

# Teaming Up for the New Men's Health Movement

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**How men's health is understood depends on the lens through which it is examined. While it has historically been viewed from biomedical perspectives, social scientists have also identified countless psychosocial factors that influence men's health. This paper explores the health concerns of two men viewed from diverse professional and disciplinary perspectives. It highlights the strengths and limitations of each perspective as it examines the complexity of these men's lives and well-being. The author proposes an interdisciplinary, biopsychosocial approach to the study of men's health that unites these complementary perspectives. Five initial strategies are recommended for fostering the men's health movement and for realizing a future interdisciplinary field of men's health.**

**Key Words: men's health, biopsychosocial, interdisciplinary, gender, masculinity, health promotion**

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When I began speaking publicly about men's health ten years ago, I felt like a prophet screaming alone in the wilderness. Nothing could evoke such an expression of complete and utter bewilderment on the part of an audience as the two simple words: *men's health*. Finally, we have arrived at the first major men's health conference in this country. But where are we headed next with men's health? And how will we get there?

The structure of this conference reveals a lot about the current status of men's health. The first day focuses on diseases and their treatment; the second day, on psychological and social risks. We make this distinction because these are the individual

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lenses through which we view men's health. Now from a biomedical perspective, this conference format makes perfect sense. Through *that* lens, diseases have the same symptoms and outcomes regardless of psychological or social factors. Through *that* lens, medicine is a socially neutral science. But medicine is not a socially neutral science. And the problem is, we start believing that we actually *can* separate men's diseases from the men who experience them. But the moment we put the word *men* into men's health, we are talking about health as *men* demonstrate health—as biological, psychological, and social beings. Men's health is by definition biopsychosocial.

Over the last several decades, our knowledge of health has grown by leaps and bounds. But from a men's health perspective, what we have learned is limited. And it is largely genderless. Although male bodies are often used to study disease and its treatment, men are rarely studied as patients, or as men. Even in research that offers enormous potential for learning about differences between women and men, most researchers treat gender as a “nuisance variable”—a factor we have to control for in order to discover the really important information. As a result, we know a lot less than we might about health differences between women and men. But there are other reasons why we seem to know so little about men's health.

It has been nearly 30 years now since researchers published the first important papers on men's health. They had provocative titles like “The Hazards of Being Male” and “Socialized to Die Younger.” These authors stirred up interest in men's health, but not much came of it. About the same time, the Boston Women's Health Collective wrote *Our Bodies, Ourselves*. That book launched a women's health movement that is still going strong. What happened to the *men's* health movement?

There are several reasons why the men's health movement has made comparatively little progress. The women's health movement was successful, in part, because it was linked with a larger social movement—one that addressed the many inequalities that women experience in this country. But there is another reason why progress has been slower for the men's health movement. That reason is because most of us men have been working in relative isolation from one another. Meanwhile, women have been networking and organizing grassroots movements that address the unique health concerns of women. This is why I used to think I was alone in the wilderness. But the truth is, I was not alone. And you are not alone. You have plenty of colleagues at your side. Teammates.

There are a lot of disciplines represented here today. This audience is made up of physicians, nurses, public health officials, health administrators, social workers, and psychologists—to name just a few. These are your teammates. The problem is, we tend not to rely on our teammates. Often, we do not even know what they do.

Let me tell you about John. He died last month of a heart attack, at the age of 65. He was a retired shopkeeper—an African-American man who learned two years ago that he was at risk for heart disease. Why did John die? Partly because the people who were helping him did not talk to their teammates. If they had, they could have learned a lot about John—and what he, and others, could have done to prevent his death.

To begin with, John insisted that his health was “just fine.” As survey researchers could have told the team, this perception is typical. Most American men

think their health is “excellent”—and rate their health as better than women’s. But epidemiologists could have set the team straight. Epidemiologists know that men have higher death rates than women for heart disease—and for the other 13 leading causes of death.

But John was unconcerned about that when he would sit down to breakfast. His favorite start of the day was two eggs sunny-side up, pancakes, and three strips of bacon. John had plenty of bad cholesterol in his system. And—had anyone asked them—the biologists could have explained that John’s lack of estrogen might be lowering his level of good cholesterol as well. The psychophysiological researchers could also have pointed out that his problem was more than hormones. John’s physiological response to stress was less effective than a woman’s would be—and this too increased his risk.

And if geneticists had been on the team, they would have learned something more. John had inherited his father’s hypertension, which also increased his risk. But these same teammates would also have raised some troubling questions. Because geneticists are quickly eroding the myth of race—the myth that John was somehow fundamentally different because his skin color was black. If the answer is not race, how do we explain the compelling fact that—like most African-American men—John died eight years younger than the average European-American man?

One reason could be that John lived in a neighborhood filled with pollution and crime. Had colleagues in environmental justice been on the team, they would have pointed out that that is typical—that African Americans are more likely than European Americans to live in these neighborhoods. The social workers would have reminded John’s team about some other cultural factors. They would have told them that John’s risk of heart disease was also influenced by whether he went to church, by where he worked, and by how he played.

Then there is John’s doctor. She could have told the rest of the team a lot about the progression and management of his heart disease. But she complained that John rarely came to her office—just like most of her male patients. In fact, three out of four people who have not seen a doctor in over five years are men. That is where those who study health communication could have helped. Doctors, they would have said, spend less time talking with men than they do with women—and less time educating men.

The child development researchers would have had something to say too. They would have pointed out that when John was a boy, his parents probably discouraged him from seeking help, and may even have punished him when he did. If sociologists had been on the team, they would have added that it was not just his parents—that boys punish each other. When John wanted to see the school nurse when he got hit by a baseball in sixth grade, it was his friends who mocked him for being a cry-baby.

So why did John die? That simple question is not so simple to answer. A physician alone could not answer it. An epidemiologist alone could not answer it. And a psychologist alone could not answer it. But together, we can answer it. Each one of us, in our various disciplines, has vital information and knowledge that can keep men like John alive—and improve their quality of life. But each of our fields, alone, leaves us with troubling and unanswered questions—like missing pieces of a puzzle.

Fortunately for Tony, the future holds promise. Tony was just seen in the emergency room for a knife wound he got in a fight. This was not his first trip to the emergency room. At age 24, Tony already has a long history of involvement in dangerous activities—as well as drinking and smoking. What do your teammates know about men like Tony? How can they help him—and help us—so his story ends differently than John’s?

The child development researchers on our team can tell us how Tony first learned risky habits at home. And how, if his parents were like most, they were less concerned about his safety than about his sister’s. Then our teammates who study cultural communication can help us to see that it was not just his parents who taught Tony unhealthy behaviors—that he also learned them from television, movies, and magazines. That on TV, men and boys are the ones who usually drink and smoke—and the ones who commit violence and get away with it.

But with psychobiologists on our team, we know that it is not just the media that are to blame—that there is another piece to the puzzle. That the hormone testosterone contributes to Tony’s involvement in dangerous activities. And a neurobiologist would add that low serotonin levels in Tony’s brain may also contribute to his aggression.

But if you think Tony is just hardwired for violence, talk to the psychologists on our team. They will tell you that it is not just being biologically male that is increasing Tony’s risks. It is also his gender. His “male gender role” and his beliefs about manhood can predict his high-risk behaviors. They will also tell you that Tony’s perception that he has no control over his life increases his health risks too. But what these teammates cannot tell you is how poverty influences Tony’s perception of the control he has over his life.

That is why there are sociologists on our team. They can answer that question. They will tell you that when Tony endangers his health, it is often in pursuit of power—and in trying to maintain his social status and privilege relative to his sister and other women. Sociologists also caution us when we start talking about how Tony “is” as a man. They remind us that there is not just one “male sex role.” That there is not one masculinity, but many masculinities. And that there are often bigger differences between men than there are between men and women.

Did I mention that Tony is gay? Well, he is gay, and he is Latino. The anthropologists on our team tell us that those are important pieces of the puzzle. They remind us to listen to the different voices of men. That when we really listen to Tony, we can learn from him what interferes with safe sex. How for him and other gay Latino men in California, condoms conjure up images of death—which, not surprisingly, can ruin any passion in Tony’s sex life.

But Tony doesn’t like to talk about this—or to talk about feelings very much. The neurobiologists on our team say that this is because his brain is soaking in hormones. They tell us that sex hormones promote divisions in brain functioning that make Tony less expressive than his sister. That putting words to emotions is more difficult for Tony because he does not move as quickly as she does between the left and right sides of the brain.

The social psychologists would say that this still leaves some missing pieces. They would point out that Tony is not inexpressive all the time. That—like many

men—he may not talk about his feelings with his peers, but he does talk about them with his mother and sister. They might add that what many of us call “risky” behaviors are often the very same behaviors that Tony is *expected* to demonstrate to prove that he is a man.

Finally, the researchers who study behavioral change can offer the rest of us powerful knowledge to inform our work with Tony and with other men. They tell us that the first step we need to take is to recognize that—if Tony is like most men—he is less ready than his sister to change his behavior. And that—because of that—he is going to need more health education than she does, if he is going to change. They also tell us that if we take the time to educate Tony—and he starts to think about change—he will double his chances of actually changing.

Tony and John. Life and death. In the last half-hour, about 60 American men have died. How many of these men would still be alive if we were working together as a team? What if we developed an interdisciplinary approach to the study of men and men’s health? If we pieced together our knowledge like the pieces of a puzzle? I think we would begin to find answers to the many perplexing questions that face us. Questions like why men—who supposedly do not get depressed—have suicide rates that are as much as 12 times higher than women’s.

The goal of understanding men’s health is not simply to understand male bodies. The goal of understanding men’s health is to improve men’s well-being. To reach that goal, we cannot isolate men’s health from all of the other aspects of men’s lives. We cannot separate men’s health from the boys who are taught the very behaviors that kill them. We cannot separate men’s health from the women who are often the first to take responsibility for men’s health care. We cannot separate men’s health from the dangerous jobs that men perform, or from the poverty they experience in the inner cities, or from the rural towns they live in. We cannot separate men’s health from what makes men men. Men’s health is by definition biopsychosocial. And it is up to you and me to put the men into men’s health.

We are on the brink of something tremendous here. The next century holds the promise of healthier lives for the men of this country. But the only way we are going to realize that promise is through interdisciplinary collaboration. We need to begin by integrating our specialized knowledge into a new discipline of men’s health. I challenge you to begin the new men’s health movement today. Here are five ways to start.

First, collect the business cards of people who are interested in men’s health at the conferences you attend. When you return to your work, keep the dialogue going with these people. When a man comes into your office—or you are writing a grant proposal—pick up the phone, call these people, and collaborate with them.

Second, actively introduce your work to colleagues in other fields. If you are a clinician, provide training on men’s health to professionals in another discipline. If you are a researcher, contribute to a journal that you might not normally consider. This will begin to expand our network.

Third, begin introducing new methods of practice into your work—whether you are a researcher or a practitioner. When you are at conferences like this, attend at least one session offered by colleagues in a completely different discipline than yours. When we combine our methods, we not only enrich our work, but also

WILL H. COURTENAY

strengthen the inferences that we can make about men and men's health.

Fourth, use the Internet as a bridge builder. For example, the next time you log onto the Internet, join the Australian-based men's health listserv or the list offered by the American Psychological Association's Society for the Psychological Study of Men and Masculinity.

And fifth, we need to reach out to our allies in the women's health movement. These colleagues have been doing this work for decades, and they can help us to jump-start our efforts. We have come as far as we have, in large part, because of the trail blazed for us by these pioneers. Furthermore, much of what is learned about women's health has implications for men's health. And much of what we discover about men can inform our work with women.

Until all of us in our various disciplines work together as a whole, we are not going to see men as whole. We are going to see men as the fragmented pieces we see through our individual lenses. So know who your teammates are. These are the people who are going to help us better understand men and men's health. These are the people who will bring a greater richness and complexity to your work. These are the people who will help you to help men live longer, healthier lives.