Men, Gender, and Health: Toward an Interdisciplinary Approach

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It has been nearly 30 years since the first scholars began studying men's health. Early works had provocative titles like "The Hazards of Being Male"[1] and "Socialized to Die Younger."[2] Although these authors stimulated new interest in men's health, little came of it. It was, perhaps, difficult to sell the idea that men, as a group, were endangered; mortality statistics about their comparative disadvantages notwithstanding, most men are more powerful than women at every level of social and economic class. Few men in most cultures have sought to claim the identity and territory of the at-risk, not-so-powerful man revealed by most men's health scholarship. Or, perhaps, the very problems that endanger men's health conspired to undermine discussion of it—especially among men.

It is not the easiest thing, the study of men's health. Open the door, and you are quickly in a different world, full of mind-bending terminology (some of which works and serves better than simpler terms to engage the meaning of masculinity and its challenges, but some of which simply generates fog and seems intended only to fortify an emerging discipline by armoring it with arcane neologisms). Read about men's health and you encounter both the "spin" of panicky overstatement and the dense thicket of sociological jargon. The trouble is, the overstatements are not all wrong, and the jargon has evolved because standard terms and descriptions somehow fail to name or characterize adequately the issues that pertain to gender, health, and, especially, masculinity. Our concern about men's health is not sufficiently addressed by traditional concepts of disease, nor by the usual health statistics. It is, itself, telling that neither our language nor our concepts of health have, until recently, accommodated the theories and questions most central to understanding the relationships among health, masculinity, and men's well-being.

Chances are, though, that you have come to hear increasingly clear signals amidst the rhetorical static. The media have begun discussing issues related to the well-being of boys and men. Although simplistic notions and stereotypes abound when men's health is popularized, the presence of men's health (and of a magazine bearing that name) on newsstands and television shows suggests the gradual development of a shared, public concept of men's health. But what do we *really* know about men's health? What do we know about the things that happen in men's lives as a result, or consequence, of their gender—which, unlike their biological sex, is always understood in social context—on men's well-being? And (an even bigger question): What are the relative contributions of sex (biologically and genetically), gender (socially), culture (the human environment), and the natural environment to men's health and well-being?

In this theme issue, we begin to answer some of those questions. The *Journal of American College Health* responds here to a "call to action" published by one of us in its own pages.[3] In what is the first issue of a professional journal devoted entirely to the subject of men's health, scholars from a wide variety of disciplines—psychologists, health educators, sociologists, physicians, and public health specialists—explore what we currently know and discuss the implications of that knowledge for practice in college health. The seven pieces published here range from a theoretical macro-view (Schofield et al's distinguished summary of the development of thinking about men's health) to the deeply practical and particular (Rogers et al, reporting on

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the process—and outcomes—of establishing a men's clinic in a college health center in San Francisco, and Davies et al, who used qualitative methods to identify men's health concerns at the University of Oregon). Some of these articles focus on the most critical issues in college health (Capraro's analysis of the relationship of masculinity to drinking among college men, and Hong's ethnographic assessment of the success and struggles of students who organize to prevent violence on campus). Weidner and McCreary, in their very different articles, explore two significant risks to men's health and well-being—and encourage us to begin, at or before college years, to reduce them; Weidner addresses atherosclerotic coronary disease (which is located at the desperate intersection of biology, behavior, and social stress), and McCreary discusses body image disturbances (not, by any means, only a women's health concern). A distinctly international perspective informs this collection, as well; Schofield et al use the Australian experience to bring focus to our thinking about men's health, and Weidner evokes important general themes in her description of the impact of social disruption on the prevalence of coronary disease among men in eastern Europe.

But this is not all: our call for submissions for this special issue netted seven more accepted manuscripts—excellent pieces that even this expanded volume could not accommodate. The *Journal* will sustain its commitment to addressing men's health by publishing one or more of those articles in each issue for the coming year. But why a special issue, and why a continuing commitment?

Gender-based medicine and healthcare are receiving increasing attention.[4,5] In addition to having different reproductive health needs, women and men have different risks for specific diseases and disabilities.[6] They also differ in their health-related beliefs, such as their perceived susceptibility to risk or control over their health, their beliefs about gender, their perspectives on body image, and their attitudes about seeking help. Feminist scholars were among the first to address gender and health, and "gender and health" have now become virtually synonymous with "women's health." Although health researchers in the past century have frequently used males as study subjects, little attention has been paid to men's gendered health concerns (which means: the health issues, from behavior to outcomes, that affect men as a result of their gender) or men's greater overall risk of premature death relative to women.[7] In fact, some authors have recently argued that medical researchers, psychologists, and other health professionals have all contributed to cultural portrayals of men as strong and healthy and women as the "sicker" gender, and to the "invisibility" of men's poor health status.[8]

Even in research that offers enormous potential for learning about similarities and differences between women and men, most researchers treat gender (or, usually, sex—which is often called "gender" in bioscientific reports) as a "nuisance variable" that is statistically controlled. Consequently, we know much less than we could about gender and health (we even know less than we could about sex and health). Little is understood, for example, about why US men, on average, die nearly 7 years younger than women and have higher death rates than women for all 13 leading causes of death.[9] Left unquestioned, men's shorter life span is presumed to be "natural" and inevitable.

Not *all* men, however, experience poor health. As Schofield and associates note in this issue, for example, it is men of color and economically disadvantaged men who have the greatest risks. Indeed, the difference in the life spans of African American men and European American men in the United States is greater than the difference between life spans of women and men.[9] Given this, Schofield et al would have us answer, "to what extent is 'men's health'sex-specific at all?" From this perspective, if there is a men's health "crisis" as some suggest (at least in terms of life span), it is a crisis among certain men: men of color; inner city, young, and poor men, for example. And the crisis, to the extent that it exists, affects only some groups of any of those categories of men; poor men of color have worse health status than prosperous men of color. Which means that many men (and women) perceive no crisis whatever. Taken alone, this is completely unsurprising; health risks and bad health outcomes generally attract greater attention when they affect privileged people than when they differentially burden younger and poorer populations and people of color.

Men's socioeconomic and educational status, their occupational risks, and their susceptibility to the harm done by prejudice are, however, rightly the shared interest of all men—and all women. And statistical assessments of macroindicators like life span notoriously miss all the nuances; if White, straight, well-to-do men have longer life spans than men of color, for example, that does not mean that they live healthy lives or that they experience well-being. The quality of a man's experiences, relationships, and connectedness in life might be as important—or even more important—than the length of it. The famous song from the musical *Rent* reminds us that life is not measured so much in seconds, minutes, and hours as in love.

Health practices are seldom recognized as gendered behavior. The articles by Hong and Capraro advance this notion, suggesting that both violence and alcohol use are linked with men's concepts and demonstrations of manhood. These behaviors are also influenced by (and sometimes embedded in) social systems that foster or inhibit healthy behavior—whether those social systems are economic disparities, fraternities, athletic teams, or workplaces that endanger men's lives or limit access to healthcare. Schofield et al provide frameworks for understanding these social systems. Think about the social systems on campus that may affect men's health behaviors; and think about the opportunities for college health, counseling, and prevention professionals to work in partnership with leaders and stakeholders in those systems—coaches, athletic trainers, faculty, and leaders in fraternities, social houses, and student organizations—to identify and begin to change those influences.

Similarly, men's health behaviors and risks cannot be understood without considering genetic, biological, and neural factors. Some reactions, behaviors, and patterns may be "hard wired"(which does not mean, though, that they are immutable). Men's physiological responses to stress, for example, differ from women's and contribute to men's increased risk of heart disease.[10] Testosterone may contribute to some men's violent and aggressive behavior. However, these processes also involve complex social interactions and cannot be understood in isolation from relational and psychological factors. Hormonal explanations for behavior are too often simplistic and deterministic. In the case of testosterone, causation might go in both directions: violence and aggression—which are fostered and socially rewarded in men and boys—elevate testosterone levels. Testosterone, as powerful as it is (and its "image" is even more so), does not define all that maleness and masculinity are, and it is only one influence on men's health behaviors.

Although there is a diversity of viewpoints on this topic, many researchers think that the explanatory power of biological factors alone in predicting gender differences in disease and death is comparatively small.[11] Given all of the uncertainty about the relative roles of biological, genetic, and neural factors in behavior and health—and about the details of the interactional effects between them and social or psychological influences—it is particularly unfortunate that there is no article in this issue addressing those factors. Men's health, as a field, suffers from the disciplinary myopia that leads researchers in one discipline (say, the social sciences) to assume that the factors addressed by their epistemology, methods, and theories are all there is. Accordingly, few social scientists even acknowledge the contribution of biological factors to men's health risks. But new research is uncovering gender differences in brain functioning that may influence behavior, as well as environmental factors that influence brain development. The answer to the question, "What causes problems in men's health?" will undoubtedly have genetic, neural, biological, social, cultural, generational, and environmental components. Mind and body are, after all, connected, and men's lives are lived in relation, not in isolation.

Schofield and associates suggest revolutionary paradigm shifts. They challenge us to study men's health in a relational context—at the intersection of men's lives with women and with other men. This approach represents far more than understanding and addressing the negotiation of condom use between sexual partners. As these authors note, women's and men's lives are inextricably intertwined. Indeed, women often take responsibility for men's health and healthcare needs—a fact that contributes to considerable stress in women's lives. And, as Hong's study illustrates, the negotiation of social relationships among men can also influence men's well-being and willingness to address health-related concerns. Her findings suggest that some college men will be reluctant to join in efforts to prevent violence for fear that they will be perceived by other men to be unmanly or gay. Davies and his colleagues explore the possibility that men can positively influence each other's well-being through discussion in small groups.

For some men, it is relationships with other men that are primary. A deficiency of this issue is that it does not include an article specifically addressing gay and bisexual men's health. Many of the authors, however, do discuss health concerns specific to men who have sex with men. Schofield and associates note that gay men experience limited health options and significant health disadvantages. Several authors describe gay and bisexual men's elevated risk for depression and suicide. Our writers also address homophobia and violent victimization; they discuss the need for safety and affirmation of gay and bisexual men in healthcare settings. These articles, taken together with forthcoming articles, illustrate the need to reconceptualize gay men's health and to develop a new model that transcends HIV/AIDS—which is by no means the only health concern for men who have sex with men. Such a model should address the variety of social, cultural, and political factors—and relationships—that influence their well-being.

All of the articles in this issue highlight the need for an approach to men's (and women's) health that is truly biopsychosocial—interdisciplinary, not just multidisciplinary—and an approach that also recognizes the influence of gender. These articles (and the ones that will appear seriatim over the coming volume year) suggest the need for a broad, new definition of "men's health," a definition that includes not only the absence of disease or disability but also embraces complete physical, mental, and social well-being. This definition—and the interventions it informs—must recognize the many differences among men, such as those based on their age, economic status, sexual identity, campus affiliation, occupation, culture, ethnicity, environment, religion, and geographic location. At the same time, neither the definition nor the interventions that grow from it should be paralyzed by a failure to focus on critical common themes among men.

As college health professionals, we are just beginning to think about men's health. This issue provides a foundation—the education and awareness we need to begin contemplating action. The action we take should, of course, be appropriate to the specific needs of the men we are serving—and to the context and culture of each campus. A men's health clinic will work in some, but not all, contexts; organizing men to confront violence will be done differently on our various campuses. But in most settings, we can assess men's needs through qualitative methods such as focus groups (which are an effective way to develop an understanding of the needs of the men on an individual campus, as well as the diversity of those needs), and we can begin to apply a gender-informed approach to our work.

We can begin by redefining masculinity. Capraro and Hong suggest that we help college men understand the many paradoxes of manhood and develop a new, "healthy masculinity." But what does healthy masculinity

mean? As some of our authors note, certain aspects of traditional masculinity are associated with positive health outcomes and need to be recognized and valued in men. Reliance on traditionally masculine characteristics, such as acting independently and being assertive and decisive, has been found to enable men to cope with cancer[12] and chronic illness.[13] Redefining masculinity does not, then, require discarding everything we think of as manly.

But, practically speaking, how might we answer the challenge posed by Davies and his colleagues: What strategies will reduce the social pressure men feel to conceal vulnerability and avoid seeking help? Reframing masculinity, vulnerability, and male independence through social marketing strategies may offer long-term promise, although substantial success will depend on interventions not only on the college campus but also in our society—and, in fact, globally. The findings from Davies's group suggest that at least some men are concerned about seeking help prematurely (relative to other men, presumably). Internet-based information or "counseling" services and anonymous telephone advice programs, together with more traditional types of educational interventions, may offer these men reassurance that their concerns are reasonable and are not premature. Male peer educators, if they are willing to disclose their own health concerns, can begin essential conversations about health among other men; discussion groups offer a relational structure that may engage some men. The findings from both McCreary and Davies et al suggest that interventions designed to address men's concerns about their physical appearance may also be effective. From a gender-relations perspective, it is equally important to bring men and women together to address the gendered health needs of students. Supporting men's involvement in antiviolence work and gay–straight alliances is a way that campuses can uphold the collaborative work of men and women.

Few of the articles in this issue are empirical studies. This fact highlights the need for rigorous studies—qualitative or quantitative—in men's health. Empirical data for guiding program development and intervention strategies are especially needed, as is research exploring differences among men. Although many counseling and psychological interventions with men have been recommended in the past two decades,[14,15] few strategies have been developed for health professionals who work with men in healthcare settings or for the purpose of addressing men's gendered physical health needs.[16] Even more rarely are health interventions designed to address the unique needs of various populations of men, such as gay and bisexual men.[17] Only recently have the specific psychosocial health needs of African American men been addressed.[18]

This theme issue represents an important step in developing an interdisciplinary field of gender-informed healthcare, one that unites diverse and complementary perspectives. Health professionals who are interested in studying men's health should seek partners in other fields (many of them not directly related to healthcare, such as anthropology, sociology, and psychology) and begin collaborating with their colleagues in women's health. When we combine our methods, we not only enrich our work, we also strengthen the inferences that we can make and discover more complete answers to the many questions that confront us.

Helpful as it is, this collection of articles cannot offer any authoritative conclusions about men's health. Despite the wealth of information the authors provide, they leave us with more questions than answers. But they are questions worth asking.

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