Men's Health Studies: Origins and Trends

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Abstract. This article provides a brief outline of the development of men's health studies in the United States. Research on men's health is discussed within critical feminist theories that highlight the reciprocality of gender relations as well as power differences between men and women and among male subgroups. A relational theory of gender and health is used to identify both positive-gendered and negative-gendered health synergies that influence the health processes and outcomes of men and women. Several examples of gendered health synergies are presented to illustrate key concepts. Finally, some directions for future research and advocacy with reference to men's health are outlined.

Key Words: feminist theory, gender, health synergies, men's health studies, masculinity, reciprocality, relational theory

The phrase *men's health,* loosely referring to an array of men's health concerns such as prostate cancer, impotence, and baldness, came into popular use in the 1990s. Trade books and magazines such as *Men's Health* or *Men's Fitness* now promote a healthy lifestyle for men by offering information on strength-and-conditioning regimens, nutrition, vitamin therapy, stress management, hygiene, and sexual potency. Some hospitals, medical centers, public health departments, and college health services now gear portions of their clinical services, health promotion programs, and marketing strategies to meet men's health needs. These approaches to men's health focus almost totally on men's bodies, organismic functions, and physical vitality or susceptibility to illness.

By contrast, the phrase *men's health studies* refers to the systematic analysis of men's health and illness that takes gender and gender health equity into theoretical account.[1,2] Gender is seen as a key influence on the patterning of men's health risks, the ways men perceive and use their bodies, and men's psychosocial adjustments to illness itself. Rather than conceptualizing men's health strictly in terms of male physiology or biological sex differences, the term *gender* refers to expectations and behaviors that individuals learn about femininity and masculinity. Variations in men's health are understood as unfolding within the larger social, cultural, and political contexts of gender relations that have emerged historically and largely revolve around inequality between the sexes and among various strata of men.

In this article, I first trace the origins of men's health studies, situating development of the field in a general historical context. Second, I discuss the study of men's health within the context of critical feminist theories and emerging theories of men and masculinities. Next, I outline and illustrate a relational theory for understanding men's health in an effort to integrate the study of men's health with studies of women's health. Finally, I recommend some future directions for men's health studies.

ORIGINS AND TRENDS

During the last 3 decades, men's health studies have drawn from a variety of sources, including epidemiology, sociology, medical anthropology, feminist research and theory, men's studies, and the efforts of feminist-identified men to rethink men's health and illness. The following thumbnail sketch shows how men's health studies took shape and evolved.

Early Understandings of Men's Health: The 1970s

The sociocultural model for understanding health and illness developed in sociological circles during the 1960s, challenging the biological determinism and reductionism of the traditional "biomedical model."[3] Sociocultural explanations of health and illness emphasized the influences of cultural practices, social conditions, emotions, environment,

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and personal beliefs. At first, researchers used a basic "add-and-stir" approach that treated "sex" (a biological category) as another demographic variable for identifying health patterns and risk factors. This approach proved useful in epidemiologic research that focused on identifying and describing differential rates of morbidity and mortality between women and men.[4,5] Data showed, for example, that men experience more life-threatening diseases and die earlier than women do, that women utilize healthcare services more than men do, and that women experience more non-life-threatening illnesses than men do.

These early descriptive examinations of gender and health were soon intersected by the growth of feminist theory and women's health movements. Some feminist researchers studied the influence of gender stereotypes on the diagnosis and treatment of women,[6–8] whereas others documented patterns of sex discrimination in the healthcare professions and medical education.[9] Feminist historians traced the marginalization and persecution of women healers during the Middle Ages.[10,11] Health promotion and women's health advocacy groups were formed across the country. The Boston Women's Health Collective's self-help book, *Our Bodies Our Selves*[12] became the banner-head compendium of the women's health movement, combining a feminist critique of the American healthcare delivery system with a comprehensive health promotion package.

One limitation of most of the early research, theory, and educational advocacy in relation to gender and health, however, was that it centered almost exclusively on women. Men were basically outside the networks of women's health scholars, researchers, and advocates. The civil rights struggle, anti-war movement, counterculture, or sexual revolution of the 1970s became a catalyst for social and personal change for some men. And some men responded to feminism, particularly on university campuses, by asking questions about sexism, gender roles, and male chauvinism.

Other men were silent about or angered by feminism, perplexed by feminists, and unsure of how the call for a transformation of gender relations applied to them. Even among the men who were interested in gender issues, however, men's health issues received minimal attention. For example, the second national Men and Masculinity Conference in 1976, a gathering of pro-feminist activists and scholars, included no major workshops devoted to men's physical health concerns. Likewise, early writings on men's liberation typically did not focus on men's health.[13,14] However, several popular writers, such as Marc Feigen-Fasteau,[15] Warren Farrell,[16] and Herb Goldberg,[17,18] did discuss some purported health risks associated with men's overinvestment in work, careerism, striving for success, and aggression. A few authors provided a biomedical tour of male physiology and hygienic concerns, but without any analysis of gender relations or evaluation of masculinity.[19,20]

In summary, the thinking about men's health during the 1970s was exploratory, tangentially informed by feminist theory and politics, and conceptually organized around the general premise that men's conformity to traditional masculinity produced certain health deficits. This latter deficit model for understanding men's health would be elaborated during the 1980s.

Sex-Role Theory and Men's Health: The 1980s

The analysis of men's health issues was advanced during the 1980s by increasing scholarly dialogue around "the study of men and masculinity," or what Brod[21] eventually dubbed the "new men's studies." Sex-role theorists elaborated on the basic 1970s assertion that aspects of traditional masculinity were potentially lethal. They saw masculinity as an inner, psychic process that is tied to an outer web of sex roles and gender expectations. Boys were said to be socialized to emulate masculine behaviors that, in turn, put them at risk for illness and early mortality. For example, an adolescent male may do some hard drinking and reckless driving to win acceptance from his peers, thereby hiking the risk for accidents. A middle-aged man's adherence to the manly code of toughness and stoicism might foment his denial of symptoms of coronary heart disease. As Harrison and associates[22] explained in 1988, ". . . the greater mortality rate of men is at least partially a consequence of the demands of the male role and emphasizes the ways in which male-role expectations have a deleterious effect on men's lives, and possibly contribute to men's higher morality rate" (p271).

Stillion[23] used sex-role theory to examine differences in the ways that women and men perceived and experienced illness and death. Sabo et al[24] tapped sex-role theory to explain the psychosocial reactions and adjustments of male partners of women who had been diagnosed and treated for breast cancer. Researchers also examined links between gender identity and coronary-prone behavior[25,26] and men's perceptions of risk for testicular cancer.[27–29]

Politically, the 1980s also saw the growth of men's movements in the United States.[30] Men affiliated with the National Organization for Men against Sexism (NOMAS) explored gender issues as varied as men's violence against women, spirituality, reproductive rights, men and pornography, homophobia, bisexuality and gay rights, including men's health. A workshop at the 1981 NOMAS conference, titled "Men's Awareness of Sexual Health," dealt with testicular self-examination, prostate examination, sexual anatomy, sexually transmitted diseases (STDs), and birth control (Men and Masculinity 7th National Conference program, June 12–16, 1981).

Gay rights activism grew during the 1980s and many gay and bisexual men developed a greater awareness of the health risks linked to some of their sexual behaviors. HIV infection became a leading cause of death among men, especially gay and bisexual men. More gay men became open about their identities and relationships, and health educators (both straight and gay) began to push for more health promotion and services for men. Workshops and educational materials were created that addressed mental and physical health, safe sex practices, and HIV prevention. Such efforts to enhance the health of gay and bisexual men were thwarted by homophobia, discrimination, and govern-

mental and public indifference. The links between masculinity and gay men's health risks, however, did not receive a lot of attention.[31]

Like gay men, men of color faced widespread discrimination and prejudice and, compared with Whites, they showed markedly higher rates of morbidity and mortality.[32] But although analyses of minority men's health problems highlighted economic inequalities and racism, very little emphasis was attached to gender analysis or a critique of traditional masculinity.

In summary, research on men's health was not plentiful during the 1980s, and sex-role theory remained the prevailing explanatory framework for understanding men's health. The focus on gender did expand in epidemiology, medical sociology, and interdisciplinary studies of psychosocial aspects of illness.[33,34] Men's studies became more popular in academe and the National Men's Studies Association was formed to stimulate writing and research on men's lives and gender issues. But the formal study of men's health remained only a small and incipient part of 1980s gender and health research and writing.

Critical Feminist Perspectives of Masculinities and Health: The 1990s

Critical feminist analyses of men, masculinity, and health emerged during the 1990s.[1] Building on a critique of sex-role theory's narrow focus on gender identity, socialization, and conformity to role expectations, critical feminist thinkers stressed that power differences shape relationships between men and women, women and women, and men and men. They also contended that gender identity and behavior are not simply imposed on individuals by socialization, but that individuals actively construct their gender identity and behavior.[35,36] Gender identity is actively worked out, revamped, and maintained by individuals who are immersed in socially and historically constructed webs of power relations.[37,38] The notion of "gender identity," therefore, refers ostensibly to the realm of the personal but, more accurately, to individual manifestations of masculine or feminine traits and cultural practices that are better understood as expressions of wider institutional processes.

In short, gender identity is best viewed as culturally patterned or shared identity and is not individual identity per se. Finally, in keeping with larger trends in feminist theory, men's health scholars tried to integrate an analysis of how race, ethnicity, class, and sexual orientation interface with gender to shape men's health processes and outcomes.[39]

By the end of the 1990s, various men's health issues, including testicular cancer, diseases of the prostate, alcohol abuse, HIV/AIDS, suicide, violence, and sports injury, were receiving attention from feminist-identified scholars. Researchers and health advocates also identified specific groups of men with unique health risks and needs—adolescent males, men of color, gay and bisexual men, prison inmates, poor men, homeless men, jobless men, male athletes, elderly men, and male caretakers. Courtenay[39,40] developed the most thorough theoretical framework for understanding the gendered aspects of men's health.[2,41–43] The following analysis of masculinities and health risks reviews some recent research within a critical feminist framework.

RECIPROCALITY, MASCULINITIES, AND HEALTH RISKS

In every society, men's and women's lives are inexorably reciprocal and bound up with one another. Cultural definitions of masculinity and femininity are historically emergent, structurally dynamic constructs through which individuals and groups actively interpret, engage, and construct their daily behaviors and relationships.[31,44,45] The social construction of different types of masculinities and femininities, both individually and collectively, produces different kinds of health outcomes within each sex and between the sexes.

Health and the Construction of Gender Identities

Individuals "do gender,"[46] that is, they actively work out, revamp, and maintain their gender identity while negotiating with socially and historically constructed webs of power relations.[1] The construction of masculinity is often associated with unhealthy behaviors which, in turn, place males at risk for morbidity and mortality.[42] Within a constructionist framework, Courtenay[39,40] argues that men in the United States actively use health behaviors in ways that influence their risk for illness. Whereas many gender scripts for women encourage them to be knowledgeable about their bodies, to recognize susceptibility to illness, or to express their emotions, the gender scripts for men often lead to unhealthy behaviors. In fact, as Courtenay[41] explains, males often use risky behavior to demonstrate their masculinity to themselves and others. He writes:

> A man who does gender correctly would be relatively unconcerned about his health and well-being in general. He would see himself as stronger, both physically and emotionally, than most women. He would think of himself as independent, not needing to be nurtured by others. He would be unlikely to ask others for help. He would spend much time out in the world and away from home. The intense and active stimulation of his senses would be something he would come to depend on. He would face danger fearlessly, take risk frequently, and have little concern for his own safety.[41(p21)]

Men's gender identities are not constructed solely within the confines of men's lives or even with exclusive reference to masculinity. Rather, men also do gender in perceived relation to women and cultural definitions of femininity. Connell[38] theorizes the social constructions of masculinity and femininity with reference to "hegemonic masculinity" and "emphasized femininity." *Hegemonic masculinity* refers to the prevailing, most lauded, idealized, and valorized form of masculinity in a historical setting. In the United States, hegemonic masculinity accentuates male dominance over women, physical strength, proneness to violence, emotional inexpressivity, and competitiveness.

Conformity to hegemonic masculinity can pose health risks for men. For example, a man who conforms to hege-

monic masculinity by consistently denying symptoms or pain may establish himself as brave or manly before his wife or friends but may also increase his risk for developing more chronic disease.[47]

The concept of *emphasized femininity* represents the cultural ideal that is celebrated for women, namely, sociability, fragility, passivity, compliance with men's desires, and sexual receptivity. Emphasized femininity is constructed in reciprocal and subordinated relation to hegemonic masculinity in ways that reinforce (or reconstitute) masculine power and male-dominated hierarchies within varying institutions. Elements of emphasized femininity can negatively influence women's health. In many western societies, for example, conformity to emphasized femininity has been associated with elevated risks for anorexia and bulimia.[48,49]

The concepts of hegemonic masculinity and emphasized femininity provide insights into the gendering of men's health behavior and outcome in two ways. First, they help reveal ways that gender identity construction influences health behavior and outcome across subgroups of men. Men are not all alike, nor do all men have the same stakes in maintaining or the resources for pursuing hegemonic definitions of masculinity. At any given historical moment, there are competing masculinities—some dominant, some marginalized, and some stigmatized—each with its respective structural, psychosocial, and cultural moorings. With reference to health, there are, first, substantial differences between the health options of homeless men, working-class men, underclass men, gay men, men with AIDS, and middle-class or upper-class White, professional men. Second, men's health can be assessed within homosocial or sex-segregated institutional settings. For example, prisons or the military are key institutional sites for the reproduction of hegemonic masculinity in the form of toughness, proneness to violence, hardness, stoicism, and homophobia.

The Construction of Masculinities and Women's Health

Social constructionism and hegemony theory can promote an awareness of the relational processes surrounding the gendering of the health behaviors and outcomes for women and men. As Connell[38] puts it,

> "Hegemonic masculinity" is always constructed in relation to various subordinated masculinities as well as in relation to women. The interplay between different forms of masculinity is an important part of how a patriarchal social order works. (p183)

A study by Pleck and Sonenstein[50] illustrates the reciprocal dynamics suffusing men's and women's gender identity construction and health outcomes. They applied critical feminist perspectives to research on problem behaviors and health among adolescent males. A national sample of adolescent, never-married males aged 15 to 19 years were interviewed in 1988. Hypothesis tests were geared to assessing whether "masculinity ideology" (which measured traits associated with hegemonic masculinity) put boys at risk for an array of problem behaviors. The researchers found a significant independent association with seven problem behaviors. Specifically, masculinity ideology was associated with being suspended from school, drinking and use of street drugs, frequency of being picked up by the police, being sexually active, the number of heterosexual partners in the last year, and tricking or forcing someone to have sex. These kinds of behaviors, which are, in part, expressions of hegemonic masculinity, elevate boys' risks for STDs, HIV transmission, and early death by accident or homicide. At the same time, however, these behaviors can also encourage the victimization of women through men's violence, sexual assault, unwanted teenage pregnancy, and STDs.

Similarly, Asencio[51] studied the beliefs and rationales for gender-based violence among predominantly second-generation, mainland Puerto Rican adolescents. She shows how gender expectations that distinguished between "machos" and "sluts" influenced enactments of sexual aggression and physical violence against women, as well as fighting among the young men. Homophobia also shaped the gender-based violence in this adolescent subculture.

Institutional Contexts

In addition to thinking about how gender influences health behavior in the contexts of individual gender identity development and interpersonal relationships between men and women, one can also consider how reciprocal gender relations have an impact on health in varying institutional contexts. Institutions are basically dynamic social and cultural processes that emerge historically and eventually surround and inform day-to-day life. Institutional processes foster certain types of behavior and identity while they constrain other kinds of social activity or personal expressions.

Different patterns of institutional relations between men and women, or between elite men and lower status men, influence health processes and outcomes in different ways. The institution of war, for example, has historically exacted high rates of morbidity and mortality among the disproportionately high numbers of men who fight in battles. Warriors were taught to conform to a type of hegemonic masculinity that embodies violence proneness, toughness, and obedience to male authority. The negative health consequences of war for both sexes are painfully evident. Many boys and men who are disproportionately enlisted to fight in wars are killed or physically and psychologically maimed, whereas elite male groups may profit or solidify political power through warfare. Men's violence on the patriarchal battlefields also often spills over into civilian populations, where women and children are victimized.[52,53]

As Sen[54] observes, "Historically, wars between nations, classes, castes, races, have been fought on the battlefield on the bodies of men, and off the battlefield on the bodies of women" (p12).

Other institutional settings in which to study the links between gender and health include the family, prisons, urban gangs, fraternities, or sports. Each particular institution can be thought of as a location in which overarching social hierarchies have historically tended to reproduce

men's collective domination of women and exploitative relations between elite and lower status men. We are just beginning to explore how the constitution of gendered relations in these larger structuring processes influences the well-being of men and women.[39]

Toward A Relational Theory of Gender and Health

Today, the key challenge (or quandary) facing those who study gender and health is to develop theories and health promotion policies that address both women's and men's health needs. Simply put, researchers and health advocates need to build bridges across the seemingly separate subfields of women's health studies and men's health studies. Scientifically, the basic question is how the study of men's health can be integrated into a theory of women's health or gender and health? Or as Sabo and Gordon[1] ask, "How can men's health studies position itself in relation to women's health studies, women's studies, gender studies, or the feminist paradigm?" (p16). Politically, these issues revolve around women's and men's finding a place for men in feminist movements and, more specifically, mapping the roles men can play in relation to women's health movements.

The concept of reciprocality developed in the previous section calls attention to the fact that women's and men's lives and health are often relational in process and outcome.[2] Stated simply, the health of each sex is influenced by sociocultural synergies between the sexes. A *positive-gendered health synergy* exists when the pattern of gender relations promotes favorable health processes or outcomes for both sexes. A *negative-gendered health synergy* occurs when the pattern of gender relations is associated with unfavorable health processes or outcomes for one or both sexes. The examples of positive and negative health synergies discussed in the following section show how health behaviors and outcomes are influenced by reciprocal gender relations, across multiple levels of gender identity construction, interpersonal relations, and institutional dynamics.

Sexual Aggression Among College Male Athletes: Negative-Gendered Health Synergies

A small body of research has focused on male athlete violence against women. Two journalistic accounts have documented what appears to be a high rate of assaults on women by male professional athletes.[55,56] A scientific study of 20 National Collegiate Athletic Association Division I universities found that, although athletes made up 3.3% of the total student population, they committed 19% of the sexual assaults reported to judicial affairs offices.[57] Other researchers have found that college athletes are more likely than their nonathletic counterparts to sexually assault women.[58,59] A study of 925 undergraduate women found that male athletes were more likely than male nonathletes to be involved with sexual intimidation and assault.[60] Boeringer[61] found that male athletes were more likely than male nonathletes to use force, coercion, or drugs and alcohol during a sexual encounter.

Two ethnographic studies of the inner workings of university athlete subcultures revealed that sexual exploitation of women (ie, ridicule, casual sex, sharing partners, rape, and gang rape) was intricately tied to both individual and group constructions of hegemonic masculinity.[62,63] At times, men used sexual relations with women as a way of defining manly identity and bolstering their status among male peers. These studies also uncovered additional factors that were tied to male-athlete violence against women, such as alcohol and drug use, male bonding, chauvinism, sexism, predatory sexual attitudes, and the lack of accountability for transgressions.

Of course, the majority of male athletes and fraternity members do not rape women or advocate sexual violence against women. Yet, it appears that certain men's subcultures can foster rape-supportive attitudes and, among a disproportionate number of males, assaultive or exploitative behavior toward women. We also know that although many men may not actively engage in the sexually aggressive behaviors of their group, they will endorse other men's actions or keep silent about opposing such actions.[64] Men's failure to challenge or criticize the exploitative behavior of their peers is a form of complicit masculinity[37] (ie, when men appear to distance themselves from the direct oppression of women but, nonetheless, their behavior covertly supports men's patriarchal privilege and domination in relation to women).

Sexually assaultive behavior in all-male groups (such as athletic teams or fraternities) may also be linked to wider patterns of gender relations. Loy[65] tested the hypothesis that the forms of hegemonic masculinity that emerge within fratriarchal relations of patriarchal (male-dominated) cultures are likely to be associated with higher rates of gang rape of women. Using the Human Relations File as a cross-cultural data base, he found that the characteristics of agonal fratriarchies were significantly correlated with higher rates of both intermale violence and gang rape of women. Loy[66] later observed that athletic teams share the following features in common with other "modern tribal groups," such as fraternities, military groups, and youth gangs: ". . . they are competitive, peer based, age graded, segmentally bonded, male-dominated groups that emphasize the pursuit of prestige through physical prowess"; all support "violent performative masculine styles"; and they are involved with intense activities that are felt to be worthwhile for their own sake" (pp266, 267).

The extent to which some of men's athletic subcultures may foster or legitimate men's sexual aggression toward women can be seen as a negative-gendered health synergy. Women who are victimized risk pregnancy, exposure to STDs, psychological harm, and social ridicule or ostracism.

Men's Involvement in Pregnancy and Childcare: A Positive-Gendered Health Synergy

The larger transformations from agricultural to industrial and postindustrial societies have been generally associated with a waning of patriarchal traditions around men's and

women's involvement with domestic activity and parenting. As women have become more involved with the work sector, they have pressed men to take on a fair share of housework and childcare. However, men's contributions to domestic labor and parenting have not approached parity, and many women find themselves returning from jobs outside the home only to do most of the housework activities inside the home.[67] The double workload exacts a toll on working women's health and on the amount of time the women might devote to health-inducing exercise and physical activity.[68] Similarly, many women in developing nations are shouldering a double burden of domestic labor and childcare, as well as growing involvement in the economic sector. Increased workloads for women elevate their risk for morbidity and, once they become ill, they often have less opportunity to rest and recover.[69] Within the profeminist, woman-centered framework I am developing in this article, therefore, men's spousal and parental identities and behavior need to be transformed to achieve greater degrees of conjugal equality that, in turn, would help yield positive health outcomes for women and children.

Swedin[70] has studied the work patterns of Swedish couples inside and outside the home. He suggests that overall family health—for wife, husband, and child—is more likely to occur when spouses adopt a partnership model for negotiating the combined demands of childcare and occupational involvement. However, few couples achieve the ideal of shared parenthood, and one reason is that men often do not have a clear view of what role to play in relation to pregnancy, childbirth, and childcare. Swedin's research showed that, when men participate in "father training" groups, they were more likely to develop closer bonds with wives and healthier relationships with their children. Although such trends toward conjugal partnership may be producing positive-gendered health synergies in some postindustrial societies such as Canada, Sweden, and the United States, policies calling for "shared parenthood," "father training," or "paid parental leave" may not be as economically or politically feasible in developing nations.

Heterosexual Men's Sexual Quests: Negative-Gendered Health Synergies Between Women and Men

In many cultures, masculinity is equated with sexual virility. The following two examples describe patterns of heterosexual sexual behavior in two different cultures that can produce negative health impacts for both sexes.

Young males in the United States and Canada often learn to use sexual behavior as a way to establish masculine adequacy. Boys sometimes demonstrate manliness by reporting their sexual conquests to their peers. "Getting laid," becoming known as a "player," or having sex with many partners are perceived as earmarks of masculinity. Epidemiologically, young men's quests to establish manhood through multiple sexual contacts not only put them at greater risk for STDs but also place their female partners at risk. Just one man who has contracted chlamydia, for example, can spread it to his female partners. Annually, sexually transmitted infections partly contribute to the development of pelvic inflammatory disease (PID) in about one million American women, resulting in about 300,000 hospitalizations.[71] PID also puts women at greater risk for ectopic pregnancy and infertility.[72]

A study of the cultural practices used by Zimbabwean women and men to prepare for sex reveals clear links between gender identity construction, sexual behavior, and transmission of HIV.[73] The researchers describe how men's perceptions of coitus and masculine potency and women's use of vaginal drying agents and passive compliance in gearing up for the sex act to evoke male pleasure are putting women directly at risk for reproductive tract infection and HIV. Meanwhile, caught in the migrant labor system spawned by development, the men work in towns, factories, or mines and periodically visit their ancestral homes in villages that are maintained by wives. The husbands' philandering with girlfriends and prostitutes while they are away from home puts them at risk for contracting STDs and HIV, which they carry back to the conjugal bed. In short, the authors point to a confluence of etiologic factors that permeate and shape gender relations in ways that promote sexually transmitted infections.

The preceding two patterns of contagion (although from two ostensibly different cultures) show how men's pursuit of hegemonic masculinity through sexual conquests puts them and their female partners at greater risk for contracting STDs. Although the social construction of masculinity and femininity varies across these two cultural settings, a discernible overarching pattern of reciprocal relations and expectations between men and women that produces negative health risks for both sexes is also clear.

Homophobia, Risky Sex, and Sexually Transmitted Infection: Negative-Gendered Health Synergies

Homophobia and discrimination against gays and lesbians generally function as social control mechanisms that reinforce male hegemony in several ways. Homophobia not only marginalizes gay and bisexual men or men who are judged to act like women (effeminate men) but it also punishes lesbians who, within the gender binary of patriarchal culture, are censured for being "masculine." Thus, homophobia not only reinforces men's overall political and social dominance over women but also induces conformity to hegemonic masculinity and emphasized femininity. Homophobia also helps maintain intermale dominance hierarchies in which boys and men who do not conform to hegemonic masculinity are earmarked for ridicule, moral condemnation, and maltreatment.

Large numbers of both men and women participate in the marginalization of gays and lesbians within the larger gender order. The resulting stigmatization and differential treatment of gay and bisexual men can contribute to a variety of negative health impacts. For gay and bisexual men who are "in the closet," the ongoing experience of shame, anxiety, and stress can erode emotional and physical health.[74] Rates

of suicide are purportedly high among gay male adolescents.[74] When seeking medical services, gay and bisexual men must often cope with the homophobia of healthcare workers or deal with the threat of losing health insurance if their sexual orientation is made known.

Whether straight or gay, men tend to have more sexual contacts than women do, and recent work on male sexuality shows that men's sexual attitudes and behaviors are closely tied to the ways masculinity is socially constructed.[75,76]. Identification with hegemonic masculinities that emphasize competence, initiative, power, courage, and assertiveness, therefore, has been linked to risky sexual practices that, in turn, can elevate the risks for sexually transmitted infection. Kimmel and Levine[77] observe that, because traditional masculinity may inform the sexual activity of men in ways that produce barriers to safer sex, to "educate men about safe sex, then, means to confront the issues of masculinity" (p322).

Contrary to common myths about gay male effeminacy, masculinity influences gay and bisexual men's identity and behavior. Courtenay[47] found that more traditional beliefs about manhood among gay and bisexual men were associated with high-risk behavior. Diaz,[78] in a study of the sexual practices of Latino gay and bisexual men in the United States, for example, found that gender identity is central to the psychocultural barriers to AIDS prevention. Gay and bisexual men are a significant risk group within the larger US Latino population that is disproportionately overrepresented in respect to HIV-related mortality. For example, although data from the Centers for Disease Control and Prevention show that Latinos were about 9% of the population in June 1994, they constituted 17% of AIDS cases in the country.[78] Diaz argues that Latino boys internalize the "double bind of Latino machismo" (ie, that being a man is a special advantage and privilege, and that one must prove manhood in order to achieve it). That mindset becomes a core concern among straight, gay, and bisexual Latino men. Diaz hypothesizes that

> . . .even though it may appear somewhat counterintuitive, . . . gay-identified men who grow up in Latino cultures are more vulnerable to the machismo double bind and therefore would be more concerned and compelled to prove their masculinity than their heterosexual- or feminine-identified peers. (p229)

Using interview and focus-group data, Diaz[78] discovered that the pursuit of hegemonic masculinity among Latino gay and bisexual men, which is intensified by homophobia in the larger culture, was associated with higher rates of casual sex and unsafe sexual practices such as anal intercourse and failure to use condoms. One pathway revolves around gay men's fears of losing an erection if they use condoms for penetrative sex. Condoms may dull physical sensation or, more psychologically, gay male condom users may perceive that condoms may dull physical sensation, thereby making it more likely that they will lose their erection. The loss of erection represents a failure of manly efficacy.

These research findings point to a larger web of causality surrounding HIV infection and AIDS in the United States that constitutes a negative-gendered health synergy. Homophobia at once expresses and preserves sex inequalities between men and women and also maintains prevailing definitions of masculinity and femininity. In addition, homophobia operates as a policing mechanism within intermale dominance hierarchies, rewarding certain forms of masculinity and sanctioning others (dynamics of inclusion and exclusion), and often pitting "hard" and "tough" men against "soft" and "weak" men (eg, job loss, gay bashing).

Malevolence against gays and government policies or religious edicts that condemn homosexual sex tend to drive gay and bisexual sex underground.[79] In a psychocultural context, the identification with hegemonic masculinity and the anxieties around proving one's manhood appear to be linked to risky sexual behavior and higher rates of infection among gay and bisexual males.

Finally, the risky sexual behaviors and HIV transmission among gay and bisexual men do not unfold strictly within insulated "gay communities." Unlike their human hosts, viruses do not discriminate on the basis of sexual orientation, and pathogenesis among gay and bisexual men may follow pathways for contagion to the larger heterosexual population (and vice versa). Bisexual men obviously have sex with women, thereby representing a potential crossover between gay and straight populations. Furthermore, homophobia drives bisexual men underground, making them more likely (whether they are married or single) to keep the gay side of their lives secret, thus making safe sex with women even more problematic. In the end, homophobia is implicated in a highly complex web of structural, cultural, psychological, and biological processes that constitute a negative-gendered health synergy around sexual practices and risks for HIV infection.

DIRECTIONS FOR FUTURE RESEARCH AND ADVOCACY

Five recommendations can be made for men's health studies in the future. First, relational analyses of gender and health should receive more attention from scholars and public health proponents. The development of relational theories of gender and health would help women's and men's health advocates and educators work together rather than separately. Second, more quantitative and qualitative research that deepens current understanding of the health needs and behaviors of boys and men is needed. Third, health educators and men's health advocates should create effective ways to help men assess how gender influences their health behaviors and outcomes.

Fourth, the emerging dialogue around the health of boys and men in public health circles has largely focused on psychological and individual explanations.[80] Although these approaches are valuable, they are also often void of any critical analysis of how certain constructions of masculinity are linked to oppressive institutional or cultural practices. Critical feminist scholars need to do a better job of showing how men's gender identities, relationships, and institutional

practices are located in and informed by larger social and historical processes.

Fifth, the globalization of the world's societies and cultures is accelerating. Feminist theory and women's health advocacy agendas have become highly informed by global awareness during the 1990s.[81–83] By contrast, men's studies scholars have yet to stretch their analytic purview beyond national boundaries. One notable exception is Connell,[84] who has recently entreated men's studies scholars to think more about "men's gender practices in terms of the global structure and dynamics of gender" (p7). One hopes that men's health scholars and advocates will follow this entreaty and work with one another and with international women's health advocates to pursue the vision of gender health equity.[2]

CONCLUSION

The relational aspects of men's and women's health have received the least attention from scholars who study gender and health. To date, most of the work on how gender influences health and illness has been within sexes rather than between the sexes.[2] This split in research and theoretical emphases is evident in the longstanding focus on "women's health" and, recently, "men's health studies."[1] Yet, as Rathgeber and Vlassoff[85] assert, "A gender approach to disease examines both the differential impact on women and men and also the social, cultural and economic contexts within which they live and work" (pp513–514). The relational theory of men's health is consistent with this view and encourages an awareness that just as women's and men's gender identities are inexorably bound up with one another, so are their respective health states.

Scientific understandings of gender and health can never be totally severed from an analysis of gender politics. Just as economic, racial, ethnic, or global inequalities profoundly influence health process and outcome, so structured sex inequalities and gender expectations are inexorably bound up with the health of both sexes.

In this article, I have discussed many health risks incurred by both sexes in relation to men's sexual behaviors. This emphasis is consonant with much of the attention given to men's health from feminist perspectives that highlights reproductive health and the need for men to use condoms. Advocating condom use among men is an important public health initiative. However, in light of the relational approach to understanding men's health developed here, more research is needed to explore how the construction of male sexualities and gender identities is linked to cultural notions of gender difference, emphasized femininities, male supremacy, men's inner sense of masculine adequacy, and the maintenance of men's collective power over women. Emerging research on men and masculinities, therefore, may offer women's health advocates and researchers who are working in the areas of reproductive health additional insights into men's reproductive behaviors.[86,87]

Finally, a great deal of emphasis has been placed on gender differences in epidemiologic and medical sociology writings on health.[88] Research has been typically geared to identifying differences in the health of women and men and then theorizing their etiology. The emphasis on gender differences has been highly useful, but perhaps it has also deflected investigation of similarities between women's and men's health risks or, in the context of this article, the relational character of gendered health synergies that may positively or negatively influence health outcomes for both sexes. American colleges and universities provide an important institutional context for further research and analysis in gender and health.

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