1 Masculinities and gender

INTRODUCTION

It has been demonstrated that men have higher mortality rates than women and their longevity is reduced in comparison to that of their female counterparts; they are also at greater risk of illness and injury. Over ten years ago it was recognized that a major factor contributing to the poor state of men's health could be risk behaviour, which was associated with traditional 'male lifestyle' (DH, 1993). Baker (2002) points out that across the developed world the health of men is in critical need of attention. Men frequently fail to seek help when their health begins to deteriorate. Men have higher rates of death than women and, it could be argued, have higher rates of serious illness (Hodgetts and Chamberlain, 2002). There are a number of explanations why this may be the case; one reason in particular is that men, it could be suggested, are reluctant to seek help and advice and adopt a stoical stance towards their health and illness (Watson, 2000).

Woolf, Jonas and Lawrence (1996) suggest that health behaviours help to explain gender differences in health and that they are some of the most important factors that influence health. If the nurse is aware of these health behaviours and is able to help men modify them, he/she can provide effective methods of preventing disease. Doyal, Payne and Cameron (2003) point out that longevity and health status are associated with economic status, ethnicity as well as access to healthcare provision. Courtenay (2000) suggests that health behaviours also impinge on longevity and modification of these behaviours is the most effective way to prevent disease.

Understanding masculinity and gender may help the nurse to begin to understand the male population and, as a result, plan appropriate care and care interventions. Masculinity and gender are dynamic entities in which we all play a part, changing over time with experience and reflection. It must be noted that there are intricate and multifaceted links between biological sex, gender and health. According to Galdas, Cheater and Marshall (2005), the role of masculine beliefs and the similarities and differences amongst men of differing background requires further investigation.

NATURE VERSUS NURTURE

White and Johnson (2000) suggest that the debate as to whether masculinity is a social construct, that is nature versus nurture, is secondary to the many complex mechanisms in place that ensure that the archetypal male continues.

Generally there are three primary explanations of human behaviour:

- biological determinism
- social determinism
- free will.

The first two will be discussed and the relationship between them, gender and masculinity, and male behaviour are also outlined.

BIOLOGICAL DETERMINISM

Biological differences allow the classification of men and women; these are predominantly related to reproductive function. Biological determinism is based on the belief that all differences (or characteristics) of men and women are a result of biology. This approach is also known as genetic determinism.

This approach asserts that certain behaviours are acceptable because 'boys will be boys' – this is 'natural' and is often genetically determined. Gross (2005) asserts that this principle has the ability to remove guilt and responsibility, for example, 'it is in my genes'.

Biological factors, in both sexes, have an influential impact on health; it has to be remembered, however, that this is not confined to reproductive characteristics alone. Doyal (2001) points out that there are a wide range of genetic, hormonal and metabolic influences that play a significant part in shaping distinctive male patterns of morbidity and mortality, for example, cancer of the prostate.

Little consideration is given to the wider variety of behaviours associated with masculinity or femininity or how masculinity or femininity relate to each other when in different settings. Biological determinism is powerful, and has the potential to undermine how men and women behave. Taken to its logical conclusion biological determinism dissociates the environmental and social factors associated with human nature.

SOCIAL DETERMINISM

The opposite of biological determinism is social determinism. This approach suggests that it is social interaction and social construction that determine individual behaviour. As with behavioural determinism, if taken to its logical conclusion social determinism would establish that the human being acts in accordance with his/her social conditioning, as opposed to any genetic predisposition. Socially constructed gender difference is also responsible for determining if an individual can realize their potential for a long and healthy life (Annandale and Hunt, 2000).

Examination of both doctrines would reveal that they are too general in scale to be reliable explanations of, and for, human behaviour. The nurture/nature dichotomy is problematic: what characterizes human behaviour and development is that they are an array of many interacting as well as intersecting causes. Both approaches are inadequate when attempting to understand or explain the diversity of masculinities.

Neither theory is able to provide a satisfactory explanation of, or for, the broad range of behaviours among men and women, parochially or globally. The nurse must be aware of the mix of both biological and social pressures in order to improve understanding and care for men and boys as there is unlikely to be one single explanation for issues that face men with respect to their health and well-being.

GENDER AND SEX

Kraemer (2000) notes that males are more vulnerable than females, even from conception, prior to any social effects coming into play. Within much healthcare literature the terms sex and gender are used interchangeably; both are important in understanding health and illness. With rare exceptions the human species comes in two sexes – male and female. This is the biological sex, anatomy as destiny. This male/female dichotomy is challenged, however, when an individual is born with a multiplicity or variation of sex and is forced into either the male or female domain.

Sex is not only determined by the appearance of the external genitalia. Advances in technology have allowed for the determination of sex by analysis of chromosomes: most often most men have external genitalia and one Y and one X chromosome; females usually have external female genitalia with X chromosomes. Not everyone, however, has discernible external genitalia and some have combinations of chromosomes that do not follow the accepted description of man or woman – their sex may be described as atypical. Blackless *et al.* (2000) suggest that in approximately 1% of live births some element of sexual ambiguity may exist.

GENDER

It has already been stated that there are many sociocultural factors that have the ability to influence health-related behaviour, and gender is one of the most influential of these factors. There are many gender inequalities associated with the provision of healthcare for men and these are discussed in further detail in Chapter 3 of this text. Adult men, for example, make far fewer healthcare visits than their female counterparts. Chapple and Zieband (2002), in a study they have undertaken, have determined that men are hesitant about seeking medical help. The men they interviewed in their study felt that it was not 'macho' to seek advice about health problems. Little is known about why men engage in less healthy lifestyles and why some men adopt fewer health promotion beliefs and behaviours than women (Courtenay, 2000). In 2001 11% of men and 16% of women reported consulting a GP. In the age group 16–44 years this percentage was 8% and 15% respectively (National Statistics, 2001). The increase in consultations for women of this age group may be associated with visits concerning birth control, child-related issues and pregnancy. This highlights how women use primary care services as a point of referral more than their male counterparts.

Most children during developmental phases of their lives acquire a firm sense of themselves as male or female. They acquire what many developmental psychologists term gender identity (Smith *et al.*, 2003). Explanations associated with theories of gender socialization are being criticized and doubt is being cast on the implication that gender represents two fixed, static and reciprocally absolute role containers (Connell, 1995; Courtenay, 2000). The formation of gender identity is a complex process and is much more than the examination of the external genitalia to determine sex. According to West and Zimmerman (1987), gender is something that a person does and does recurrently in interaction with others. Gender does not live within the person; it is the result of social interactions and transactions (Gray *et al.*, 2002). In this way gender can be viewed as a dynamic, gendered, social structure (Crawford, 1995). The actions and interactions are, according to Gerson and Peiss (1985), produced and reproduced through people's actions.

Gender stereotypes are used by society when it attempts to construct gender. Gender is a living system of social interactions. The stereotypes constructed are stereotypes that represent the characteristics that are often believed to be typical of men or women. Society has strong and entrenched beliefs of what men and women should and should not do, what is masculine or feminine. There are several activities that are used in the construction of male gender stereotypes:

- language
- work
- sports
- crime.

The ways men and women engage in the above activities contribute to the definition of an individual's gendered self, as well as conformation of society's expectations.

Courtenay (2000) notes that research (for example, Martin, 1994) has indicated that men and boys are under comparatively greater social pressures than women and girls to endorse society's gendered prescriptions; for example, men are stronger, tougher and self-reliant. These prescribed behaviours are often acted out by men. Wall and Kristjanson (2005) address the issues of men and their experiences of prostate cancer from a masculine perspective. They discuss the findings of several pieces of empirical research that have dealt with the same issues. Gray *et al.* (2000) have noted that, following a diagnosis and treatment of prostate cancer, the men in their study demonstrated a tacit personal and societal expectation that men are expected to cope, adjust, move on and accept the impact the diagnosis and treatment may have on their lives and relationships.

The analysis provided by Gray *et al.* (2000) and Chapple and Zieband (2002) demonstrates how men appear to sign up to cultural expectations; their experiences of prostate cancer become mute and non-emotional; and they have to demonstrate a stoic attitude and appear independent.

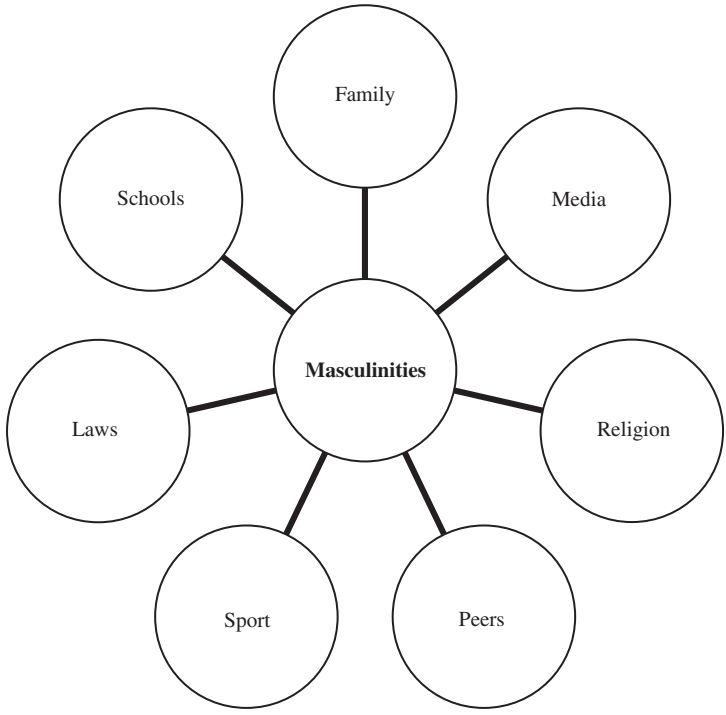

Figure 1.1. Some of the many influences which contribute to gender construction

Gender is taken to mean what it is to be masculine or feminine. This classification is analogous with the male and female classificatory systems used in the biological sexes. Gender roles are a set of norms associated with what it is, or appears to be, male or female. Society in many ways – for example, through the media, family, schooling, linguistics and peer pressure – determines what it is to be male or female, the social construction of gender. These essentialist views are continually reinforced, but are beginning to be challenged more and more (see Figure 1.1).

Consider what messages are being transmitted by the media in advertising, for example; note what it is to be feminine and masculine and in what way families provide role modelling. See Table 1.1 for some common socially constructed features (generalizations) of masculinity and femininity.

The dichotomies noted in Table 1.1 are the result of society's widely shared beliefs of what it is to be feminine or masculine. Society conforms to these stereotypical beliefs and adopts the norms associated with them. Conforming and playing out the stereotypical beliefs result in and reinforce a self-fulfilling prophecy of how we are expected to behave.

Table 1.1. Some common socially constructed descriptions of masculinity and femininity

Masculinity	Femininity
• Strong	• Soft, gentle
• Powerful	• Weak
• Rational	• Emotional
• Self-reliant	• Dependent
• Breadwinner	• Child-raiser

(Source: Adapted from Laws, 2006)

De Visser and Smith (in press) state that masculinity is characterized by both physical and emotional toughness, risk-taking, predatory heterosexuality and being a breadwinner; competence is displayed in specific social domains, for example in:

- sport
- alcohol and drug use
- sexual activity.

McQueen and Henwood (2002) suggest that masculinity is often set up in binary opposition (see Table 1.1) to their alternatives; the result of this is that anything that is not seen as masculine becomes non-masculine. Hence, it might be suggested that it is non-masculine to be weak or gentle.

Courtenay (1999) points out that men and boys are not passive victims of this socially agreed role; they are neither conditioned nor socialized by their cultures and are actively engaged in exerting power and producing effects in their lives in the construction and reconstruction of dominant norms of masculinity.

MASCULINITIES AND HEALTHCARE PROVISION

Traditionally the terms masculinity and femininity have represented a stable and essential set of gender attributes that distinguish men from women (Sabo and Gordon, 1995). There is no dispute regarding the stability of sex differences as descriptors of physical characteristics; for example, morphology and physiology (Wall and Kristjanson, 2005). Martin (1994), however, challenges the idea that gender is also a fixed and a stable entity. Gender is a dynamic construct and can be produced by individuals who negotiate and transact with their social, cultural and bodily contexts (Courtenay, 2000). As a result of the possibility of these transactions, gender is capable of change over time and according to place; hence temporal and spatial elements emerge as the variables described which alter or have the potential to alter.

The plural masculinities are used to emphasize the case that there is no one pattern of masculinity: just as there is no one fixed pattern of gender, masculinities are not simple settled, homogeneous constructions. Connell (1987) argues for multiple

masculinities and, he states, multiple femininities. Frosh, Phoenix and Pattman (2002) and Speer (2001) reveal that there are several different ways of being masculine, although most men appear to aspire to a hegemonic masculinity.

Men have specific roles to play in society and their position within that society is predominantly based on a mythical archetype that is built around ideal body form and body function. Men in society have several, specific roles to play (White and Johnson, 2000).

Being a male patient is one role that men have to learn (Seymour-Smith, Wetherell and Phoenix, 2002), and the practice nurse who has insight into the many roles men have to perform can aim to provide care that is sensitive and appropriate to the male patient. Healthcare beliefs and behaviours can be understood as means of demonstrating gender; the healthcare behaviours and the beliefs men hold have the potential to construct and represent gender, health actions (Courtenay, 2000), and if this premise is accepted, they also become social actions. Health behaviours and beliefs can, unlike social behaviours, such as wearing a dress or wearing a tie, as has already been stated, have a bearing on an individual's health.

Some researchers (Lee and Owens, 2002, for example) suggest that the differences noted between genders are accounted for not by gender but by the behaviours and attitudes related to particular career and lifestyle choices. The shift in perspective means that, in order to understand (or appreciate) fully the way men go about seeking help in relation to their health, the nurse will have to focus their investigations on not only men and their gender differences but also the differences between genders (Galdas, Cheater and Marshall, 2005).

Men are not a homogeneous group of individuals: they are not all the same, but are a heterogeneous entity. Within this heterogeneity there is group variability: not all individual men behave the same. Addis and Mahalik (2003) encourage healthcare providers to take this difference into account when planning and delivering effective healthcare.

The way men seek healthcare advice – health-seeking behaviour – is multifaceted. Sharpe and Arnold (1998) have identified that men consistently ignore health symptoms as well as avoiding seeking help from health services. Sanden, Larsson and Eriksson (2000) note similar findings in their research that was related to men who had discovered a testicular lump. Significant delays in discovering the lump and treatment were found; they attributed this to men's 'wait and see' attitude. Physical problems experienced by the men in their study (Sanden, Larsson and Eriksson, 2000) were seen as things, initially, that would cure themselves such as symptoms associated with a cold, and seeking help was often viewed by these men as strange. Richardson and Rabiee (2001) report similar findings in their investigations; they also note that seeking help from a GP was regarded as unpopular, confiding in the GP was uncomfortable and problems associated with communication, unfamiliarity and feeling vulnerable were cited as reasons for discomfort.

Gascoigne and Whitear (1999) suggest that men in their study who experienced issues associated with testicular cancer associated their reluctance to seek help with feeling embarrassed, appearing foolish and an attempt to normalize their symptoms.

White and Cash (2004) state that normalizing pain (chest pain, for example) or symptoms results in delay in seeking help. These responses are an indication of dominant internalized gender notions of masculinity and masculine identity (Gascoigne and Whitear, 1999). Chapple, Zieband and McPherson (2002) demonstrate that men delay seeking help, and thus treatment, because they did not know the symptoms associated with testicular cancer; they did not want to appear weak, hypochondriacal or lacking in masculinity.

There is evidence to suggest that occupational and socioeconomic status are as important as other variables such as gender when considering the help-seeking behaviours of men (Galdas, Cheater and Marshall, 2005). Socioeconomics are also variables that the nurse has to take into account when considering the help-seeking behaviours of the male patient. Richards, Reid and Murray-Watt (2002), in their study concerning men with chest pain in deprived and affluent areas of Glasgow, determined that men in the deprived area in contrast to those men from the more affluent area tended to normalize their chest pain, which led to a significant delay in seeking help. Social and cultural factors as well as gender have the ability to influence perceptions of symptoms and health behaviours (Richards, Reid and Murray-Watt, 2002; Galdas, Cheater and Marshall, 2005).

HEGEMONIC MASCULINITY

'Heterosexual masculinity', according to Connell (1995), is the most dominant form of masculinity. Hegemonic masculinity is the most culturally dominant of masculinities (Connell, 1987). Subordinate to heterosexual masculinity is homosexual masculinity (Connell, 1995). Courtenay (1999) suggests that hegemonic masculinity has the potential to shape relationships between men and men and men and women, as well as the relationship the male has with his health and his healthcare requirements.

Table 1.2 outlines some characteristics that are associated with hegemonic masculinity. Wall and Kristjanson (2005) describe these characteristics as signifiers of hegemonic behaviour.

Table 1.2. Characteristics or signifiers associated with hegemonic masculinity

- Restricted experience and expression of emotion
- No emotional sensitivity
- Toughness and violence
- Powerful and successful
- Self-sufficient – has no needs and needs no support
- Stoicism
- Being a stud – endorsing heterosexuality
- Misogyny

(Source: Adapted from Wall and Kristjanson, 2005; Frank, 1991; Kiss and Meryn, 2001)

Gray *et al*. (2002) note that hegemonic masculinity is associated with, and incorporates, as a result of its relationship with subordinate masculinities, power and domination, acted out through, for example, aggression, competition, heterosexism and homophobia.

The notion of masculinities as opposed to masculinity moves away from the dated concept of the 'male sex role'. Different circumstances, different cultures and different periods in time construct masculinity differently. They are therefore subject to change; they are fluid and dynamic. The male sex role theory is inadequate when it comes to trying to understand diversity in masculinity (Connell, 1987). Laws (2006) states that for decades researchers and authors have tried to define masculinity. It is difficult, however, to define, as it is a complex concept. However, being able to define masculinity may help healthcare providers to explain and predict male behaviour and as a result of these predictions offer care that is appropriate and meeting individual's needs.

The practice nurse must be constantly aware of this when providing care to men. It should be remembered that there are many different ways that men 'do' masculinity. An increased awareness and insight associated with gender and masculinity can help the nurse understand, for example:

- how men live;
- how and why they encounter high levels of injury;
- why they engage in risk-taking activities;
- patterns of illness and mortality rates;
- drug use and inadequate use of health service provision (Walker, Butland and Connell, 2000; Schofield *et al*., 2000).

The meaning of masculinity for men who are from a lower social background may differ from the meaning of masculinity for those men from a middle-class background; this may also be the same for those men from very rich economic backgrounds and very poor economic backgrounds. Within the various types of masculinities there can be tensions and contradictions, inconsistencies and disagreements.

In health, there has been much debate around the issue of men's health; contemporary deliberation includes discussion around issues such as identity, sexuality and relationships (Schofield *et al*., 2000). Doyal (2001) asserts that over the last two decades much activism has taken place by women with regards to the quality of their health and healthcare; she also states that men have also begun to draw attention to the negative effects associated with health and maleness. Links are beginning to emerge between the effects of masculinity on well-being (Schofield *et al*., 2000). It has been suggested that gender behaviour is socially governed or conditioned – men and women learn as boys and girls what it is to be masculine and feminine; they are actively involved in determining their own gender identities.

Luck, Bamford and Williamson (2000) discuss a 'crisis in masculinity', which is associated with a recognition that there are differences associated with male and female mortality rates. Lyons and Willott (1999) suggest that men are victims of

social change and as a result their masculinity is in crisis; they have unequal social relations. Men appear to hold certain abstract ideas with regard to health and these ideas are, according to Watson (2000), enacted in gender-specific ways encouraging and/or constraining the negative and positive effects of health practices. The nurse needs to develop an awareness of how these abstract ideas are enacted in an attempt to provide men with gender-specific healthcare – reacting to their gender-specific needs.

Seymour-Smith, Wetherell and Phoenix (2002) identify that it is not only the way men conceptualize and internalize their health from a gendered perspective but also the way the healthcare professionals approach men's healthcare. These barriers prevent men from addressing their own health; furthermore, they also prevent the healthcare professional from providing appropriate care. Male socialization, and the processes most men go through, has the ability to create difficulties associated with their health. White and Johnson (2000) suggest that as a result of this the maintenance of the male body becomes problematic.

The need for men to ascribe to a socially agreed male role may prevent them from being able to express their needs in association with their illness; they may feel unable to express needs as a result of 'traditional masculinity' (Möller-Leimkühler, 2002).

CONCLUSION

Being male or female influences the understating we have, and the experiences we encounter, of health, as well as the uptake of services and health outcomes; furthermore, gender impinges on the decisions made by those who provide health services. There is much evidence to demonstrate that men die earlier than women and report illness less than women. Much of the theoretical debate describes how men's health behaviours and beliefs are influenced by several factors, such as culture, environment and social class.

Understanding the way men seek help in relation to their health – for example, the way they evaluate symptoms associated with their health and how they arrive at the decision to seek healthcare – can be of value to those who develop strategy, provide policy and offer care. This may encourage men to seek help earlier, and as a result achieve earlier diagnosis and thus treatment.

Men are not a homogeneous group that can be compared with women, and neither should women be compared with men. Nurses are at the vanguard of healthcare provision and must be aware that men can react differently to the way healthcare services are offered as well as health promotion messages as a result of different ages, social and ethnic groups (Galdas, Cheater and Marshall, 2005). Much of the evidence cited in this chapter is based on research associated with homogeneous groups of men, for example, white, middle-class men. More work is needed that takes into account those men from a variety of backgrounds and situations in order to determine if there are any similarities between men.

Masculinity can put male healthcare at a low priority. Men find it difficult as a result of this label to ask for help. The nurse has the skill to encourage men to seek help for their problems, to encourage them to say it's OK to ask for support.

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