Masculinity and Health: A Multiple Method Examination of a Sample of African-American men

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Abstract

We research links between masculinity and physical and mental health using qualitative and quantitative data of a sample of 192 African American men. We examine the ways in which these men construct their masculine identities and analyze the associations between these identities, a standardized measure of sex roles (BSRI), and physical and mental health. Many men define masculinity with reference to social institutions such as the family and work. Some definitions refer explicitly to mental and physical health, whereas others may have indirect health consequences. In quantitative analysis, we do not find significant associations between an index constructed from the masculinity items of the BSRI. However, we find that the number of masculinity accounts mentioned by the men in open-ended questions predicts better mental health but worse physical and self-rated health. This suggests that narrow conceptions of masculinity get rewarded in American culture, although they might compromise health.

Background

It is widely held that American men are socialized into conceptions of masculinity that lead them to hold beliefs and engage in actions that are detrimental to their health (e.g. Courtenay 2000). At the same time, many scholars argue that men can hold multiple masculinities, some of which can be more consequential for health than others (e.g., Connell and Messerschmidt 2005).

African American men provide an interesting population to study the connections between masculinity and health due to the historical legacies that have made hegemonic conceptions of masculinity elusive ideals for most of them. Partly as a result of this legacy, African American men also are in clearly worse health than males from other groups.

In this study, we examine links between masculinity and physical and mental health using a sample of 192 African American men from a large Midwestern city (cf. Duck 2009). The sample was collected for the purposes of a research project, of which this study is part. Our data are rich in information, combining subsamples of focus-group interviews, face-to-face interviews, and answers to a structured questionnaire. We analyze these data both using qualitative and quantitative methods.

Research questions

We ask the following questions:

(i) How do African American men define masculinity?

(ii) How is masculinity related to African American menôs physical and mental health?

a. How do African American men talk about masculinity and health?
b. How is a standardized measure of masculinity (masculinity index from the Bem Sex Role Inventory) related to physical and mental health?
c. How are menôs conceptions of masculinity (what is included in a definition of masculinity and how broadly or narrowly masculinity is conceived) related to physical and mental health?

Data, variables, and methods

This study uses a unique sample of 192 African-American men, collected in a large Midwestern city. The data contain focus-group interviews, face-to-face interviews, and responses to a structured questionnaire. The sample was collected using snowball sampling, which was regarded an efficient and purposeful strategy in contacting men to tell about their views on health and masculinity, which are potentially sensitive topics. In this study, we analyzed both the qualitative and the quantitative data to provide a rich perspective on views of masculinity among African-American men and the links between masculinity and psychical and mental health.

The qualitative data were analyzed by coding the data into emerging themes with the aid of microanalysis, computer-aided content analysis, and open coding techniques.

The dependent variables for the quantitative analysis are self-rated health, physical health, and mental health, the last two being based on physical and mental health components of the SF-12 Health Survey. All dependent variables are ordered variables with five levels. Self-rated health ranges from excellent through very good, good, and fair, to poor. The decision to recode the physical and mental health variables to ordered ones followed from an observation of their clearly skewed distributions.

We have two main independent variables. The first one is a measure of masculinity constructed from the masculinity items of the Bem Sex Role Inventory (BSRI). The second is a measure of how broadly or narrowly the men conceive masculinity, defined through the number of distinctive accounts the men brought up in open-ended questions. This variable ranged from 1 to 8 categories brought up by any one person, with a mean of 3.75. The variable was very closely normally distributed. These two masculinity measures were only weakly correlated (0.10, not significant), suggesting that these measures tap into distinct aspects of masculinity. We also tested whether bringing up specific masculinity accounts predicted physical or mental health, but these relationships were not significant after the control variables were included in the models.

Our control variablesð age, years of schooling, annual household income, employment status, and marital statusð were chosen both on theoretical and practical grounds.

Given the ordered nature of our dependent variables, we use ordered logit models. Our models do not violate the parallel regression assumption.

Results

Many men mentioned attributes and themes regarding masculinity that related to social institutions (e.g., family or the workplace) or were described within social contexts (family, personal autonomy, doing gender). The themes centrally reinforced masculinity as a socially constructed concept, that is, as something achieved through interacting with others. The emphasis on marriage and the family stressed the normative role of heterosexuality; additionally, other frequent and recurring themes included personal autonomy and mental and physical strength. Table 1 summarizes the five most frequent themes (of a total of 26) that were mentioned.

Table 1 Five most popular masculinity themes mentioned by the study participants

Theme	Mentioned by
Family care (being a father, being married, taking care of family)	62.5 %
Economic aspirations (holding a job, taking care of finances, econ. Provision)	61.7 %
Behaviors (ñdoing genderò: styles of walking, talking, dressing, etc.)	45.8 %
Autonomy (Freedom from others in work, responsibility, self-sufficiency)	25.8 %
Physical strength/Health (Being strong, healthy, physical size)	24.2 %

Some ways of talking and thinking about masculinity were also found to be often related to health practices. For example, previous work in the project found that for many men, being sexually active was a core component of masculinity (Duck 2009). Sexual activity was used and avoided as a way of preserving masculine identity, sometimes to effect of health compromising behavior, such as avoidance of testing for sexually transmitted diseases, which could lead someone to having to reducing sexual behavior.

Table 2 Ordered logistic regression models for physical health, mental health, and self-rated health.

	Physical health		Mental health		Self-rated health	
	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
BEM masculinity score	-0.26 (0.28)	-0.36 (0.29)	0.19 (0.29)	0.15 (0.30)	0.43 (0.29)	0.39 (0.30)
Number of categories	0.32* (0.12)	0.26* (0.13)	-0.27* (0.12)	-0.25À (0.13)	0.24* (0.12)	0.23À (0.12)
Log-likelihood	-186.02	183.73	-185.43	-185.43	-152.29	-151.79
Chi2 (df)	13.27 (4)	17.85 (7)	15.51 (7)	15.51 (7)	27.79 (4)	28.78 (7)

Notes: Controls: Age, schooling (model 1); + employment status, marital status, household income (logged) (model 2). N: 120. * $p<0.05$; À$p<0.10$

In our quantitative analyses, we found that the Bem masculinity score was not a statistically significant predictor of any of the three health indicators. At the same time, however, the number of masculinity categories mentioned by the men in the open-ended questions predicted physical health, mental health, and self-rated health (see Table 2).

These results show interesting patterns. The broader the menôs conception of masculinity, as measured by the number of categories they mentioned, the better their physical health and self-rated health, but the worse their mental health.

These results are not merely statistically significant but also substantively important. We calculated predicted probabilities of having the highest value of each variable (highest quintile for physical and mental health; excellent self-rated health). Those mentioning five instead of two masculinity categories (approximately one standard deviation above and below the mean) were almost twice as likely to be in the highest quintile of physical health and to report excellent health, but only half as likely to be in the highest quintile of mental health.

Conclusions and discussion

Men are generally in worse health than women and menôs life expectancy considerably lags that of women. Some commentators have argued that part of the explanation lies in the conceptions of masculinity men are socialized into that lead men to hold beliefs and engage in behaviors that can be detrimental to health.

In this study we used a mixed-method approach to study the links between masculinity and health in a sample of African American men, who as a group have worse health than other males. We wanted to examine this issue using both qualitative and quantitative data, and both standardized measures of masculinity and the menôs own conceptions of it.

We found that many men define masculinity with reference to health and to behaviors and beliefs that can have consequences on these menôs health. We also found that narrowly defined conceptions of masculinity tend to have payoffs in terms of mental health but are potentially detrimental to their physical and self-rated health. These results suggest that there are certain, narrowly defined, conceptions of masculinity in American culture that men are expected to confirm to, and for which they are rewarded. These conceptions, however, can have negative implications for the health of these men.

Our results, furthermore, suggest the usefulness of studying the relationships between self-defined masculinity and health outcomes in addition to more established measures.

Bibliogaphy

Connell, R., & Messerschmdt, J. (2005). Hegemonic masculinity: Rethinking the concept. G*ender and Society*, 19, 829ï 859.

Courtenay, W. (2000). Constructions of Masculinity and their Influence on Menôs Well-Being: A Theory of Gender and Health. *Social Science and Medicine* 50: 1385-1401.

Duck, W. (2009). ñBlack Male Sexual Politics: Avoidance of HIV/AIDS Testing as a Masculine Health Practice.ò *Journal of African-American Studies*, 13(3): 283-306.