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The Case for Retaining a Focus on "Masculinities" in Men's Health Research

Within the health research literature there is increasing attention focussed on how the concept of "masculinities" can be employed to understand health and illness and used to inform health care practice and policy. At the same time, valuable critiques of masculinities frameworks have emphasised that there is often, within the published literature, a lack of rigour in defining and using these ideas, a tendency towards rigid and essentialist notions about men and gender but also recognition that some approaches specify masculinities as the "cause" of poor health outcomes for men, women and children. We consider and respond to these important questions and, using examples from empirical studies, make the case that it is important to advance the use of masculinities in men's health research both as a means to describing the challenges to men's health and the strengths men draw upon to promote their health and remedy illness. We argue, first, that masculinities be operationalised as "configurations of social practice" and understood as part of the dynamic processes involved within the "gender order." Second, configurations of social practice are diverse, dynamic and hierarchical in terms of the material and representational benefits they bring to men. Third, configurations of social practice are relational and negotiated within institutions and other structures wherein the doing of masculinities and health and illness can be co-constructed, contested and/or constrained. Finally, we suggest some practice implications and applications for further conceptualising masculinities to the field of men's health.

Key terms: men's health; masculinities; gender; public health; health inequalities

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The emergence of gender studies as an academic discipline has generated an interest in men qua men, that is, in men as gendered subjects. To understand the diverse and structurally mediated positions of men and women in all spheres of society in a nuanced way requires the ability to recognise how power operates and is operationalised within gendered relations and diverse social contexts. This, in turn, relies on a consideration of the gendered nature of men's varied social interactions, how these are shaped, and also how they themselves act to shape and (re)form social structures and institutions. As others have suggested (Connell, Hearn, & Kimmel, 2004; Hearn, 1996), pursuing this interest in men's subjective positions has taken two main forms: those who align themselves with an interest in "men's studies" (as analogous with, and quite often oppositional to, "women's studies") and those who are interested in "critical studies on men" (CSM), an approach inspired by feminist research and attending to gendered (power) relations between men and women. For both groups of academics, the term *masculinities* has been an anchor for exploring and understanding "how men are" in a variety of social contexts. Indeed, a brief search of Google Scholar© since 2000 returns well over 9,000 academic papers/books that have "masculinity" or "masculinities" in the title in diverse areas including education (e.g., Skelton, 2001), the domestic sphere (Aarseth, 2007), sport settings (McKay, Messner, & Sabo, 2000), the media (Benwell, 2003) and health (Robertson, 2007), to name but a few.

Within the field of health, much attention has been paid to the role that masculinities play in accounting for men's lower life expectancy compared to women. The dangers attached to male roles such as heavy manual labour, a (supposed) reluctance to seek help or show weakness and a propensity to "risk-taking" lifestyles have all been linked to specific masculinities and how those practices impact on men's health and wellbeing. Yet, the way that masculinities and health are thought to interact varies depending on how both are conceptualised. Some have questioned the way that homogenising notions of a singular "masculinity" are seen to determine men's health practices and outcomes in simple causal fashion (e.g., Macdonald, 2011; Robertson, 2007).

Whilst being some of the first to develop and use the terms in a sociological sense, Men's Studies and CSM scholars have also been at the forefront of questioning the use and application of the terms "masculinity" and "masculinities." This has led one leading scholar in the field to state that, "To date, 'masculinity' has certainly served a purpose in developing a focus of attention on men; the question is whether it has served its purpose" (Hearn, 1996, p. 214).

The present article considers Hearn's important question and in so doing develops an argument for why it is important to retain a focus on masculinities (specifically, rather than a focus on "masculinity") in future studies on men and health. The present article comprises three parts. We begin by exploring three critiques, from differing perspectives, that have questioned the value and utility of a notion of "masculinity" including, in the third critique, its value in relation to the field of "men's health." Second, we consider what components might advance the adequate conceptualisation of masculinities. Within this section, we include a range of empirical work to elucidate connections between men and their health practices. Finally, we consider what the implications are for men's health research, policy and practice.

PART ONE:
CRITIQUES OF THE CONCEPT MASCULINITY AND/OR MASCULINITIES

There has been a considerable amount of academic endeavour involved in defining, (re)de-

veloping and critiquing the concepts of "masculinity" and "masculinities".[1] This section does not revisit all of these prior debates, nor does it consider the specific issue of "hegemonic masculinity" (Connell, 1995), which in itself has been the subject of a huge amount of discussion and debate (Connell & Messerschmidt, 2005). Instead, the aim here is to focus on two main arguments, informed by differing theoretical positions, for dispensing with the concepts of masculinities. We outline the core themes in these arguments whilst raising questions about underpinning rationales and the conclusions they draw. The section then moves on to consider a third argument that specifically critiques the use of masculinities for helping understand and address issues that impact on men's health. In highlighting these core themes we recognise that we are not able to reproduce the complete, nuanced nature of some of the arguments being made. Nevertheless, we provide a fair representation of the main features of these arguments, that is, we are not disingenuous in the way we discuss the work of these academic peers. We also recognise that these peers are not insisting that the term *masculinities* is completely dispensed with but rather are strongly suggesting the problems arising from use of the term and the associated benefits that may accrue from abandoning the term.

Critical Studies of Men Critiques

The first set of arguments for dispensing with masculinities can be found in the work of Jeff Hearn (1996, 2004) and Kenneth Clatterbaugh (1990). Whilst their arguments differ slightly they share several common themes, which we briefly outline and examine.

The concepts masculinity and masculinities are used widely and often without being precisely defined (Hearn, 1996, p. 203; Clatterbaugh, 1990). The concepts are often presented as if it is clear and self-evident what is being spoken about but, as Clatterbaugh points out, many different meanings are implicitly present when the terms are used and these are often conflated and confused within and across published articles. However, the same can be said for several other concepts, not least the much contested concept of "health" (Blaxter, 2004), but this in itself does not mean that such terms should be abandoned. What is required is a clear outline of how the concepts are being used, attention to variations on the themes and distilling what constitutes consistent deployment within research and academic articles describing that work. As Clatterbaugh (p. 24) himself points out, the difficulty and "cost" entailed in clarifying these definitions may well be worth the benefits that can accrue and we think, and hope to show within the current article, this is indeed the case.

Masculinity as shorthand for social phenomena connected to men but located in the individual. The point here, expanded at length by Hearn (1996, p. 204ff), is that "masculinity" has been hijacked, mainly by the "psy" sciences. Specifically, a singular masculinity (more so than recognition of pluralised "masculinities") is often associated with sets of characteristics that are individually "possessed" and/or "internalised," to greater or lesser degrees, by men through processes of sex-role socialisation, attachment anxieties

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[1] Indeed, this already highlights an important issue of definition that has caused confusion within the field. Within the present article we use the term *masculinities* as a more accurate representation of the diverse and plural ways that practices around "being a man" function in everyday life. Nevertheless, we refer to the singular form, "masculinity", at times when discussing how others have directly used or implied this singular form in their work or in describing the work of others.

forming part of a "deep centre" psychological essence of men. Whole bodies of research, indeed journals in their entirety, have taken this form of conceptualisation and committed themselves to developing measures of various aspects of these characteristics within individual men, making correlations with men's behaviours, including their health behaviours (an example would be the "Special Section: Recent Research on Men's Health", in *Psychology of Men and Masculinity, 12*[1]). We agree with Hearn that conceptualising masculinity in this way is flawed. It fails to recognise the socially contingent and diverse nature of men's practices and is thereby divested and distanced from accounting for contradictions, change or the dynamic nature of power and agency within men's intersubjective encounters. However, again, what is important here is not to abandon but to further conceptualise masculinities in ways that avoid these crude, singular, cross-sectional, decontextualised and overly individualised intra-psychic explanations.

Masculinity as a primary and underlying cause of social problems. The concern here is that masculinity (again often spoken of in singular form), in and of itself, is seen to lead to negative social consequences. For example, as we have already intonated, in health terms "masculinity" is seen to lead to risk-taking, violence and reluctance to seek help. It is attributed "causal power" (Hearn, 1996, p. 213), seen to act almost independent of the person, in determining men's social, including health, practices. This then, it is argued, obscures a more appropriate focus on "men" and their material practices, that is, a focus on what men do. For both Hearn (1996, p. 214) and Clatterbaugh (1990, p. 42), there is a desire to focus more on "what men do", what roles they play, and what their material practices are. Such a focus is clearly important. Yet, equally important, are "why" questions in relation to men's social practices. That is, importance resides not only in what men do, but why they do what they do. In the health field, we know a considerable amount about what men do, or do not do, in relation to prescribed healthy "lifestyle" practices offered as a means to optimising health outcomes. For example, epidemiology can disaggregate gendered patterns in men's and women's health practices and outcomes (White & Richardson, 2011). However the mistake we have made to date is to rely almost unquestioningly on simple and often ill-defined concepts of individualised masculinity (as mentioned in the two points above) as an explanation in its own right for understanding the "why" of men's health practices (for example, Peate, 2004). This trend has indeed detracted attention away from materially based explanations. Men are frequently presented in health literature as socialised to greater or lesser degrees, into the possession of male characteristics, "masculinity," that then determine their propensity toward negative health (and other social) practices. We believe that adequately conceptualising masculinities, as we will below, can overcome this and help address the important questions of "why" in relation to men's health practices and outcomes.

Complexities in masculinities conceptualisations create elitism and thereby diminish the ability to relate to the "man in the street." Clatterbaugh (1990, p. 43) expresses concerns that the academic exercise of (overly) conceptualising masculinities can divert us from wider goals within a men's movement that relate to social change. It is true that too much time can be spent on "over-thinking" concepts at the expense of action. However, sometimes the tools and frameworks needed to understand complex issues are necessarily complicated and action based, and without sufficient thinking they can be more detrimental than helpful. It is important perhaps to consider here the quote often attributed to Einstein; "Everything should be made as simple as possible—but not one bit simpler." It is vital to find ways to make our work accessible and to apply it in real world contexts. How-

ever, research and theorising in other disciplines and fields does not cease when ideas are problematised and highly specialised; so why should work around conceptualising masculinities be any different? We see theory, research and practice as being interdependent with transformation and changes in health practice and policy. A coherent, consistent and rigorous use of the concept "masculinities" helps inform these processes.

Masculinities and the "Post-Modern" Critiques

This brings us on to a second area of critiques around what we might call "masculinities and the post-modern." This work is diverse but the key common threads highlighted here are drawn from the work of Alan Petersen (1998, 2003) and John MacInnes (1998).

"Masculinity" essentialises the character of men and creates a false unity. To talk about "masculinity" can create a false notion that all men share, to a greater or lesser extent, certain natural, innate, characteristics; that is, to assert or concede unitary aspects of masculinity wields homogenising tendencies. Rather, (male) identities need to be understood as fragmented, multiple and somewhat fluid in formation and expression. We agree that recognising diversity is of great importance if we are to understand differing health practices and outcomes within and between men. However, it is also important not to get drawn into extreme relativism. As Hearn (1996, p. 211) points out, whilst there are differences between men, men are bound together as a gendered social group in power relations with women. To consider male identity as *too* multiple, *too* fragmented, runs the risk of creating a case for anti-foundationalism which, in turn, can suggest a concomitant diminution of recognition of men's power and domination. Developing an adequate concept of "masculinities" is vital to understanding the processes which bind men together in this way and to understanding how this impacts upon, and is impacted by, other social divisions such as ethnicity, disability, sexuality, among others.

"Masculinity" is part of a false binary, a "dualism" of gender relations, a discursive construct used to "regulate identity" and resolve a range of contradictions in late modernity. For Petersen (1998, pp. 21ff; 2003, pp. 55ff), it is important to recognise how gender dualisms can obscure connections and similarities, and how they can predicate essentialist features of what is "masculine." For example, such dualisms help obscure the fact that men and women from lower socio-economic groups are likely to have more in common in terms of health practices and outcomes than men from high and low socio-economic groups (Griffiths, 2012). But once again, an adequate conceptualisation of masculinities takes care not to collapse into essentialist notions; in fact it can help illuminate and maintain a critical view of dualisms/binaries and actively engage diversity rather than difference.

As "masculinity" and "masculinities" only exist in discourse, the only significant questions around it relate to their occasions of use; that is, questions about when they are used, by whom, and for what purpose. For Petersen, not only masculinity and masculinities but even (male) bodies are to be understood only as products of discourse: "Rather than seeing bodies as biologically given, or prediscursive, bodies have come to be seen as fabricated through discourse as an effect of power/knowledge" (1998, p. 66). The postmodern focus on discourse facilitates excellent interrogations of when, why and how concepts are used for particular ends. Recent examples of such critical examination in the health

arena (Rosenfeld & Faircloth, 2006) explore how and why—for whose benefit and through what processes—masculinities have become discursively medicalised in a range of contexts including erectile dysfunction, post-traumatic stress and male aging (the "andropause"). However, an emphasis *only* on discourse can itself obscure a focus on materiality and corporeality that are also significant in relation to men and their health. Gender relations are about more than discourse. As Connell (1995, p. 71) points out, to consider masculinities in social analysis means considering the materiality of gendered relations in production and consumption, in institutions and in places of social struggle; the possibility for maintaining dominant forms requires subordination of other forms "by an array of quite material practices" (Connell, 1995, p. 78).

Critiques of Masculinities in Men's Health

A final area of critique is much more directly related to the use of masculinities in the men's health field. It is found in the work of John Macdonald (2006, 2011) and has been influential during the development of the Male Health Policy in Australia (Australian Government, Department of Health and Aging, 2010). The basic tenants of the argument are threefold:

a) Masculinities are presented as something endogenous to men and "reduces the causality of male ill-health largely to some internal (psychological) deficiencies" (p. 90);
b) Masculinities are thereby mainly used in a pejorative (rather than a neutral) way to explain men's poor health practices and outcomes. This presents a "deficit" view of men in relation to their health practices;
c) This approach promotes a "blame" discourse, having too strong an emphasis on personal behaviour, that deflects attention from how exogenous factors, specifically how social and political factors, influence men's health practices and outcomes.

In short, for Macdonald, masculinities should be dispensed with as it represents both a false cultural and false social pathological explanation for men's health practices and outcomes. What he advocates instead is a strengths-based and social determinants approach to men's health. We have a great deal of empathy with much of this argument. Masculinities are often used in a wholly negative way when considering men's health, and insufficient attention is indeed given to the influence of the wider socio-economic context. As mentioned *apropos* earlier critiques in this article, singular conceptualisations of masculinity that collapse into "essentialist," individualised notions fail to recognise the socially contingent and complex nature of men's practices and the dynamic interplay of power and agency within men's intersubjective encounters and within social institutions. In the health area, we have previously highlighted the importance for health professionals of working with positive aspects of male identity whilst not neglecting to recognise how gender power relations are institutionalised often to the detriment of women (Robertson & Williams, 2007). We have also argued strongly for recognition that the current dominant ideology in public health policy is grounded in a perspective that emphasises biomedical, neo-liberal and psychological explanations of health which neglect the relationship between gender, poverty, and concomitant inequalities when planning preventive health work with men (Williams, Robertson & Hewison, 2009). However, unlike Macdonald, we make clear that adequate conceptualisations of masculinities and gender relations are key to understanding the impact

of wider social determinants on health inequalities and this point is also well argued in the work of other gender and health academics (e.g., Annandale & Hunt, 2000; Creighton & Oliffe, 2010; Dolan, 2011; Evans, Frank et al., 2010; Lohan, 2007).

Representation of the critiques outlined in this section has been necessarily brief and does not fully reflect some of the nuances and complexities within the arguments these authors make. Nevertheless, they identify the main themes within these three areas of work. Whilst they provide some excellent insights into issues of concern around masculinities, none are sufficiently robust as they stand to throw the boy out with his bathwater. What is certain when considering these critiques is the need to be clear, precise and consistent in the development and deployment of an adequate conceptualisation that can help overcome these concerns and it is to this that we now turn our attention.

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PART TWO:
FURTHER CONCEPTUALISING "MASCULINITIES"

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Within this section we consider what represents the main components of an adequate conceptualisation of "masculinities." When exploring each of the main components, published empirical examples are used to illustrate the case being made.

Component One: Masculinities should be seen as "configurations of social practice" and understood as part of the dynamic processes involved within the "gender order." Addressing some of the concerns highlighted in the first part of this article, rather than seeing masculinity as singular and consisting (to greater or lesser degrees) of the character types, or attributes held by individuals, masculinities should be recognised as diverse processes of arranging and "doing" social practices that operate in individual and collective settings, that is, what Connell (1995) terms "configurations of practice". Masculinities therefore are not "essential" aspects of the (male) self but are conceptualised as occurring within (generated through and impacting upon) sets of social relations and specifically as part of the wider dynamic of gender relations. Importantly, such a conceptualisation helps us see how men can be involved in changing and contradictory practices in different times and places. O'Brien, Hunt and Hart's (2005) research, for example, shows how men's previous practices around not seeking help shifted for men who had experienced various aspects of ill-health:

> Before I'd say "alright I'll just go on and not see anyone." [...] You didn't tend to go to the doctors you know, well I didn't. It was only when I got the pains in my heart that made me go to the doctor. I wouldn't hesitate now if I had to go to the doctor's if I felt anything was wrong. (p. 510)

They also found that fire-fighters interviewed for the same study held positive views of help-seeking, even when well, in order to ensure their ability to work was not jeopardised (p. 514). What they conclude is that "men's reluctance to consult could be understood with reference to a 'hierarchy of threats' to masculinity" (p. 514). Configurations of practice linked to maintaining competency within a specific male-oriented job (fire-fighting) meant that help-seeking to stay well did not pose a threat to identity, in fact it was required within that context. However, for those men in the study seeking help for depression, discursively constructed as a "feminine" complaint, did seem to pose an identity threat:

The very idea of going to the doctor if I feel, you know from personal experience, if I feel in any way down or in a depressed mood.… If I was a woman I'd probably go to the doctor and get some … antidepressants.… But as a man you just pull your socks up. (p. 511)

Evident here and elsewhere (Johnson et al., 2012; Oliffe et al., 2012) are the contexts whereby help-seeking can be normalised or avoided based on the context and ailment, with varying levels of stigma influencing men to deny the need for mental health care or take control toward mustering resources to recover from depression. This also has relevance to Macdonald's critique outlined above. It seems likely that the cause of men's physical and/or mental ill-health, and the help-seeking for such issues, are strongly linked to social class, socio-economic status and culture permeated by this rather than abstracted to individualised masculinities. For example, in the UK, social deprivation has been shown to have a greater influence on mortality for men than for women (ONS, 2012) and on attendance in a national male only screening programme (Crilly et al., 2015). Nevertheless, as seen here, constructions of masculinities play a significant role in also affecting men's material practices in relation to how they deal, or don't deal, with various aspects of emotionality, the body and well-being. In addition, as we shall see shortly, gender relations and configurations of gender practices are embedded within social structures and are therefore fully implicated in the generation of social determinants and concomitant health inequalities.

Component Two: These "configurations of practice" vary but are hierarchical in terms of the material and representational benefits they bring. Whilst configurations of practice vary, some are dominant over others; that is, some arrangements of social practice are "hegemonic" being seen to have greater status or being held in higher value than others. Thus, whilst variable, power still remains more invested in some masculinities, some gendered arrangements and processes, than in others. Understanding configurations as hierarchical allows us to consider the contradictory nature of individual men's health practices (how they vary in different settings), to explore differences within and between groups of men, and to understand how the subordinating/marginalising of some configurations of practice creates diverse health practices.

We have already seen how men's practices are often arranged around a "hierarchy of threats" to masculinities that impact upon health. The interplay of gender with other structures such as social class, ethnicity, sexuality and disability creates particular relationships to masculinities. For example, work by Robertson (2006) shows the identity disruption and related psychological impact that can occur when men cannot live up to (hierarchically) dominant configurations of masculinities due to physical impairment:

I: "Has that [becoming physically impaired] changed the way you think of yourself as a man?"
Vernon: "Yeah, 'cause though you know you're still a man, I've ended up in a chair, and I don't feel like a red blooded man. I don't feel I can handle 10 pints and get a woman and just do the business with them and forget it, like most young people do. You feel compromised and still sort of feeling like 'will I be able to satisfy my partner'! Not just sexually, other ways, like DIY, jobs round the house and all sorts." (p. 445)

The aforementioned quote from Vernon draws on aspects of what is normative in terms of (hegemonic) male bodies and behaviour (drinking, sexual prowess, and skilled labour)

to explain how his increasing physical impairment impacts on his sense of male self. But this is not just concerned with the level of the individual. As Shakespeare (1994) suggests, and Vernon's narrative attests, the representation of disabled people as "other" also acts as a visual reminder to able-bodied people of their own potential vulnerability, challenging notions of bodily invincibility, and this is intrinsically tied up with masculinities through concerns with potency, supremacy and domination. Vernon also references these masculine ideals as those that women want in a man. In this respect heterosexual gender relations are implied as contingent on the able bodied man fulfilling his role(s) in order to sustain the relationship.

This is not just about matters of representation. Hierarchies of masculinities also determine access to material resources, as Robertson (2006) goes on to highlight:

> We actually went up to the Job Centre, well we couldn't actually get into the Job Centre 'cause the Disability Officer was upstairs.… They actually came down and discussed my case in front of everyone, I couldn't believe it, just couldn't believe it. (p. 448)

Only three of the six disabled men interviewed in this study were in employment and these three all worked in "aspects of the disability industry" often having to take a substantial reduction in income after becoming impaired (Robertson, 2006, p. 449) confirming how society is structured to value these men less when they cannot perform particular (normative hegemonic) configurations of masculinities. Representations of masculinities and the materiality attached to hierarchies of configurations of practice become wrapped around each other to create and sustain unequal socio-economic patterns, and this occurs as particular dominant configurations shape social institutions. It is this that we now consider.

Component Three: Configurations of masculinities practice become embedded within institutions and social structures. Through emergent and often subtle processes, dominant configurations of practice become embedded within social institutions and structures thus acting to replicate, support and maintain the gender order. In this way, masculinities should be conceptualised as structuring forces. Recognising that hegemonic configurations of gendered practice are embedded in social structures allows us to understand the role that structural power plays in determining men's health practices and thereby avoid essentialising notions around "difference."

For example, it allows us to understand the over-representation of Black men in certain areas of mental health services, and their concentration at the "hard end" of services and treatment options (e.g., secure units, more physical treatment like ECT, neuroleptics, seclusion) not as a result of biological or psychological make-up but as an example of the historical, hierarchical subordinating of particular configurations of gendered practice within social institutions (McKeown, Robertson, Habte-Mariam, & Stowell-Smith, 2008). Furthermore, in a study with African and African Caribbean fathers, Williams and colleagues (Williams, 2007; Williams, Hewison, Wildman & Roskell, 2011) found that the men were reflexive about, and tried to resist, the negative health outcomes linked to the structural constraints they encountered in their everyday lives. For example, one father stated:

> [In spite of] institutionalised racism and prejudice and lack of opportunities, the man still has to be strong … because he has to be resilient … to the best of his ability … because when he's in contact with his child now … she may be affected by the

trauma that he's going through … which will cause him or her to be a product of the negativity. (Williams et al., 2012, p. 93)

The concept "strength" here is used to convey the need for resilience in dealing with wider social constraints and limited life opportunities. Such resilience is necessary if men who are fathers are to deal with poverty, the fear of Black men by White health professionals within healthcare and racism within wider social institutions in order to ultimately maintain and protect child and family health.

This work is important in addressing some of the post-modern critiques around the fragmented and fluid nature of masculinities and the associated dispersed nature of power. Whilst individual men do move into and out of varied gendered subject (identity) positions in differing social contexts, the embedding of dominant (hegemonic) forms also creates situations where power becomes predominantly centred in structures that act to replicate current gendered hierarchies and hegemonic configurations by actively subordinating and marginalising other configurations. That is not to say that there is no resistance or challenge to these structures, nor should it imply that gender norms and roles are unimportant to individual men especially in specific local contexts and inter-personal relationships. But even where this is the case, identities are often developed or performed with reference to the hegemonic standard (see de Visser & Smith, 2006, p. 693), and deviations from hegemonic configurations in one area are routinely compensated for by developing "masculine capital" in another area (de Visser, Smith & McDonnell, 2009). Significantly, and again in contrast to some more extreme post-modern views of identity as being about choosing from "free floating signs and signifiers," this embedding of power within social structures therefore acts to constrain the subject positions available to men and to specific groups of men in particular. As Griffith (2012) poignantly reminds us, men's health is rooted in structures shaped by race and ethnicity—which in turn have important social, political, economic and cultural meaning.

Component Four: Because of this embedding, the opportunities available to men to engage in varied configurations become constrained by social structures. This embedding of masculinities within social structures allows us to understand that whilst men's health (and other) practices are diverse; they are not simply a matter of "free choice." Power invested in social structures does not determine action in a simplistic sense, individual men's conceptualisation of gender roles and norms clearly impact their health priorities, but it does limit and constrain the choices available; that is, it acts to encourage particular configurations of gendered practice and restricts others.

Dolan's (2007, 2011) work around working class masculinities and health provides useful examples of how these constraints operate. Whilst all the men in his study (Dolan, 2011, p. 590) portrayed their relationship with their family as that of "provider," many experienced high levels of unemployment and a related "depth of hardship":

Bob: "Christmas wasn't what I liked it to be.… We managed to get the children a couple of presents, the rest came from second hand places. And the church donated some.… If any father turns round and likes that idea, no… We were struggling, just getting the food and this, that and the other." (p. 591)

Whilst Bob clearly wishes to comply with (hegemonic) configurations as provider for his family, he is constrained from doing so through the situation within his socio-economically

deprived locality. This pressure to meet expected gender norms, yet being constrained from doing so by his lack of masculine capital, is clearly a source of personal strain for Bob that will impact his health and wellbeing.

For those men in work, there were also constraints to the configurations of practice they would engage in (to their agency) that were held in place through (structural) representations of normative (male) behaviour in manual labour employment contexts and linked threats to access to material resources:

> *Chris*: There is a culture of toughness and being macho and running up the ladder as fast as you can with no harness on.… Sometimes I'd think "I fucking well don't want to go up this ladder. I'm shit scared but I have to." … You're seen as a troublemaker if you don't do it.… You can loose your job. (p. 592)

Far from a tendency for notions of masculinities to "de-contextualise the body and behaviour of men" as Macdonald (2011, p. 91) suggests, Dolan's work here shows how an understanding of the embedding of particular configurations of masculinities help fully elucidate the lived experiences of working class men within socio-economically deprived localities. Macdonald rightly points out the health impact on men of hard manual labouring jobs, which "demand considerable physical output" (2006, p. 457). But, in not recognising the role that the embedding of particular configurations of masculinities plays in generating risk and harm in such settings, as exemplified with Chris above, he fails to elaborate fully the causal mechanisms that generate the gendered health inequalities which are of concern. Specifically, absent are linkages between structure and agency. Recognising this embedding of particular configurations of practice in specific places and spaces does not constitute a "victim blaming" or "deficit" model. What it does is show the importance of conceptualising masculinities as part of a wider set of hierarchical gender relations that helps our understanding of how particular social practices are facilitated and constrained in specific social contexts. It helps demonstrate how masculinities are both formed within such settings and how they also act to produce and replicate them. In this sense, masculinities can be recognised as both the producer and product of both structure and agency. Evident also are how workplace hierarchies and gendered relations and the co-construction of masculinities can forge risk-taking in specific contexts to coerce some men to operate outside of the comfort zones (Oliffe & Han, 2014).

PART THREE:
IMPLICATIONS FOR MEN'S HEALTH

Whilst elements of the discussion so far have alluded to the implications of these debates about masculinities to the field of men's health, this section aims to draw these out more fully.

Recognising that men are involved in changing and contradictory practices—that they move in and out of different configurations of gender practices in different contexts—should influence both our approach to research in the field, and the ways that health work with men is developed and applied. Within the research arena it means using approaches and methods that can help identify and understand these points of contradiction looking for where, when and why they occur as a way of helping us understand how 'doing gender' links to 'doing health' for men. For practice it means taking such research findings and using them to develop interventions that are most likely to engender, legitimate and embed positive configurations of practice.

Oliffe et al.'s (2010) work with fathers who smoke provides a poignant example for how descriptive findings can be transitioned toward aiding men's efforts to reduce or quit smoking. For example, one man shared the following details about how his smoking had changed since becoming a father.

> Well, I would never smoke in front of her [wife], like I would never contaminate the air that was around her and then even with our daughter, I would never smoke in front of her. I never wanted her to see me smoking and then even when I was done I'd go right to the bathroom, wash my hands, wash my face. I'd wear a jacket outside so my shirt didn't smell as bad.

Evident here is the father's commitment to protecting his daughter and wife, and in the wider context of the article participants also accepted that being smoke-free was ultimately contingent on their will power and discipline. Masculinities connecting to determination and protector and provider roles abound in this context, in turn signaling how strategies devoid of shame, blame and stigma will best support and mobilize fathers' efforts to be smoke-free (Oliffe, Bottorff & Sarbit, 2012).

Following on, that configurations of masculinities practices are recognised as hierarchical should ensure that health research funding is focused on groups of men most likely to be restricted to marginalised and subordinated configurations linking in to the important health inequities agenda. It should further help focus men's health practice on approaches that look to empower such groups of men both personally and materially in ways that generate better health outcomes. For example, work with men from areas of deprivation using soccer as an engagement tool has helped generate positive social interactions allowing men to see new possibilities for action, new ways of living that help them move away from previously damaging and chaotic environments and lifestyles (Robertson et al., 2013). That is, it has facilitated these men's engagement in positive configurations of practice that has benefit both for them and those around them. Such work can, to some extent, improve access to material resources as men gain confidence in new social practices and in their ability to move confidently into new areas of life such as volunteering, education and employment. As has been shown using the theoretical framework of Bourdieu, such interventions need to target field (the settings used by men), habitus (those dispositions men have that lead to action) and capital (the resources they have access to) if they are to address relationships between social positions and structural hierarchies and therefore generate sustained changes in men's social practices (Robinson & Robertson, 2014).

As yet, insufficient research has been completed considering the health impacts of the embedding of particular configurations of masculinities within social structures. Whilst useful theoretical work has emerged around this area (e.g., Lohan, 2007; Scott-Samuel, Crawshaw & Oakley, 2015; Williams et al., 2009) there is not yet a substantive body of empirical work that considers the links between the nuanced qualitative work on various men's narratives of health with wider social structures.

There are important policy implications when understanding masculinities as we conceptualise them in this article. Noting how the embedding of hegemonic forms of masculinities restricts and constrains the opportunities for certain groups of men means ensuring that social policy (housing, education, employment as well as direct health policies) acts in a way that reduces inequality and inequity. Health promotion policies that are built on and implemented within an individualist framework (as most are within neoliberal policy environments that encourage a move away from welfare) can inadvertently act to increase in-

equalities by favouring those in hegemonically privileged positions. The work of Lorenc et al. (2013) demonstrates how certain "downstream" preventative health programmes lead to what they term *intervention-generated inequality* as the latter act, albeit unintentionally, to benefit already advantaged groups, whereas interventions with a focus on provision of resources and fiscal interventions show evidence of reducing health inequalities. This links to other work (Scott-Samuel et al., 2015; Williams et al., 2009) which suggests that policies such as redistributive taxation, increases in the minimum wage, investment in good quality, affordable housing and addressing unemployment and under-employment, would be by far the most effective for improving men's health outcomes. It is these policy approaches which create the structural conditions that promote the opportunities for men to engage in positive social, including health, configurations of practice.

The notion of maintaining the concept "masculinities" in health research with men is not therefore an abstract issue of concern. Providing the concept is adequately understood and applied it has resonance for the way we design and carry out research but also for how this can be translated into practice and the implications it has for how policy to improve men's health would best be developed.

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Conclusion

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Critiques of notions of masculinities over the last 15 years have been helpful in guarding against the continued use of naïve forms of conceptualisation and their application. Work from within the CSM field and post-modern critiques have highlighted how insufficient attention is often paid to exactly what is being suggested when masculinities are named and the concept not clearly defined when deployed in the literature. Both these critiques also show how this can result in a collapse to singular, essentialist ideas that individualise masculinity (and to a lesser extent masculinities) as character types that act to homogenise "how men are." Such endogenous views, it is argued, also act to present masculinities (rather than men's material practices) as a cause of social problems—including health problems. However, whilst in agreement about the need to dispense with masculinities because of the causal powers attributed, critiques vary in how the subsequent vacuum can be addressed. For Hearn (1996, 2004) what is needed is a focus on what men do: the range of their material and discursive practices and the specific ways that these practices act to generate and sustain systems of domination in varied contexts. For Macdonald (2011), however, the answer is to focus on men's strengths and to recognise the importance of social determinants on men's health outcomes. We suggest that adequately conceptualising masculinities can play a vital role in elucidating how men's health practices impact on social relations in creating and sustaining gendered hierarchies. We argue that masculinities should be seen as "configurations of social practice" and understood as part of the dynamic processes involved within the "gender order." Configurations of practice vary, they are diverse and dynamic but they are also hierarchical in terms of the material and representational benefits they bring. Furthermore, dominant configurations of masculinities practices are embedded within institutions and social structures and hence the opportunities available to men to engage in varied configurations can be constrained by these social structures. Masculinities, then, should be conceptualised as both the producer and product of both social structures and human agency. We believe these conceptual concerns are important as they inform thinking, writing and empirical research but are also vital in effectively informing transformation in men's health practices and policy (Williams, Robertson, & Hewison, 2009).

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