 Health Sociology Review (2010) 19(4): 409–418.

Theorising masculinities and men's health: A brief history with a view to practice

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ABSTRACT

Sex comparisons reveal men as more likely than women to die earlier and experience debilitating injury. Historically, this trend has been positioned as somewhat inevitable, an outcome of men's 'natural' biologically charged tendencies for risk-taking and reluctance around help-seeking. More recently, gender research has emerged to describe cultural norms about masculinity and explore their relationships to men's health and illness practices. Empirically, masculinities and men's health research has revealed diverse practices that suggest some men's risky health behaviours are amenable to change. This article provides a brief review of how masculinity has been understood in men's health research before making recommendations for where we might next go in theorising social constructions of masculinities. Specifically, a vignette drawn from a study examining young men's responses to the death of a peer is used to illustrate how the communities of practice framework can be applied, and might conceptually advance future masculinities and men's health research.

Keywords: masculinities; men's health; men's risk-taking; communities of practice

Introduction

Over the past few years there has been growing concern about men's poor health outcomes. For example, in Western countries, males between the ages of 15 and 29 have 2.6 times greater risk of dying than females (Phillips 2005), and are 3.9 times more likely to experience accidental death (Statistics Canada 2005). Overall, men's mortality rates are higher than women's for the top 15 causes of death including cancer and heart disease while morbidity rates reveal men as more likely to suffer chronic illness at an early age (Schofield et al. 2000; Verbrugge 1985). While these sex comparisons are often used to make the case for dedicated men's health research and services, competing victim discourse can also emerge, whereby men's and women's health are pitted against each other (Broom 2009). Oliffe et al. (2010a) argue that it is more useful to highlight where men's lower life expectancy flows from. For example, the top five causes of mortality contributing to the excess years of life lost for Western men versus women are cardiovascular disease, suicide, motor vehicle accidents, infectious diseases (most often HIV) and liver disease (most often secondary to alcohol dependence) (Bilsker et al. 2010). Implicated in these male mortality causes are men's risky health behaviours, most of which seem amenable to change (Capraro 2000; Miller 2008). Yet the origins of masculinity and men's risky practices and

disconnects from self-health and professional services have long been debated.

Some contend, for example, that men's health risks stem from a *crisis in masculinity*, a byproduct of men's disorientation over their collective loss of place and identity (Bly 1990; Phillips 1999). This standpoint positions men as victims of a society that privileges femininity and 'women's issues' to the detriment of strong masculinities (Clatterbaugh 1990; Hearn 2004). Of course, this is contested terrain, and as Lohan (2007) argues, conceiving of men's ill health as an outcome of men's symbolic subjugation obscures the material fact of women's inequality. Others posit, with less political charge, various male biological determinants, most of which are not modifiable. These cause–effect relationships are used to explain, and perhaps accept, the status quo around men's poor health outcomes. For example, men's testosterone levels can be linked to male aggression and violence which, in turn, leads to negative downstream outcomes including homicide and suicide. In essentialising males in this way, biologically driven masculinity is portrayed as the culprit for men's risky practices and the morbidities and mortalities that flow from them.

Emergent over the last 20 years have been commentaries and empirical evidence connecting socially constructed masculinities and men's health. As a result, gender identities, roles and relations have been shown to mediate men's health and illness practices (Lippa et al. 2000; Robertson 2006, 2007; Rosenberg 2009; Sabo 2000). In recognising a plurality of masculinities, men's health researchers disrupted taken-for-granted linkages between masculinity, risk and men's poor health outcomes. The work of Connell (1995) Hearn (2004) and Kimmel (1997) was key to Courtenay (2000) and Lohan's (2007) call for men's health studies to be framed by critical gender approaches. While some empirical products have emerged in response to those recommendations (O'Brien et al. 2005; Oliffe et al. 2010a; Robertson 2007; Sloan et al. 2009), it is ever clear that the methods for investigating, as well as theorising social constructions of masculinity in men's health are inflected differently depending on the researcher's ontological, epistemological and political alignments.

Concurring with Lohan's (2007) assertion that men's health research has too often been done without sufficient critical enquiry, we suggest that more can and needs to be done to capture the complexities, contradictions and nuanced productions and performances of masculinity. Additionally, imposing a theoretical framework to interpret the experiences of others, without delineating what informs that frame, can unwittingly contribute to the reproduction of hegemonic discourses (Cassell 2005). Conversely, to claim empirical findings without drawing wider theoretical connections and conclusions runs the risk of appearing (and arguably, being) anecdotal. There are also limited possibilities for moving thickly described yet theoretically barren insights toward men-centred interventions. Needed then are theoretical frameworks that investigate masculinity and men's health in ways that authentically represent and locate study participants' gendered health experiences, both in describing their health problems and thoughtfully informing potential solutions.

In making recommendations about how we might theorise masculinities, in what follows we briefly map the emergence of sex and gender theories in men's health. The purpose here is to foreground various frameworks in showcasing the communities of practice framework by drawing on a vignette from a study examining young men's responses to the death of a peer.

Biology, sex roles and socially constructing masculinities in men's health

Early work linking masculinity with men's health was dominated by biological frameworks. From this perspective, biological sex played the primary role in determining health behaviours.

The underpinning premise was and is that aggression and risk-taking behaviours are naturally occurring expressions of maleness. Male psyches were considered 'hardwired' to perform behaviours that risk rather than promote self-health. Although ideas about sex and gender are most often ontologically and epistemologically estranged, there is increasing pressure for men's health researchers to reconcile that disagreement. At a superficial level, sex might foreground a particular men's disease (e.g., prostate cancer) in making the case for better understanding gendered illness experiences (e.g., impotence and urinary incontinence). However, there are calls to design integrated sex and gender studies as the means to delivering robust descriptions about particular men's health problems, which in turn, might fast track the development of men-centred interventions (Johnson and Repta 2011).

In response to biology's overly deterministic way of interpreting masculinity, the 20th century saw a proliferation of gender theories that critiqued the utility of the male–female binary that permeated sex studies. For example, psychoanalytic thinkers including Freud, Chodorow and Dinnerstein theorised that masculine and feminine behaviours are products of the complex workings of the psyche. Bem's (1974) work on sex role typology also challenged the legitimacy of claiming unitary sex based behaviours, and she eloquently argued that Western cultures were so powerfully gendered that even young children took on dominant notions of sex-typed behaviour. Afforded by the sex role work was the possibility of a continuum of gender alignments rather than sex dichotomy that in many ways paved the way for socialisation theory.

With the advent of sex role socialisation theory, research questions about men's health shifted to better understand how men enacted masculinity through their health and illness practices (Messner 1997; Sabo 2000). In his paper *Warning: The Male Sex Role May Be Dangerous to Your Health*, Harrison (1978) presented a synthesis of scholarly works to demonstrate the strong negative influence of male socialisation on men's health. Building on the literature about male socialisation and health, the research attributed men's avoidance of health care services to masculine norms that emphasise self-reliance and stoicism (Addis and Mahalik 2003). The discrepancies between male and females sex roles were also implicated in men's health. The pressure placed on young men, for example, to break with the maternal 'apron strings' and demonstrate their autonomy and courage led many men to engage in risky practices such as substance misuse, extreme sports and aggression. Gendered divisions between domestic and public spheres anchored 'wives' and 'mothers' as the private caretakers of health for the men and children in their lives (Lee and Owens 2002) amid male breadwinners who laboured selflessly outside the domestic sphere (Schofield et al. 2000). Socialisation theory, while providing innovative insights to processes about how gender is learned and performed, is most often criticised for its reliance on individualistic and psychological examinations of gendered attitudes and personality traits. What is lacking is an historical analysis examining the evolution of 'roles' within the context of gender relations (Connell 1995; Kimmel 2008; Messner 1997), whereby boys' and men's health practices were reduced to a set of behaviours (Smith and Robertson 2008) in ways that inadvertently fostered a diluted version of the biological essentialism it sought to challenge.

Social constructionism emerged to conceptualise gender as intersecting with culture, social class and history, actively constructed and produced (Connell 1995; Connell and Messerschmidt 2005; Gerson and Preiss 1985). Key was Connell and Messerschmidt's (2005) work in hegemonic masculinities, a dominant positioning that subordinates femininities as well as other forms of masculinity. Hegemonic masculinities constituted idealised patterns of practice and power both materially and discursively,

and although few men embody those ideals, many men are deeply invested in sustaining them (Connell and Messerschmidt 2005). In the context of men's health, hegemonic masculinities, as normative performances, idealise men as robust, autonomous and self-reliant rather than concerned with self-health, illness or injury (De Visser 2009; Kimmel 1997). Recognising that masculinity is intertwined with various social locations, the theory of multiple masculinities emerged to describe men's varying alignments to health practices, some of which are synonymous with hegemonic masculinities (Connell and Messerschmidt 2005). Marginalised and subordinate were the poor, working-class, racially oppressed and homosexual men, identities bordered and contained by white and upper/middle-class hegemony. The plurality of masculinities within, as well as across men, revealed diverse locale dependant 'configurations of practice' (Connell 1995; Connell and Messerschmidt 2005).

Courtenay (2000) first adapted Connell's (1995) framework to predict how various alignments, including subordinate and marginalised masculinities, might emerge in the context of men's health and illness. Courtenay (2000) argued that health practices were mediated by and expressed through men's masculine performances within specific settings. Proving one's manhood, then, involved enacting masculine strength, power, and disregard for danger (Capraro 2000; Connell 1995; Kimmel 1997). De Visser (2009), for example, suggests that young men's binge drinking is an example of men aligning with masculine ideals. Being drunk can negatively impact both men's and women's health through linked practices including aggression, violence, predatory heterosexuality, motor vehicle accidents and sexual assault. Men's idealised health practices also disallowed their engagement with feminine self-care practices, such as applying sunscreen (Courtenay 2000).

Courtenay and Keeling (2000) described a health hierarchy whereby privileged men maintained and defended their social power while marginalised men endured the most compromised health. Courtenay (2000) claimed strong connections between social location and the performance of idealised masculine health practices. For example, in order to contest subordinate status and reaffirm their masculinity, men amplified their risk-taking and engaged in activities such as crime and substance abuse (Courtenay 2000). A US Department of Health and Human Services study confirms that men with the least education were twice as likely to smoke and three times as likely to engage in heavy alcohol use (Department of Health and Human Services 1998). Building on this, De Visser and Smith (2006) explained that the degree to which young men binge drink is inversely related to the number of other currencies of masculinity that they possess. A young man who is athletic, for example, does not necessarily need to drink heavily to prove his manhood (De Visser 2009; De Visser and Smith 2006). Masculinities researchers also assert that improving men's health and well-being rests, not only on prompting men to embrace healthy practices, but by unsettling structures that maintain hegemonic masculinity itself (Connell 1995; Kimmel 1997; Messerschmidt 1993). Said another way, understanding the how masculinities connect to men's health requires a theoretical framework that accounts for both the agency of an individual in making health choices and the social structures that shape those options.

As useful as Courtenay's (2000, 2009) masculinity frame was for unpacking the empirical men's health products that followed, understandings have been limited by insufficiently nuanced accounts of social location and a lack of attention to men's gender relations. While applying Connell's (1995) multiple masculinities, Courtenay (2000) failed to account for men's individual meaning making and relationships. For example, when describing the risky health practices of marginalised men, such as older, homosexual and/or men of African-American

ethnicity, Courtenay (2009) drew the conclusion that the risky health practices of men in these subgroups flowed from differential access to power, suggesting these hegemonic 'signifiers of true' masculinity (including reckless driving and substance use) were readily accessible to men who may otherwise have limited social resources for constructing masculinity. Assumed and arguably reified here are subordinate masculinities which, in the absence of empirical data, inadvertently reproduce hegemonic discourses about marginalised populations (Thompson 2006). Absent in this theory are the nuanced ways that men experience masculine roles and gender relations in the context of a variety of intersecting identities. So, while marginalised men attempt to 'prove' their masculinity, the meaning of the phenomenon is imbued with many levels of significance including aligning with cultural values, attending to family traditions and responding to media characterisations of masculinity. For example, a young gay man might not have unprotected sex as a means to contest his marginalised status but rather as a practice aligning with a sub-set of the gay community that socialises bare-backing (Rowe and Dowsett 2008). Similarly, older Punjabi Sikh Canadian immigrant men might not 'officially' drink alcohol because of religious beliefs but socially share hard liquor as a sign of respect and status in welcoming others into their home (Oliffe et al. 2010b).

In sum, the leap of logic in depicting hegemonic masculinities as having uniform and unitary meanings and negative influence within and across men's lives is short on both theoretical savvy and empirical weight. As Sloan et al. (2009) confirm, the idea that men attempting to embody hegemonic masculine ideals results in negative health behaviours and outcomes is overly simplistic. Indeed, Sloan et al. demonstrate that men enacting *positive* health behaviours, such as drinking less alcohol and reducing fat intake, also draw on discursive elements of hegemonic masculinity. By making choices dedicated to preserving a healthy body, men can and do situate themselves as rational, decisive and autonomous manly men, actively demoting illness and promoting self-health (Oliffe et al. 2010a).

While Courtenay's (2000) masculinities and men's health framework has grappled with debunking a monolithic view of hegemonic masculinity, it has also failed to integrate gender relations (Schofield et al. 2000; Smith and Robertson 2008). Connecting men's health practices to agency and/or structure has tended to trump men's peer, partner and parental relationships, despite the widespread acknowledgment that 'significant others' strongly influence men's health practices (Lee and Owens 2002; Robertson 2007). Whilst not putting the 'communities of practice' framework forward as the cure all remedy to these challenges, in what follows we argue for its inclusion in future descriptive as well as intervention based men's health research.

Communities of Practice

Communities of practice is a theoretical framework for investigating how identities are learned and reproduced within various subgroups and locales (Lave and Wenger 1991; Paechter 2003; Wenger 1998). Paechter (2003) applied the communities of practice frame to the learning of masculinities and femininities at local levels. She explicitly accounted for the roles of cultural and institutional discourse amid a focus on the local formation of masculinities and femininities. Within these foci, the conceptual model of hegemonic masculinities were neither assumed synonymous with negative health behaviours nor constructed in isolation under the influence of a fixed set of masculine ideals. Instead, the framework locates men's health practices as products of masculine identity that emerge within a particular community. As such, the communities of practice framework takes into account the meaning made from practices, and the way practitioners relate to each other as well as those considered outsiders.

Community can be broadly defined as groups or networks of people with shared understandings of identity, norms and social practices (Paechter 2003; Wenger 1998). For example, communities of practice can include families, workplaces, high school cliques, fraternities, support groups and sports teams as well as less formal groupings and gatherings based on gender, race, ethnicity and class. Paechter (2003) and Wenger (1998) among others, argue that an individual's identity is formed by way of participating in social practices within the context of a specific group. A 'community of practice' builds identity in much the same way that Bourdieu (1977) described how the gradual acquisition of habitus is shaped by way of situated learning (Hewitt 1988; Lave and Wenger 1991) in a process similar to apprenticeship (Wenger 1998). Specifically, one can participate peripherally in a community of practice, gaining expertise in the groups' activities until they become proficient and move toward a more central role within the community (Wenger 1998). Learning identity, therefore, takes place in a collective environment (Wenger 1998), within the constant negotiation of meaning, through decision making processes around communal terms of engagement. In short, one is *becoming* through the act of doing.

In an ongoing urban Canadian-based study we adapted the community of practice framework to better understand how the death of a peer impacts young men and influences their subsequent health practices. Forty young men, between the ages of 19 to 25 who had lost a friend in the past three years, were individually interviewed twice. Participants were purposely recruited from a variety of ethno-cultural and socio-economic backgrounds to maximise the sample diversity. Using a focused ethnographic design, the ways in which men responded to the death of a peer resulting from risky activities including drag car racing, extreme sports, excessive drug and alcohol use, and other thrill-seeking experiences, were explored. Using photo elicitation as a form of participant observation (Oliffe and Bottorff 2007), diverse visual representations also accompanied the men's interview text data to offer important insights to the connections between masculinities, risk-taking and grief and loss responses following the death of a peer. In distilling the key aspects of communities of practice we share some insights drawn from that study as a vignette to illustrate the robustness of the framework.

Vignette: The famous five

Five boys met up in elementary school and continued on together through high school, all the while forging strong bonds and a group identity they proudly named the 'famous five'. Self-proclaimed 'bad ass' guys, in their senior years of high school, it was all about being 'the MAN', and embodying a strong, aggressive, collective masculine identity. The famous five took pride in their disengagement from parental authority and embodiment of the 'negative role model' label assigned by their school teachers. Indeed, the group's resilience amid school imposed suspensions and eventual expulsion prevailed. In some ways, school sanctioned punishments inadvertently provided additional opportunities for producing particular 'risky' masculine practices. For example, drinking to excess and then driving, purposefully getting into fights, taking and passing on street drugs were normalised and celebrated as the key components of a good night out for the famous five.

Evident was a community of practice whereby static, rigid, negative embodiments of masculinity presented health risks to the famous five collective as well as those residing outside the group. Central to the group's identity was their closed system and impenetrable walls and decisiveness in 'othering' outsiders by showing hostility for non-members (Paechter 1998, 2003). To maintain their closed system, the group governed its members through teasing and insults for not embodying or maintaining the groups idealised 'party hard' masculine performances. The most extreme versions of hyper masculine communities of practice are collectively referred to as 'toxic'

masculinities (Connell and Messerschmidt 2005; Kupers 2005), characterised by homophobia and the domination and subjugation of weaker men and women. Street gangs are an example of such communities of practice. While the famous five fell short of the hardened street gang activities that would classify their masculine performances as 'toxic', their escalating risky behaviours laid claim to some destructive practices.

On a rainy June evening prior to graduating from high school, Ryan, one of the famous five, attended a party where he enjoyed a few drinks. Dominating the discussion that night was talk of Ryan's motorcycle, a Kawasaki 750 no less, which he had saved for and recently purchased. Amid the one-upmanship and palpable envy of his buddies, Ryan decided to ride home. While making a turn on the highway, he lost control of his bike and hit a telephone pole. His unresponsive body was found 20 m from the crash site along with his smashed helmet. His running shoes laid blood stained in a nearby tree. Ryan was rushed to hospital but died soon after surgery as a result of his many injuries.

The boys were deeply shaken by Ryan's death. Amid the chaos of the tragedy, the previously rigid walls that demarcated the famous five's community of practice became fragile allowing the infusion of new 'outside' ideas, values and information. Ryan's unexpected death had forced the now famous four to reconstitute their collective masculine identity under the influence of adjacent yet evermore relevant practice communities (Connell 1995; Paechter 2003). For example, after the death of her son, Ryan's mother gathered the four young men together on a regular basis to talk and grieve. As the relationship between the friends and the mother deepened, the boys felt a responsibility to her: 'I always wanted to get a motorcycle but I couldn't let that mother lose another son', one of boys commented. Another boy explained, 'I was just so furious at Ryan. How could he be so selfish as to do a stupid thing and leave everyone do deal with the awfulness after his death?' Another boy remembered his girlfriend's mother telling him, 'You're not living life for one any more, you're living life for two', an assertion he carried with him into everything he did from that moment on. While still having the kind of fun they had previously enjoyed together, the boys were less reckless and hedonistic, and instead they were mindful in the way that one is when thinking of another. One of the boys, for example, changed his approach to dealing with conflict. 'I was always a fighter but now, when I feel like doing that, I think that Ryan wouldn't want me to'.

With various levels of self-regulation, each man's thinking about what it meant to be masculine was adjusted and, eventually, served to reconfigure the group's 'new' norms. While the young men still exhibited behaviours that could be defined as risky (e.g., partying hard and embodying and affirming emotional and physical strength) they also embodied some profoundly different health promoting practices. Group norms were revised, for example, to prohibit the pairing of substance use with driving, recreational violence and aggression toward others. The group's prescribed practices were also relaxed to enable one member to openly use art to express his grief over losing Ryan. Another was motivated to involve himself in sports as an outlet for his high energy and aggression.

As research has demonstrated, there is a long-standing tradition whereby women influence the health of men (Norcross et al. 1996). Illustrated in this vignette is the role that women can play in male dominated communities of practice. When the famous five's community was rigid, the perspectives and advice of others who resided outside the boy's primary group were dismissed. With its openness came a reconstitution of the collective group identity, their gender relations and interactions with others. Ryan's death gave the boys reason to reconfigure their relationships with women, revealing closer relationships with their mothers and the replacement of 'one-night-stands' with long-term girlfriends. The vignette also highlighted the ways in which self-health can

be taken up by men to protect and honour significant others (in this case Ryan's memory and his mother). In essence, the boys' masculinities and health were increasingly contextualised within, not just one but several communities of practice.

Consistent with the conclusions of Sloan et al. (2009), the powerful influence of hegemonic cultural references is accounted for, but not universally equated as negative for men's health. Indeed, the community of practice model determines 'health' by looking at various elements such as health risking behaviours, the rigidity of practice boundaries that mark and police gender relations within and outside diverse communities of practice (between and among men and women). The multitude of communities of practice that one person inhabits can clearly account for shifts and contradictions in men's health and illness practices. Oliffe et al. (2009), for example, documented the way in which men at prostate cancer support groups used humour to simultaneously embody masculinity in how business was done while breaking with masculine ideals about what men ordinarily disclose or talk about.

Conclusion

While the community of practice framework is informed by cultural studies, sociological research on peer groups, hegemonic masculinities, gender practice as well as psychological research on identity formation, its application to men's health is new. We suggest that the community of practice framework, in linking with Connell's (1995) configurations of gender practices, has much to offer in terms of contextually anchoring the patterns and diversity that exist between and within men's health and illness practices (Connell and Messerschmidt 2005). While death is an extreme circumstance for prompting change, our vignette highlights the potential benefit for targeting interventions to particular communities of practice as a means of positively influencing the health and well-being of discrete subgroups of boys and men. Furthermore, understanding how gender identities and masculine norms operate in various communities of practice can deeply impact the efficiencies of efforts to intervene. There is evidence to suggest that those best situated and equipped to support interventions in communities of practices do not necessarily reside in formal health and social services systems. This may mean that interventions dedicated to positively influencing the health of some communities of practice have to be championed differently (i.e., supporting the work of coaches, mothers, bar owners).

We do not propose the communities of practice framework as a cure all answer to men's health research. It is, however, a robust analytic framework for understanding particular problems and leveraging solutions for men's health issues. The pedagogical underpinnings focus on strengthening existing sites in which the most positive healthy masculine performances prevail to advance self-health and well-being. Extending ideas about the fluidity of individuals and collective communities of practice, health care professionals and lay persons alike can identify and mobilise viable alternatives to waylay or reformulate the pressures that accompany diverse masculine norms.

In summary, there is much to be gained from connecting masculinities and men's health to the communities of practice framework. While thick descriptions about men's health and illness experiences have been developed, the specificities about where, why and how men's varied practices are constructed within structural and discursive systems are often poorly understood. Communities of practice research examining the influence of hegemonic masculinities and men's health bodes well for exploring peer groups, social networks (including virtual communities) and places of social change. In these ways existing as well as emergent communities of practice can be accessed and new communities created to advance the health and well-being of boys and men.

Acknowledgements

Support for the first author is provided by a doctoral fellowship from the Canadian Social Sciences and Humanities Council. Career

support for the second author is provided by a Canadian Institutes of Health Research new investigator and a Michael Smith Foundation for Health Research scholar award.

References

Addis, M.; and Mahalik, J. (2003) 'Men, masculinity, and the contexts of help-seeking' *American Psychologist* 58(1):5–14.

Bem, S. (1974) 'The measurement of psychological androgyny' *Journal of Personality and Social Psychology* 42(2):155–162.

Bilsker, D.; Goldenberg, L.; and Davison, J. A. (2010) *A roadmap to men's health: Current status, research, policy and practice* UBC and Centre for Applied Research in Mental Health and Addition: Vancouver.

Bly, R. (1990) *Iron John* Addison-Wesley: New York.

Bourdieu, P. (1977) *Outline of a theory of practice* Cambridge University Press: Cambridge.

Broom, D. H. (2009) 'Men's health and women's health-deadly enemies or strategic allies' *Critical Public Health* 19(3–4):269–277.

Capraro, R. (2000) 'Why college men drink: Alcohol, adventure and the paradox of masculinity' *Journal of College Health* 48(6):307–315.

Cassell, C. (2005) 'Creating the interviewer: Identity work in the management research process' *Qualitative Research* 5(2):167–179.

Clatterbaugh, K. (1990) *Contemporary perspectives on masculinity: Men, women and politics in modern society* Westview Press: Oxford.

Connell, R. W. (1995) *Masculinities* Polity Press: Cambridge.

Connell, R. W.; and Messerschmidt, J. (2005) 'Hegemonic masculinity: Rethinking the concept' *Gender and Society* 19(6):829–859.

Courtenay, W. (2000) 'Constructions of masculinity and their influence on men's well-being: A theory of gender and health' *Social Science and Medicine* 50(10):1385–1401.

Courtenay, W. (2009) 'Theorising masculinity and men's health' in Broom, A.; and Tovey, P. (eds) *Men's health: Body, identity and social context* Wiley-Blackwell: West Sussex, pp. 9–32.

Courtenay, W.; and Keeling, R. (2000) 'Men, gender and health: Toward an interdisciplinary approach' *Journal of American College Health* 48(6):259–267.

Department of Heath and Human Services (1998) '*Socioeconomic status and health statistics'* in *Statistics* Center for Disease Control and Prevention: Hyattsville, MD.

De Visser, R. (2009) 'Young men, masculinity and alcohol' in Broom, A.; and Tovey, P. (eds) *Men's health: Body, identity and social context* Wiley-Blackwell: West Sussex, pp. 126–144.

De Visser, R.; and Smith, J. (2006) 'Mr. In-Between: A case study of masculine identity and health-related behaviour' *Journal of Health Psychology* 11(5):685–695.

Gerson, J. M.; and Preiss, K. (1985) 'Boundaries, renegotiations, consciousness: Reconceptualizing gender relations' *Social Problems* 32(4):317–331.

Harrison, J. (1978) 'Warning: The male sex role may be dangerous to your health' *Journal of Social Issues* 34(1):65–86.

Hearn, J. (2004) 'From hegemonic masculinity to the hegemony of men' *Feminist Theory* 5(1):97–120.

Hewitt, J. (1988) *Self and society* Allyn and Bacon: Boston.

Johnson, J.; and Repta, R. (2011) 'Sex and gender: Beyond the binaries' in Oliffe, J.; and Greaves, L. (eds) *Designing gender, sex and health research* Sage: Thousand Oaks, CA.

Kimmel, M. (1997) 'Masculinity as homophobia: Fear, shame and silence in the construction of gender identity' in Gergen, M.; and Davis, S. (eds) *Toward a new psychology of gender* Routledge: New York, pp. 223–242.

Kimmel, M. (2008) *The gendered society reader* Oxford University Press: New York.

Kupers, T. (2005) 'Toxic masculinity as a barrier to mental health treatment in prison' *Journal of Clinical Psychology* 61(6):713–724.

Lave, J.; and Wenger, E. (1991) *Situated learning: Legitimate peripheral learning* Cambridge University Press: Cambridge.

Lee, C.; and Owens, R. G. (2002) 'Issues for a psychology of men's health' *Journal of Health Psychology* 7(3):209–217.

Lippa, R.; Martin, L.; and Friedman, H. (2000) 'Gender-related individual differences and mortality in the Terman longitudinal study: Is masculinity hazardous to your health?' *Personality and Social Psychology Bulletin* 26(12):1560–1572.

Lohan, M. (2007) 'How might we understand men's health better? Integrating explanations from critical studies on men and inequalities in health' *Social Science and Medicine* 65(3):493–504.

Messerschmidt, J. (1993) *Masculinities and crime: Critique and reconceptualisation of theory* Rowman and Littlefield: Lanham.

Messner, M. (1997) *Politics of masculinities: Men in movement* Sage: London.

Miller, K. (2008) 'Wired: Energy drinks, jock identity, masculine norms and risk taking' *Journal of American College Health* 56(5):481–489.

Norcross, W.; Ramirez, C.; and Palinkas, L. (1996) 'The influence of women on the health care-seeking behaviour of men' *Journal of Family Medicine* 43(5):475–480.

O'Brien, R.; Hunt, K.; and Hart, G. (2005) 'It's caveman stuff, but that is to a certain extent how guys still operate: Men's accounts of masculinity and help seeking' *Social Science and Medicine* 61(3):503–516.

Oliffe, J. L.; and Bottorff, J. L. (2007) 'Further than the eye can see? Photo elicitation and research with men' *Qualitative Health Research* 17(6):850–858.

Oliffe, J. L.; Grewal, S.; Bottorff, J. L.; Dhesi, J.; Kang, B.; Ward, A.; and Hislop, T. G. (2010a) 'Masculinities, diet and senior Punjabi Sikh immigrant men: Food for western thought?' *Sociology of Health & Illness* 30(5):761–766.

Oliffe, J. L.; Robertson, S.; Frank, B.; Mccreary, D. R.; Tremblay, G.; and Goldenberg, S. L. (2010b) 'Men's health in Canada: A 2010 update' *Journal of Men's Health* 7(3):189–192.

Oliffe, J. L.; Ogrodniczuk, J. S.; Bottorff, J. L.; Hislop, T. G.; and Halpin, M. (2009) 'Connecting humor, health and masculinities at prostate cancer support groups' *Psycho-Oncology* 18(9):916–926.

Paechter, C. (1998) *Educating the other: Gender, power and schooling* Falmer Press: London.

Paechter, C. (2003) 'Masculinities and femininities as communities of practice' *Women's Studies International Forum* 26(1):69–77.

Phillips, M. (1999) *The sex-change society: Feminised Britain and the neutered male* The Social Market Foundation: London.

Phillips, S. (2005) 'Risky business: Explaining the gender gap in longevity' *Journal of Men's Health and Gender* 3(1):43–46.

Robertson, S. (2006) '"I've been like a coiled spring this week": Embodied masculinity and health' *Sociology of Health and Illness* 28(4):433–456.

Robertson, S. (2007) *Understanding men and health: Masculinities, identities and well-being* McGraw Hill Open University Press: UK.

Rosenberg, J. P. (2009) 'Circles in the surf: Australian masculinity, mortality and grief' *Critical Public Health* 19(3–4):417–426.

Rowe, M.; and Dowsett, T. (2008) 'Sex, love, friendship, belonging and place: Is there a role for "Gay Community" in HIV prevention today?' *Culture, Health and Sexuality* 10(4):329–344.

Sabo, D. (2000) 'Men's health studies: Origins and trends' *Journal of American College Health* 49(3):133–142.

Schofield, T.; Connell, R.; Walker, L.; Wood, J.; and Butland, D. (2000) 'Understanding men's health and illness: A gender-relations approach to policy, research and practice' *Journal of American College Health* 48(6):241–256.

Sloan, C.; Gough, B.; and Conner, M. (2009) 'Healthy masculinities? How ostensibly healthy men talk about lifestyle, health and gender' *Psychology and Health* 25(7):783–803.

Smith, J.; and Robertson, S. (2008) 'Men's health promotion: A new frontier in Australia and the UK?' *Health Promotion International* 23(3):283–289.

Statistics Canada (2005) *Deaths, by selected grouped causes, age group and sex, Canada, annual* Government of Canada: Ottawa.

Thompson, E. H. (2006) 'Images of old men's masculinity: Still a man?' *Sex Roles* 55(9–10); 633–648.

Verbrugge, L. M. (1985) 'Gender and health: An update on hypothesis and evidence' *Journal of Health and Social Behaviour* 26(3):156–182.

Wenger, E. (1998) *Communities of practice: Learning, meaning and identity* Cambridge University Press: Cambridge.

Received 28 April 2010 *Accepted 24 October 2010*