Men's Health and Illness

Gender, Power, and the Body

EDITED BY

DONALD SABO & DAVID FREDERICK GORDON

RESEARCH ON MEN AND MASCULINITIES

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Published in cooperation with the Men's Studies Association,
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Men's Health and Illness

RESEARCH ON MEN AND MASCULINITIES SERIES

Series Editor:
MICHAEL S. KIMMEL, SUNY Stony Brook

Contemporary research on men and masculinity, informed by recent feminist thought and intellectual breakthroughs of women's studies and the women's movement, treats masculinity not as a normative referent but as a problematic gender construct. This series of interdisciplinary, edited volumes attempts to understand men and masculinity through this lens, providing a comprehensive understanding of gender and gender relationships in the contemporary world. Published in cooperation with the Men's Studies Association, a Task Group of the National Organization for Men Against Sexism.

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   MEN'S HEALTH AND ILLNESS

Series Editor's Introduction

The data are as startling as they are familiar: Men are nearly six times more likely to die of lung cancer than women, five times as likely to die of other bronchopulmonic diseases, three times as likely to die in motor vehicle accidents, nearly three times as likely to commit suicide, and two times as likely to die of cirrhosis of the liver and heart disease. AIDS, now the leading cause of death for all Americans ages 25 to 44, is perhaps the most highly gendered disease in our history, affecting men at a rate of about nine to one.

Some have used these data to complain that feminist initiatives to improve women's health are misguided in that women already "have it made." But such complaints only hint at the larger point: Most of the leading causes of death among men are the result of men's behaviors—gendered behaviors that leave men more vulnerable to certain illnesses and not others. Masculinity is among the more significant risk factors associated with men's illness.

As with women, men are also fragile and vulnerable creatures, susceptible to a wide variety of health-related problems. Feminist women, it seems to me, have been able to theorize vulnerability and susceptibility to disease into a social movement to promote women's health. But masculinity is not only a risk factor in disease etiology but it is also among the most significant barriers to men developing a consciousness about health and illness. "Real men" don't get sick, and when they do, as we all do, real

men don't complain about it, and they don't seek help until the entire system begins to shut down.

Pointing out simple sex differences in rates of various diseases only scratches the surface of the issue. We must look inside these health issues, inside the mechanics and symbolic structures of specific diseases to understand better men's experiences of health and illness. This volume begins that process.

This volume is the eighth in the **Sage Series on Research on Men and Masculinities.** The purpose of the series is to gather together the finest empirical research in the social sciences that focuses on the experiences of men in contemporary society.

Following the pioneering research of feminist scholars over the past two decades, social scientists have come to recognize gender as one of the primary axes around which social life is organized. Gender is now seen as equally central as class and race, both at the macrostructural level of the allocation and distribution of rewards in a hierarchical society, and at the micropsychological level of individual identity formation and interpersonal interaction.

Social scientists distinguish gender from sex. *Sex* refers to biology, the biological dimorphic division of male and female; *gender* refers to the cultural meanings that are attributed to those biological differences. Although biological sex varies little, the cultural meanings of gender vary enormously. Thus, we speak of gender as socially constructed; the definitions of masculinity and femininity as the products of the interplay among a variety of social forces. In particular, we understand gender to vary spatially (from one culture to another), temporally (within any one culture over historical time), and longitudinally (through any individual's life course). Finally, we understand that different groups within any culture may define masculinity and femininity differently, according to subcultural definitions; race, ethnicity, age, class, sexuality, and region of the country all affect our different gender definitions. Thus, it is more accurate to speak of "masculinities" and "femininities" than positing a monolithic gender construct.

It is the goal of this series to explore the varieties of men's experiences, remaining mindful of specific differences among men, and also be aware of the mechanisms of power that inform both men's relations with women and men's relations with other men. This volume helps us understand those dynamics as men relate to the inner workings of their bodies.

MICHAEL S. KIMMEL
Series Editor

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Don dedicates this book to his father, Donald F. Sabo, Sr., with great love and admiration. Dave dedicates this book to his parents, Fred and Viola, with thanks for their love, guidance, and encouragement.

Contents

PART I

MASCULINITY, HEALTH, AND ILLNESS

1

Rethinking Men's Health and Illness

The Relevance of Gender Studies

DONALD SABO
DAVID FREDERICK GORDON

Someone once said that "the fish are the last ones to discover the ocean." So it is with men and patriarchy. Feminist scholars long have emphasized the analysis of patriarchy—that is, social hierarchies that are male dominated. Gerda Lerner (1986), for example, defines patriarchy as,

> the manifestation and institutionalization of male domination over women and children in the family and the extension of male dominance over women in society in general. It implies that men hold power in all the important institutions of society and that women are deprived of access to such power. It does not imply that women are either totally powerless or totally deprived of rights, influence, and resources. (p. 239)

Heidi Hartmann (1981) defines patriarchy as,

> a set of social relations between men, which have a material base, and which, though hierarchical, establish or create interdependence and solidarity among men that enable them to dominate women. Though patriarchy is hierarchical and men of different classes, races, or ethnic groups have different places in the patriarchy, they also are united in their shared relationship of dominance over their women. . . . In the hierarchy of patriarchy, all men, whatever their

> rank in the patriarchy, are bought off by being able to control at least some women. (pp. 14-15)

Although feminist scholars differ in the ways they define patriarchy, none fail to recognize its historical longevity and societal pervasiveness. Unlike most feminist scholars, who have been *women,* men inside academia and the health professions have generally failed to reckon with the fundamental realities of sexism, male dominance, and social grouping by sex. Centuries of efforts of feminist scholars and women's rights activists to get men's attention were often met with derision, puzzlement, and resistance. Yet as Kimmel and Mosmiller (1992) have documented, there have always been pro-feminist men, such as Thomas Paine, Matthew Vassar, Robert Owen, Horace Greeley, Ralph Waldo Emerson, Frederick Douglass, Charles Beard, Lester Ward, Thorstein Veblen, Herbert Marcuse, Isaac Asimov, and Kalamu ya Salaam, who sided with women's bid for equal rights and reformist visions. Most recently, men have begun to attune to feminist writings and analyses under the bannerhead of "men's studies." Men's studies practitioners are attempting to re-vision men and masculinity in the context of historical and modern permutations of patriarchy and in light of feminist theory and practice.

The authors in this book attempt to see the patriarchal "ocean" for what it is and to forge new understandings of men's health and illness from these intellectual, empirical, and theoretical trends. One does not have to be a card-carrying feminist to realize that patriarchy and contemporary patterns of gender relations profoundly influence our customs, religious beliefs, political institutions, family relations, sexuality, medicine, and, in the context of this book, our understandings of men's health and illness. The contributors to this book contend that gender influences the patterning of men's health risks, the ways men perceive and use their bodies, and men's psychosocial adjustments to illness itself.

Gender and Men's Health and Illness

Beginning in the 1960s, initial thinking about gender and health issues was grounded in the "sociocultural model" that challenged the prevailing biological determinism and reductionism of the traditional "biomedical model." Critics of the biomedical model cited its mechanistic approach, the overemphasis on biochemical processes, and overly simplistic expla-

nations that attribute disease to one or two specific etiological factors (Cockerham, 1986; Dubos, 1959; Wolinsky, 1980). Within the sociocultural model, in contrast, health and illness are understood primarily in light of cultural values and practices, social conditions, and human emotion and perception.

The development of the sociocultural model during the 1960s fostered a reconceptualization of health and illness in light of gender. At first, researchers followed a basic "add and stir" approach, which treated gender as just another demographic variable for identifying health patterns and risk factors. The additive approach proved useful in epidemiological research that uncovered differential rates of illness between males and females or across male populations subgrouped by domain sociological variables such as race or ethnicity, socioeconomic status, or residential area. For example, descriptive research findings revealed that (a) men experience more life-threatening diseases and die younger than women, (b) women experience more non-life-threatening illnesses and live longer than men, and (c) women see doctors more frequently than men. By the late 1970s, gender had become accepted as a standard demographic variable to be included in epidemiological research. A growing body of research findings made it evident that variations in women's and men's health could not be adequately accounted for by biomedical explanations alone. It was also increasingly evident that sociocultural explanations of health and illness were not complete unless gender was taken into account.

During the 1970s and 1980s, researchers developed more comprehensive theoretical approaches to understanding linkages between gender and health issues. Most of the advances in theory and research on gender and health were fostered by the women's health movement[1] and the growth of feminist scholarship. Researchers studied the ways that differential gender socialization influenced perceptions of illness and adjustments to death. Sex discrimination in the health care delivery system and sex stratification in the health professions were documented (Muff, 1982). Feminist historians documented the oppression of women healers by the male-dominated clergy and physicians during the Middle Ages (Ehrenreich & English, 1973, 1974), whereas feminist philosophers of science argued that medical "science" was tainted by patriarchal and androcentric biases (Daly, 1978). Sexism and structured sex inequality were believed to lead to the misdiagnosis and maltreatment of women (Coopersmith, 1978; Corea, 1977; Scully & Bart, 1973). By the mid-1980s, the growing salience of gender in understanding patterns of health and illness were an

undeniable presence in epidemiology, medical sociology, and interdisciplinary studies of psychosocial aspects of illness (Stillion, 1985).

One limitation of most of this pioneering scholarly work was that until recently researchers tended to equate the study of *gender and health* to studies of *women's* health and illness. While women were in the gender-analytical spotlight, men resided backstage. Even men who were affiliated with the American "men's movement," which budded in the early 1970s, were slow to cultivate awareness around men's physical health issues.[2] Some early work on men and masculinity by Marc Feigen-Fasteau (1974) and Warren Farrell (1975) did make connections between conformity to traditional masculinity and men's emotional and physical health. In 1979, physician Sam Julty published *Men's Bodies, Men's Selves,* which integrated a biomedical tour of male physiology and medical hygienic concerns with rudimentary commentary on masculine psychology. Others focused on men's sexual and emotional health. For example, Michael Castleman (1980) couched his therapeutic suggestions for men to transform their sexual conduct and experiences within a critique of traditional masculinity. In the 1980s, scrutiny of men's health issues got a boost from scholarly dialogue under areas variously dubbed the "study of men and masculinity," "men's critique of gender," or the "new men's studies."[3]

Professional scholars and researchers have been slow to study connections between gender and *men's* health and illness. This collection of readings helps to correct this lack of knowledge. We owe our intellectual origins to the sociocultural model in mainline social science, feminist theory and research, and the incipient efforts of feminist-identified men to rethink men's health issues.

Theorizing Men's Health and Illness

Efforts to explore how gender influences men's health derive from the sociocultural model that underpins interdisciplinary studies of health and illness as well as research and theory generated by feminist scholars and researchers. In addition, the writings in this book represent a variety of approaches that when taken collectively point toward the development of an "inclusive feminism" that facilitates systematic study of men and masculinity (Brod, 1987; Kimmel & Messner, 1993). Men's health and illness can be explained as a gendered phenomenon in several frameworks.

Gender, Nature, and Nurture

The nature-nurture debate has infused much thinking about differences in gender identity and behavior. Biologistic thinkers have argued that gender differences are natural in origin, deriving from instinctual, hormonal, morphological, neurological, or phylogenetic endowments. Proponents of the nurture thesis, in contrast, contend that gender differences are learned via socialization, social conditioning, or cultural adaptation.

Ingrid Waldron (1983) has pioneered research that explores the border crossings between biogenetic and sociocultural explanations for variations in men's and women's health (see also Verbrugge, 1985). In Chapter 2 she examines recent historical trends in mortality among women and men. She finds that some changes in behavioral patterns between the sexes, such as increased smoking among women, have narrowed the gap between men's formerly higher mortality rates from lung cancer, chronic obstructive pulmonary disease, and ischemic heart disease. In contrast, the trend toward decreased alcohol consumption during the 1980s was more marked among females than males and, in part, was responsible for increases in men's mortality from chronic liver disease and cirrhosis. In Chapter 3, Judith Stillion presents an analysis of premature death among men that depicts a "hierarchy of risks" that men incur as a result of both their biogenetic makeup and lifestyle and psychology. Waldron and Stillion discuss gender differences in health and illness that provide theoretical frameworks that take into account the complex interplay between biogenetic and sociocultural processes. Indeed, each chapter in this volume represents an application of the sociocultural model to understanding men's health and illness.

Masculine Identity and Sex Role Theory

Sex role theorists called attention to the lethal aspects of the male role (Fasteau, 1974; Filene, 1974; Sabo & Runfola, 1980). In the words of Harrison, Chin, and Ficarrotto (1992),

> It is time that men especially begin to comprehend that the price paid for belief in the male role is shorter life expectancy. The male sex-role will become less hazardous to our health only insofar as it ceases to be defined as opposite to the female role, and comes to be defined as one genuinely human way to live. (p. 282)

Just how does masculinity or men's roles put men at risk for illness and early death? Researchers have varied in the ways they have conceptualized and measured *masculinity, masculine identity,* or *men's sex role identity.* As Vicki Helgeson details in Chapter 4, psychologists in the 1970s initially saw masculinity as a conglomeration of traits that in turn could be identified and measured (Bem, 1974; Spence, Helmreich, & Stapp, 1974). Consonant with the tenets of sex role theory, researchers recognized that masculinity as an inner, psychic process was intricately tied to an outer web of sex roles and gender expectations. Robert Brannon (1976), for example, identified the following four major components of the male role:

1. No Sissy Stuff: the need to be different from women
2. The Big Wheel: the need to be superior to others
3. The Sturdy Oak: the need to be independent and self-reliant
4. Give 'Em Hell: the need to be more powerful than others, through violence if necessary

Gender socialization influences the extent to which boys adopt masculine behaviors, which, in turn, can impact on their susceptibility to illness or accidental deaths. A give 'em hell approach to life can lead to hard drinking and fast driving, which account for about half of male adolescent deaths. As Helgeson suggests in Chapter 4, the need to be a sturdy oak and to avoid the semblances of feminine dependency may account for the tendency men have to deny symptoms of coronary heart disease.

In Chapter 5, Alan Klein analyzes why bodybuilders put their health at risk by using steroids, overtraining, and engaging in extreme dietary practices. He reports on years of ethnographic research in the muscled world of the bodybuilding subculture, where masculinity is equated to maximum muscularity and men's normative strivings for bigness and physical strength hide a psychic substratum of insecurity and low self-esteem. The links between masculinity and muscle have been embodied in cult heroes such as Joe Weider, Charles Atlas, Arnold Schwartzenegger, and Sylvester Stallone, who have served as male role models for generations of American boys and men. Klein's analysis lays bare a tragic irony in American culture; that the powerful male athlete, a symbol of strength and health, has often sacrificed his health in pursuit of ideal masculinity (Glassner, 1989; Messner & Sabo, 1995). Klein also emphasizes the theoretical necessity of linking sex role theory's focus on gender identity and socialization to a critical analysis of the political, economic, and cultural contexts of gender relations.