health. In addition, manhood is especially precarious for certain subgroups and at certain developmental periods of life, creating unique health challenges. We begin with a brief summary of precarious manhood theory.

Table 3.1 The Leading Causes of Death in the United States, 2015

Cause of Death	*Percent of Total Deaths*	*Male-to-Female Rate*
1. Heart disease	23.4	1.6
2. Cancer	22.0	1.4
3. Chronic lower respiratory disease	5.7	1.2
4. Accidents	5.4	2.0
5. Cerebrovascular disease	5.2	1.0
6. Alzheimer's disease	4.1	0.7
7. Diabetes	2.9	1.5
8. Pneumonia or influenza	2.1	1.3
9. Kidney disease	1.8	1.4
10. Suicide	1.6	3.5

Source: Centers for Disease Control and Prevention (2017). Deaths: Final data for 2015. *National Vital Statistics Reports, 66*. Adapted from https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_06.pdf

Precarious Manhood Theory

Despite widespread, systemic gender disparities that afford men greater status and resources than women across cultures (Glick & Fiske, 1996), manhood itself is a relatively fragile social status (Vandello et al., 2008). In diverse cultures around the world, people view manhood (relative to womanhood) as an elusive and tenuous social status that must be earned and then defended repeatedly via public action (Gilmore, 1990; Vandello & Bosson, 2013). Note that *manhood* is distinct from *masculinity*. Whereas masculinity refers to sets of traits that are culturally associated with men, manhood is a social status. Sociologists refer to multiple forms of masculinities, with hegemonic masculinity being the most culturally prized and idealized form (Connell & Messerschmidt, 2005). Other masculinities (e.g., complicit, marginalized, subordinate) are lower in the status hierarchy (Evans, Frank, Oliffe, & Gregory, 2011), but all men are assumed to possess some degree of masculinity. In contrast, manhood is a socially conferred status that men may or may not attain, and may or may not retain. Whereas gender role theories have long characterized the male gender role as especially problematic and anxiety provoking (Courtenay, 2000; Kimmel, 2006; Levant, 1996; O'Neil, 2008; Pleck, 1981), the precarious manhood approach locates the source of this anxiety squarely in the structural precariousness of the male gender role. The specific traits that make someone masculine can vary from culture to culture or across time periods, but the precariousness of manhood itself is ubiquitous and perhaps universal.

Precarious manhood theory (Vandello et al., 2008) proposes three assumptions about the male gender role that distinguish it from the female gender role. First, manhood is widely viewed as an elusive, achieved status, or one that must be earned (in contrast to womanhood, which is an ascribed, or assigned, status). Second, once achieved, manhood status is tenuous and impermanent. Men can lose manhood status by enacting stereotypically feminine behaviors or by failing to demonstrate adequate levels of masculinity. Furthermore, whereas a wide range of social transgressions can call men's gender status into question, women's gender status is relatively permanent and assured. Third, manhood status is conferred primarily by others and thus requires regular, public demonstrations of proof. Such demonstrations are most effective if they involve action, risk, bravery, or toughness.

In our research, we propose that the precariousness of manhood offers a powerful explanatory mechanism for explaining a host of seemingly unrelated gender disparities. For instance, the relative precariousness of the male gender role can help illuminate why men, compared to women, anticipate and receive more punishment for gender role violations; view their gender group in

more stereotypical terms; more rigidly punish peers' gender role violations; respond to gender status threats with more anxiety, physiological arousal, and mental illness symptoms; seek more status and dominative control over others; and more often enact risky and (sometimes) dangerous "proofs" of masculinity such as aggressive posturing, financial risks, and sexual prejudice (Bosson & Michniewicz, 2013; Bosson, Vandello, Burnaford, Weaver, & Wasti, 2009; Bosson, Weaver, Caswell, & Burnaford, 2012; Caswell, Bosson, Vandello, & Sellers, 2014; Michniewicz, Vandello, & Bosson, 2014; Vandello et al., 2008; Weaver, Vandello, & Bosson, 2013; for reviews see Bosson & Vandello, 2011; Vandello & Bosson, 2013).

Given the requirements of proof associated with manhood, the male gender role is associated with powerful prescriptive (expected, desired) and proscriptive (forbidden, undesired) norms that govern behavior. Two norms in particular—risk-taking and antifemininity—are central to understanding how men negotiate the precariousness of their gender status and, as we explicate later, both of them are theorized to play roles in men's health choices. Moreover, men's adherence to prescriptive and proscriptive norms is related to their masculine capital or gender-based prestige (de Visser & McDonnell, 2013). To the extent that men conform to male role norms, they may earn masculine capital, which can serve as insurance to offset perceived masculine inadequacies. Conversely, when men violate gender role norms, they may lose masculine capital. Given that several health-relevant behaviors—such as playing competitive and aggressive sports, risky driving, and drinking alcohol—are prescriptive male role norms, men may use such behaviors to build masculine capital. Similarly, other health-relevant behaviors—such as ordering a healthy salad or visiting a doctor about a lingering pain—can lower masculine capital. Thus, men's pursuit of masculine capital can lead to behaviors that both inhibit and promote health in complex ways (de Visser & McDonnell, 2013; Gough, 2013). We expand on these ideas in the sections that follow. Note that our review focuses on the health of American men. A thorough review of manhood and health around the world is beyond the scope of this chapter, but we believe that the same mechanisms that influence the health of American men likely influence other groups as well.

Men's Avoidance of Healthy Behaviors

One of the core directives of the male gender role is the antifemininity mandate—the rule that boys and men must avoid femininity in their behavior, personality, appearance, and interests (Bosson & Michniewicz, 2013; Thompson, Grisanti, & Pleck, 1985). Whereas both men and women face pressure to avoid cross-gender behavior, femininity is more strongly proscribed for boys and men than is masculinity for girls and women (Levy, Taylor, & Gelman, 1995). This proscriptive norm can lead men to avoid health-promoting behaviors that are perceived as feminine.

Dietary Choices

Consider gender differences in diet. Men's diets are notoriously unhealthy relative to women's (Hiza, Casavale, Guenther, & Davis, 2013). In relative risk terms, men have a 30% higher chance than women of adopting an unhealthy diet (Finke & Huston, 2003), and men are more likely than women to suffer from many diet-related diseases (Crimmins & Beltrán-Sánchez, 2011). Women tend to eat more fruits, vegetables, and fiber, whereas men tend to eat more red meat, salt, and high-fat foods (Prättälä et al., 2007; Wardle et al., 2004). This may be because food and diet are strongly gender stereotyped: People view fruits and vegetables, fish, and healthy, low-fat diets as feminine (Jensen & Holm, 1999; Ruby & Heine, 2011), and they view red meat, alcohol, and unhealthy diets as masculine (Oakes & Slotterback, 2004; Rozin, Hormes, Faith, & Wansink, 2012). Thus, purposefully eating healthy foods can be a gender threat for men because it violates the antifemininity mandate. Conversely, eating unhealthy foods can signal men's masculinity to others and thereby increase their masculine capital.

Precarious manhood theory leads to a number of specific predictions about gender differences in people's dietary choices, and research thus far bears these out. First, given the male gender role's relatively stronger prescriptive and proscriptive norms, men's (versus women's) attraction to foods should be driven more strongly by the foods' perceived masculinity. Second, men's preferences for masculine over feminine foods should be heightened when their choices are made publicly. Third, men should gain masculine capital from eating masculine foods, and they should lose masculine capital from eating feminine foods. Supporting these hypotheses, correlational data (shown in Figure 3.1) indicate that men's attraction to foods is strongly positively predicted by the foods' masculinity and strongly negatively predicted by the food's femininity (Vandello, Bosson, Caswell, & Cummings, 2017). Experimental evidence indicates that men avoid food more when the food is described in feminine versus neutral terms, especially when they believe that others will observe their eating behavior (White & Dahl, 2006). Consuming masculine foods such as red meat bolsters men's feelings of masculinity (Rothgerber, 2013), whereas publicly endorsing a vegetarian diet leads men to compensate by increasing their subsequent conformity to male gender role norms (Vandello et al., 2017). After a task that threatens, rather than affirms, their feelings of masculinity, men select from a menu of food items that are more masculine than feminine (Gal & Wilkie, 2010). Finally, priming masculinity leads both men *and* women to prefer unhealthy foods (Zhu, Brescoll,

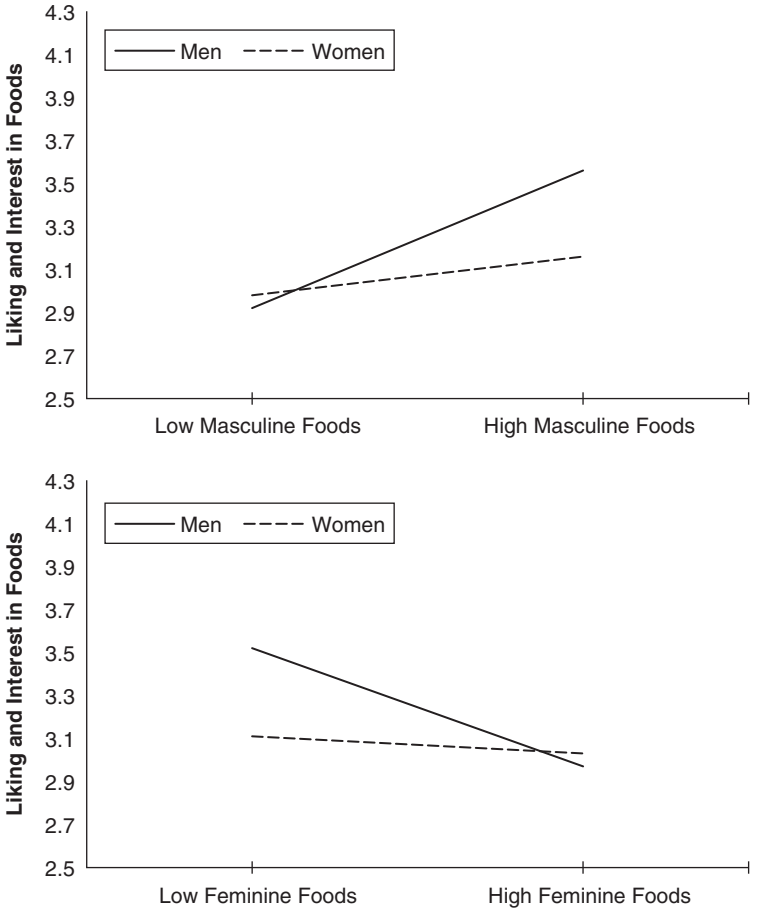

Figure 3.1 Men's and women's liking of, and interest in, foods as a function of the foods' perceived masculinity and femininity.

Newman, & Uhlmann, 2015), suggesting that the strong association between unhealthy foods and masculinity can "leak" across gender lines and affect the behavior of women.

Food and drink advertisers are well aware of the identity threat that healthy and diet products represent to men, and when marketing to men, they take pains to avoid any feminine connotations. For years, beer companies have successfully marketed low-calorie beers to men by avoiding any reference to diet, instead opting for the term "light." More recently, soda companies followed suit by rebranding diet products with black and grey packaging and removing the "diet" label (e.g., Coke Zero, Pepsi Max, Dr. Pepper 10). This masculine branding appears to be effective, as men's share of the diet beverage market has increased substantially over the last few decades (White, Oliffe, & Bottorff, 2014).

Use of Healthcare Professionals

Another major barrier to men's health is men's reluctance to seek help from healthcare professionals. In the United States, women are more likely than men to visit doctors; they visit doctors more frequently, and they are more likely to have a personal physician or to have a regular place where they receive healthcare (Blackwell, Lucas, & Clarke, 2014). Not only are men less likely to seek healthcare when ill or in pain, but they are also less likely than women to schedule regular checkups. This can produce or exacerbate gender differences in health by reducing the likelihood of early detection of men's physical and mental illnesses. For instance, men are far less likely than women to disclose emotional problems to a medical doctor, and this type of disclosure is one of the most common first steps toward help for mental illness and emotional problems (Susukida, Mojtabai, & Mendelson, 2015).

The precariousness of the male gender role can help to explain men's avoidance of routine checkups and denial of health problems. Given male prescriptive norms of self-reliance and toughness, men may view help-seeking as a gender threat that depletes their masculine capital. Consistent with this idea, men who endorse more traditional beliefs about masculinity are especially likely to postpone healthcare visits (Himmelstein & Sanchez, 2016). These men are also more likely to choose male doctors, which further reduces their likelihood of open doctor-patient communication, as people talk more with female doctors (Roter, Hall, & Aoki, 2002).

Men's Pursuit of Unhealthy Behaviors

While avoiding healthy but feminine behaviors is one way of maintaining manhood, men actively engage in other behaviors to achieve the same purpose. In general, men use behaviors that signal willingness to take risks as both a response to gender threats and a way to accrue masculine capital. On average, men take greater risks than women (Byrnes, Miller, & Schafer, 1999; Wilson & Daly, 1985). The bleak consequences of this sex difference in risk-taking are especially apparent when examining mortality rates in late adolescence and early adulthood. Young men between the ages of 20 and 24 years old are three times more likely to die than young women (Kruger & Nesse, 2006).

Consider alcohol, tobacco, and drug use, for instance. Boys and men smoke more tobacco and marijuana and drink more heavily than girls and women, and this sex disparity is larger in late adolescence and early adulthood when young men feel the greatest pressure to establish manhood credentials (Blackwell et al., 2014; Evans-Polce, Vasilenko, & Lanza, 2015). However, it is not just that men use drugs and alcohol more than women; they are also riskier users. Many young men equate being able to drink excessively, and to hold one's alcohol, with masculinity (de Visser & Smith, 2007). In one large, representative sample of U.S. adults, men were twice as likely as women (24.6% vs. 12.5%) to report binge drinking over the past month (Kanny, Liu, Brewer, & Lu, 2013). In another survey of U.S. adults, men were nearly twice as likely as women (4.5% vs. 2.5%) to meet diagnostic criteria for alcohol dependence (Esser et al., 2014). Similarly, although

men are only somewhat more likely than women to take drugs, they are 1.8 times more likely to die from drug-related causes (Centers for Disease Control and Prevention [CDC], 2017). The fact that young men equate excessive drinking and alcohol tolerance with masculinity suggests that their greater substance abuse is a byproduct of their risk-laden pursuit of masculine capital (de Visser & Smith, 2007).

Men's greater risk-taking is also reflected in fatal and nonfatal accidents. Although accidents are the fourth leading cause of death in the United States (see Table 3.1), they are the third leading cause of death for men but only the sixth for women (CDC, 2017). Men account for 93% of accidental deaths in the workplace and 83% of accidental deaths at home (Driscoll et al., 2003; U.S. Bureau of Labor Statistics, 2016). Men are more likely than women to work in dangerous occupations (e.g., logging, construction), and they are also more likely to do dangerous chores at home (e.g., fixing electrical problems, climbing on the roof). Even in leisure activities and sports, men take greater risks. Men are more likely than women to rock climb, whitewater raft, cliff dive, skydive, scuba dive, race motorcycles, and bungee jump (Schrader & Wann, 1999). In the United States, men are also three times as likely as women to own a personal gun (Pew Research Center, 2013), and they are almost six times more likely than women to die from unintentional firearm injuries (CDC, 2015a). Men also drive more recklessly than women, accounting for 71% of motor vehicle fatalities in the United States (Insurance Institute for Highway Safety [IIHS], 2016), even controlling for miles driven. Men are more likely to speed, less likely to wear seatbelts, and more likely to drink and drive than women are (IIHS, 2016).

These correlational findings are consistent with precarious manhood theory, which proposes that men use public, risky behaviors to establish and maintain their gender status. Moreover, a novel prediction posited by precarious manhood theory is that men increase their risk-taking behavior after a challenge to their masculinity. Although it is difficult or impossible to examine some kinds of risky behavior in the laboratory, in several studies researchers find increases in men's financial risk-taking and in risky, aggressive posturing after gender threats (Bosson et al., 2009; Bosson et al., 2012; Parent, Kalenkoski, & Cardella, 2018; Weaver et al., 2013).

Healthy Masculine Behaviors

Masculinity is often framed in problematic and negative terms, such as when researchers discuss "toxic masculinity" and its consequences for men's health (Connell, 2000; Gough, 2009). Although, as we have discussed, the precarious nature of manhood can motivate negative health behaviors, men can also use positive health-related behaviors that are traditionally masculine to accrue masculine capital (de Visser & McDonnell, 2013). For instance, men may demonstrate masculinity through physical toughness and strength. Being physically fit translates to rewards, such as being able to accomplish tasks, to protect others, and to best competitors. Similarly, athletic participation is a valued marker of masculinity. More generally and informally, exercise and physical activity can be both manhood affirming and health promoting. Physical fitness, particularly in middle age, is a strong predictor of longevity (Sandvik et al., 1993). While Americans, in general, are not very active, boys and men are about twice as likely as girls and women to meet minimum guidelines for sufficient daily activity (Troiano et al., 2007).

Although the precariousness of manhood can motivate physical activity and exercise, and fitness and exercise can promote health, two caveats are in order. First, some boys and men lack confidence in their physical appearance or athletic skill (Allender, Cowburn, & Foster, 2006). For these men, concerns about public shame may discourage rather than promote healthy athleticism and physical activity, as doing poorly at masculine tasks can threaten their gender status. Second, when taken to an extreme, striving to prove masculinity can result in harmful exercise practices among men whose motivations are primarily external and ego driven. For instance, although working out and building muscle can have health benefits, having a high drive for muscularity is associated with

negative health outcomes such as depression and steroid abuse (Edwards, Tod, & Molnar, 2014). Unfortunately, developing a stronger drive for muscularity is one way that men compensate when they feel that they lack masculine capital (Edwards, Molnar, & Tod, 2017). Similarly, men who participate in sports may do so for different reasons: Whereas some adopt a task-oriented approach to sports centered on health and fitness, others take an ego-oriented approach to sports that is associated with conformity to masculine norms and health risk-taking (Miller, 2009). The latter type of athlete is more likely to endorse hegemonic male gender role norms, take sexual health risks, drink problematically, and even engage in interpersonal violence. From a precarious manhood perspective, men who pursue sports for ego-driven reasons may be especially likely to take dangerous risks to prove their masculinity when it is challenged. Thus, for some men, the physical health benefits of athletic involvement may be offset by a heightened tendency toward health risk-taking.

Finally, although the precariousness of manhood can motivate men to enact some positive health behaviors as a way of accruing masculine capital, many men still remain reluctant to admit that they value their health. Instead, men often frame their health behaviors in terms of agency and autonomy (Sloan, Gough, & Conner, 2010). This suggests that the most effective way to reach men may be to downplay health concerns (which are seen as feminine) and instead emphasize how health can help men achieve goals.

Intersectionality and Health

Intersectionality refers to the complex ways in which multiple forms of discrimination interact for individuals who occupy multiple marginalized identities. Although few studies of men's health have empirically tested an intersectional approach, scholars are increasingly acknowledging the importance of this topic (Griffith, 2012; Hankivsky, 2011). Not surprisingly, men with marginalized identities (e.g., racial, ethnic, and sexual minority men, transgender men, men of low socioeconomic status [SES], disabled men) face unique health challenges and often suffer additional health disparities compared with nonmarginalized men. Precarious manhood theory leads to the prediction that low-status identities are associated with negative health outcomes for marginalized men. For these men, who have less masculine capital to leverage, manhood status is chronically more precarious.

Race and Ethnicity

Just as sex disparities in health are well documented, so too are race and ethnicity disparities. Black and Native American men have higher rates of fatal chronic conditions and shorter life expectancies than women or White men (Men's Health Network, 2013; Williams, 2003). While Latino men have lower mortality rates than non-Latino White men, they suffer from greater obesity and more deaths from diabetes and chronic liver disease (CDC, 2015b). In addition to being less likely to have health insurance, racial and ethnic minority men are more likely to mistrust the healthcare industry, and as a result, they are less likely to have regular healthcare visits (Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010). While only 23% of White men have no regular doctor, 30% of Black men and 49% of Latino men have no regular doctor (McFarlane & Nikora, 2014). Economic stressors and the stress of discrimination also disproportionately impact the health of racial and ethnic minority men (Brown, Hargrove, & Griffith, 2015). As one example, Asian American men are frequent targets of the "perpetual foreigner" stereotype (Huynh, Devos, & Smalarz, 2011), in that they are viewed as less fully American than White Americans. Among Asian men, those who encounter more "perpetual foreigner" stereotyping also report more unhealthy drives for muscularity (Chang, McDermott, Wong, & Lu, 2016). Experiences with racial discrimination can also increase men's use of risky health behaviors (e.g., smoking, substance use, risky sex) as coping strategies (Bowleg et al., 2013; Chavez, Ornelas, Lyles, & Williams, 2015; Stock, Peterson, Gibbons, & Gerrard, 2013).

Racial discrimination may be particularly harmful to men of color, not simply because it is stressful, but because it constitutes a threat to dignity, which is central to manhood for some racial and ethnic minority men (Griffith & Cornish, 2018; Griffith, Metzl, & Gunter, 2011). Whereas White men in the United States may be more likely to define manhood through economic success, men of color are often denied this route to manhood due to generations of structural discrimination. Men of color, and especially Black men may, therefore, place more importance on dignity and respect in defining what it means to be a man. Thus, chronic experiences of race-based disrespect—such as being routinely stopped, frisked, and questioned by police officers without cause—may feel like gender threats to Black men (Bowleg, Teti, Malebranche, & Tschann, 2013). Demonstrating the overlap between race-based and gender-based threats for men of color, Black men who experience racial discrimination may compensate by bolstering their gender status, i.e., by more strongly endorsing male gender role norms and masculine behaviors (Goff, Di Leone, & Kahn, 2012).

Socioeconomic Status

Low-SES men face additional health risks for a number of reasons—including greater exposure to environmental hazards, poorer diets, economic stress, lack of insurance, and lack of access to healthcare (Young, Meryn, & Treadwell, 2008). Poverty can magnify sex differences in health for a number of reasons. First, because men may experience economic insecurity as a gender threat, men low in SES may enact risky health behaviors as a way of restoring manhood. Second, because women represent a disproportionate percentage of the world's poor, poor men are relatively less visible. For instance, researchers and health advocates often overlook structural and socioeconomic factors when explaining men's health disparities, instead focusing on individual behaviors (Hodgetts & Chamberlain, 2002).

Thus, people may not recognize and appreciate the health challenges that face low-SES men. Health messages targeting men are not always effective at reaching working-class and low-SES populations, as they may ignore the structural barriers facing these populations (Hodgetts & Chamberlain, 2002). This can reinforce the view that low-SES men are simply lazy or do not take proper measures to protect their health. However, for many men, health risks are not choices: They are built into the structure of their daily lives (Lorber, 1997, p. 18). It is difficult to disentangle the effects of SES and racial discrimination on health because structural economic disadvantages have been part of the experiences of racial minority individuals for generations (Thorpe et al., 2015). Nonetheless, both SES and race appear to independently account for health disparities (Thorpe, Bowie, Wilson-Frederick, Coa, & LaVeist, 2013; Thorpe et al., 2015).

Sexual and Gender Minority Status

Like racial and ethnic minority men, sexual minority and transgender men face prejudice-based stressors that can adversely impact their health (Frost, Lehavot, & Meyer, 2015). Because sexual minority and transgender men are often perceived as violating male gender role norms, they are particularly vulnerable to stigmatization. This may help explain why gay, bisexual, and transgender men have generally poorer health than heterosexual and cisgender men (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Fredriksen-Goldsen et al., 2014). To cope with chronic stressors associated with stigmatization, sexual minority men exhibit riskier health behaviors, such as smoking and drug use, risky sex, and physical inactivity (Conron, Mimiaga, & Landers, 2010). Stigma-based stressors begin early in life and can create biological markers for later cardiovascular risks (Hatzenbuehler, Slopen, & McLaughlin, 2014).

Like racial minority men, sexual minority men use less preventive healthcare than straight, cisgender men. Sexual minority and transgender individuals are also less likely to have health insurance (Dahlhamer, Galinsky, Joestl, & Ward, 2016), and even when they do access healthcare, their

experiences are often more negative than those of heterosexual and cisgender men. Healthcare providers may lack education about how to treat the health problems of gay, bisexual, or transgender men. In addition, doctors' homophobia and transphobia, or even fears of accusations of prejudice, may make both doctors and patients reluctant to discuss issues related to sexual minority and transgender status (Haider et al., 2017).

Having supportive social resources and an accepting community can help protect the health of sexual minority and transgender men. Men who have strong social support from family and friends show better physical and mental health (Hill, Rooney, Mooney, & Kaplow, 2017; Pflum, Testa, Balsam, Goldblum, & Bongar, 2015; Wilson, Meyer, Antebi-Gruszka, Boone, & Cook, 2016). Furthermore, before the U.S. Supreme Court struck down the Defense of Marriage Act in 2015, same-sex couples who lived in states that legally recognized their relationships experienced better physical and mental health than those who did not (Williams & Fredriksen-Goldsen, 2014). Social support and supportive community norms, therefore, may buffer sexual minority and transgender men from poor health outcomes and help them negotiate the precariousness of their gender status.

Implications for Public Health Campaigns

Public health campaigns commonly emphasize the dangers associated with certain behaviors (e.g., drinking, reckless driving, smoking, unhealthy diets; Hastings, Stead, & Webb, 2004). To be sure, campaigns that highlight the negative consequences of risky behaviors, such as the decades-long antismoking campaign or Mothers Against Drunk Driving, have been tremendously successful in shifting public behavior. Nonetheless, they may also have unintended, counterproductive effects as well. Ironically, by emphasizing the risks of unhealthy behaviors, health promotion campaigns may backfire, at least among some men. Because acts that court danger signal manhood, messages that highlight the health risks of certain behaviors may have the paradoxical effect of increasing men's attraction to these behaviors. A college antidrinking campaign that emphasizes how binge drinking is both dangerous and illegal, for example, may inadvertently signal how it is also manly to a group of young men who are on their own for the first time and seeking ways to demonstrate manhood.

The paradoxical effect may help to explain the mixed findings regarding the effectiveness of fear appeals, which tend to be less effective in changing men's healthy attitudes and behaviors than women's (Ruiter, Abraham, & Kok, 2001; Tannenbaum et al., 2015). For instance, the authors of one study found that road safety ads meant to reduce speeding and driving under the influence increased women's, but not men's, intentions to avoid these behaviors (Lewis, Watson, & Tay, 2007). Although provocative, however, this idea requires further research. Precarious manhood theory predicts that men who are especially motivated to prove their manhood—due to chronic or manipulated manhood concerns—will be unpersuaded by some fear-based health appeals, or perhaps even demonstrate a boomerang effect and increase their intentions to enact risky health behaviors.

Whereas health promotion approaches that ignore audience gender may be limited in effectiveness, an alternative approach is to target men by leveraging the precariousness of manhood. How might this look? Some campaigns use manhood-affirming health interventions that emphasize male role norms (Courtenay, 2004a). As one example, a campaign in Virginia called "Man Up Monday" sought to increase men's testing for sexually transmitted infections (STIs) by encouraging them to go to clinics after weekend sexual risk-taking. The campaign deployed edgy visuals (e.g., flaming boxer shorts) and taglines such as "If you hit it this weekend, hit the clinic on Monday." This doubled the number of men who tested for STIs (Fleming, Lee, & Dworkin, 2014).

Despite their success, efforts to change men's health behaviors using this approach can have unintended consequences. Campaigns that portray manhood in overly narrow, caricatured ways may reinforce a view of manhood that prizes risk-taking, self-reliance, aggression, or degradation and conquest of women, which can prove detrimental to health (and relationships) in the long

run (Fleming et al., 2014). Thus, we recommend caution in using this approach, to avoid reinforcing maladaptive versions of manhood. Nonetheless, if done thoughtfully, messages that highlight manhood and masculinity can be potent, particularly among populations of men who hold traditional notions of manhood. As noted previously, although endorsement of traditional masculinity is associated with increased health risks, some themes of masculinity can promote good health (Courtenay, 2004b). For example, Courtenay (2004b) suggests that physicians can encourage men to be assertive and decisive with their health by using messages such as "It's great that you took control of things the way you did and got yourself in here so quickly" (pp. 67–68). Men may be more likely to take proactive measures with their health if they believe it is a sign of strength and if they see themselves as active participants rather than passive recipients in healthcare.

In contrast to interventions that leverage existing (and sometimes stereotypical) notions of manhood, gender-transformative interventions (Fleming et al., 2014) seek to address the normative roots of men's unhealthy behaviors by transforming gender roles more broadly. Advocates of this approach encourage messaging that questions cultural notions of manhood and masculinity. For instance, researchers might challenge men (through focus groups or flyers) to question why they do not seek healthcare or why they take unnecessary health risks. Fleming et al. (2014) provide the example of Program H, a Brazilian program that recruits young men for discussion groups that question male gender roles. This program has improved health behaviors among participants, including safer sex practices. Gender-transformative interventions might also recruit respected, popular male role models to advocate for changes to retrograde, harmful male risk-taking. Such interventions may be especially effective among men who either reject traditional manhood norms or do not feel that they can live up to them.

More generally, as this chapter makes clear, there is no one-size-fits-all approach to improving men's health. Even successful public health campaigns do not benefit everyone equally (Frohlich & Potvin, 2008), and the most effective strategies target subgroups of men. Targeted approaches are a hallmark of effective social marketing for health (Palmgreen & Donohew, 2006). Given that manhood status is especially precarious for certain vulnerable populations, health interventions targeting these groups (e.g., men of color, low-SES men, sexual and gender-identity minority men) would do well to be sensitive to this and to tailor messaging appropriately.

Similarly, designers of health interventions should be sensitive to the ways in which the meaning and practices of manhood differ across the life course (Evans et al., 2011; Griffith, 2015). For youth and young adults, manhood can be especially precarious, as boys are socialized to seek hegemonic masculinity. Lacking some avenues for demonstrating manhood (e.g., economic), and lacking certainty about their manhood status, young men may prioritize risky physical or sexual behaviors. As men enter midlife, they may experience manhood as less precarious, particularly if they become breadwinners, get married, or have children. However, because manhood is largely defined by work at this age, men may still take risks that can impact their health, by ignoring pain and taking physical work risks, or by working long, stressful hours, for example. In later life, some men may feel liberated from the rigid gender expectations of their youth, but manhood threats may arise with the loss of physical strength, stamina, vitality, and sexual functioning. In addition, retirement may erase a central masculine identity for men, leaving them searching for a fulfilling sense of manhood. Efforts to improve men's health should take into consideration that, for better or worse, men's sense of manhood is likely reflected in their health-related behaviors at every stage of life.

Conclusions

Men's health disparities are neither natural nor inevitable. Men take unhealthy risks and avoid healthy behaviors because manhood is a precarious status that men feel pressure to protect. Because gender norms are deeply rooted and infused with identity, changing men's health behaviors is challenging. However, the precarious nature of manhood can also be leveraged to improve health. The

most effective strategies will differ across subgroups of men. For men with more traditional gender role attitudes, it may be best to use positive notions of masculinity (e.g., exercise as a manly pursuit, getting regular checkups as part of one's obligation to protect and provide for the family, or eating healthful diets to give one energy for agentic pursuits). For men who reject traditional gender role norms, health messages may encourage healthcare use or may advocate against unnecessary risk-taking, perhaps by mocking traditional male role norms. Health messaging should also be sensitive to marginalized subgroups. The health challenges faced by poor men, men of color, and sexual and gender minority men are embedded within larger institutions of structural discrimination, and so improving health within these groups remains uniquely challenging. As we argue in this chapter, framing manhood as a precarious social status can help shed light on why men take risks that can harm their health. We hope that this framing can also guide health interventions that will help close the gender gap in health and longevity.

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