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MASCULINITY AND MEN'S HEALTH DISPARITIES

Conceptual and Theoretical Challenges

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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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