Theories in health care and research

Theories of masculinity

Clare Moynihan

This is the second in a series of six articles on the importance of theories and values in health research

Institute of Cancer Research and Royal Marsden NHS Trust, Sutton SM2 5PT

Clare Moynihan, *senior research fellow*

clare@icr.ac.uk

Series editor: Priscilla Alderson

BMJ 1998;317:1072–5

How do theories help us to grasp various truths about men's and women's responses to illness? How do theories of masculinity illuminate the reactions of young men who have lost a sexual organ and face a life threatening disease? Why are men sometimes treated differently from women in life threatening situations?[1] This paper shows how theories that underlie research influence the ways in which we perceive phenomena and how we deal with them. It questions assumptions about the concept of masculinity in medicine and how these assumptions affect men. Alternative ways of seeing may widen our perceptions, but at the same time they present us with more difficulties.

Summary points

- In the positivist view, membership of the male sex is signified by the male anatomy
- In the social constructivist view, male gender is practised in social interactions and is signified by beliefs and behaviour, like being hard and strong. Each society assumes that "given" attributes are fixed, although they vary across cultures and between individuals
- Postmodernism will not work with rules—the fixed categories of sex and gender disintegrate altogether and are replaced by "floating signifiers"
- Floating signifiers give no credence to "a sexual identity": "masculine" or "feminine" characteristics stereotypically assigned to sex or gender are no longer defined
- The ways in which practitioners and researchers perceive masculinities can affect health care and research

The biological concept of sex—a positivist approach

In the biological approach, sexual anatomy equates with sexual destiny. Anatomy is proof of being a man. Being a man takes on a universal status, generalisable and immutable. Aggression, reason, a need for control, competitiveness, and emotional reticence are thought to be "natural" attributes for a man[2]; contradiction or ambiguity is anathema to him.

Men are consistently reported to live shorter lives, but women have higher rates of physical and mental morbidity.[3] Numerous surveys report that health behaviour practised by men adversely affects their health outcomes in terms of, for example, the underuse of medical and psychotherapeutic services.[3 4] Their rigidly stoical stance contributes to some physical and mental disorders that are disproportionately experienced by men.[5] Other studies question the methodology in general[6] and report contradictory findings.[7–9] Explanations for men's poor health outcomes and adverse practices include physiological differences and a "fixed role" hypothesis. Men are apparently not like women, who tend to go to the doctor because it is thought they have time on their hands.[3]

Medicine acknowledges ambiguity in anatomical states, but it seldom recognises the complex, social issue of gender. This is ironic because surgery may be offered to people with gender dysphoria—a difficulty in establishing an adequate gender identification.[10] Sex reassignment is usually seen as a biological "fix"; men are asked to prove their ability to take on a "feminine role" by undergoing a one year "real life test." However, newly assigned women may continue to identify with their male pasts or align themselves with neither man nor woman but see themselves as something that transcends that cultural dichotomy.[10] Health promoters assume and reinforce notions of masculinity when they recommend, for example, that men take vigorous competitive exercise[11] but do not consider the many links between the "virile" male and morbidity.

Equating masculinity with success[5] perpetuates a Western myth, making it hard for men to accept becoming ill and to express their fears and needs. Taking illness "like a man" means hiding behind a brave façade, however lonely or painful.

Masculinity and research

Stereotypes of masculinity inform research design, data collection, analysis, conclusions, and men's own responses. When we instigated a randomised trial of up to six sessions of psychological therapy for men with testicular cancer, only a minority of men agreed to enter the trial.[12] Among them, those who received treatment seemed to be more anxious than men in the control group, who received no extra support, only standard care. The intervention was deemed to be ineffective, in line with evidence based medicine. This trial was not designed to take into account that counselling itself may increase men's fear of vulnerability and exposure in revealing their feelings, possibly for the first time. Higher recorded anxiety is not necessarily an adverse outcome, however, and counselling may have benefited men, allowing them to break down defences in the face of chaos and to experience self knowledge, letting them admit to their distress. Contradictions between evidence of anxiety and satisfaction tend to be taken as proof that the survey is invalid.

Self report measures may be biased.[6] Men who present themselves as "highly masculine" underreport symptoms.[13] Motives and feelings are veiled when men report on the emotions they "ought" to have, according to oppressive stereotypical myths of masculinity. Questionnaires are devised without actual observation of

Signifiers of masculinity

Fixed:

- Male anatomy

Examples of signifiers that may be perceived as fixed:

- Independence
- Aggression
- Inexpressiveness
- Ambition
- Stoicism

Floating signifiers:

- A man being stoic and seeking comfort—for example, refusing psychotropic drugs while holding his teddy bear
- A man showing strength and weakness—for example, accepting a chemotherapy regimen and crying because he feels sick
- A man being aggressive and gentle—for example, shouting at his doctor while cradling his baby

possible behaviours[14] and the contradictions that undoubtedly exist. Instead, men are asked to rate their personality characteristics on a scale in answer to questions such as, "How desirable is it for a man to be assertive/yielding?"[15] Cultural mores and expectations built into the questionnaire will pre-empt (limited) static responses, only perpetuating the myth of what it means to be masculine and proving that men behave in certain ways. This, however, tells us more about the researchers than it does about men.

When men are observed, however, masculinity can no longer be perceived as a single variable but as a highly complex state of being.[14] In the wake of bewilderment, apprehension, and fear, Mr G asked for psychosocial support four years after his diagnosis of testicular cancer. He described himself as being like a "shutter pulled down," stark and unflinching, and explained that sympathy was not welcome but neither was dismissal or intolerance.

The social concept of gender

Another way of looking at masculinity (and its supposed opposite, femininity) is through the more fluid concept of gender. Gender is influenced by historical, social, and cultural factors,[14] rather than anatomical factors, and is not part of a person's essential,

Gender stereotypes[2 5]

Masculine	Feminine
Inexpressive	Emotional
Aggressive	Expressive
Ambitious	Compassionate
Analytical	Childlike
Assertive	Gentle
Successful	Loyal
Competitive	Sensitive
Forceful	Tender
Independent	Understanding
Dominant	Yielding
Strong personality	Gullible
Athletic	Refined
Invulnerable	Warm

REX FEATURES

Two of the many faces of Boy George. Floating signifiers give no credence to "a sexual identity." A man may represent himself in many lights: strong men may cry; weak men may not; kings and priests wear skirts and necklaces

"natural," "true" self. It combines many different, even contradictory, theories of what it means to be male.

Social theories do not ascribe a single meaning to maleness.[14] Males consist of, for example, toddlers and octogenarians; they are fertile and infertile; gay and straight; leaders and followers. Within these nebulous boundaries, nuances abound. Both men and women live inside rippling muscular bodies; some women are covered in bodily hair, some men are not. Transvestism, transsexualism, and bisexuality are not uncommon practices.

Researchers asked men and women to score their own "masculine" and "feminine" traits.[16 17] They were surprised to find that women and men who scored highly on feminine traits were more likely to use health services[16] and showed greater practical concern regarding their health care.[17] A large psychosocial literature acknowledges gender (rather than sex)—yet it still perceives that men's masculine and feminine traits develop individually. It continues to theorise masculinity as a "thing"; the making of a man is preordained, comprising either male or female attributes or both, with no credence given to an external context.

Social construction of "masculinity" or "gender"

Social constructivist theories of masculinities[18] recognise that gender is achieved through and by people and their context. The supposed distinction between sex and gender disappears. Gender is not something we are, but something we do in social interactions. The way the doctor allows the patient to achieve a mode of masculinity depends on the role the doctor expects the patient to act out, the type of health care, and the relation between the doctor and the patient. The doctor may be seen as an authority figure, an expert, a bringer of bad news. The patient will respond as a "sick man" and what that means to him in terms of his own identity as a male and in relation to the doctor and the institution in question.

This way of constructing masculinity is borne out in my work with testicular cancer patients who are young and have had to lose a sexual organ but who are "cured." I embarked on my research believing that men who face a life threatening disease would express their emotions and fears. After all, men regularly embrace, express joy, or weep (sometimes horizontally) on football pitches.

My study showed that a significant minority of men who were cured of cancer and had been treated one to five years before interview were experiencing anxiety or depression, or both.[19] Yet no man had sought help, which suggests that it was crucial for men to be controlled and silent about their emotional life. Men in this study were given an opportunity to talk in a place of their own choosing that was safe and non-threatening. This enabled them to reveal aspects of themselves that many men admitted they had never voiced before. A few men recounted how they recoiled in overt fear and sadness, sometimes cuddling soft toys, usually in secret. But the concept of "self control" was clearly demonstrated and a stereotypical masculine identity constantly re-enacted in the face of illness when men described how they wept ("blubbered") in private far away from their families, and often in their cars where they felt "enclosed and safe."

When I asked men if their sense of masculinity had been affected as a result of their experience, they were unanimous in their denial. Yet when the subject of work was raised, employment issues were described as an overriding concern throughout the ordeal. I carried out the interview at a time of high unemployment, but men's narratives support the theory that traditional concepts of masculinity are defined and reinforced within the public realm of work.[5 20] This was only achieved, however, through anxious personal negotiation, illustrated in an elaborate plan laid down by one patient who took his work with him to hospital. No work colleague was informed of his health status. He conducted business on the hospital telephone, his calls to and from his colleagues never revealing that he was a patient. This made it impossible for him to share either the distress he experienced at the time of diagnosis and treatment or his subsequent relief at being "cured." An active coping style may be appropriate, but in this man's case it blocked his grieving process. His pride prevented him from asking for help, but it was not offered to him—perhaps because of his façade of control and stoicism, and the doctors' expectation that men behave like this, even in the face of overwhelming threat. This is the cost of the heavy burden of maintaining what we have been led to believe is "the making of a man"—which women do not have to live up to as they are handed other attributes, such as "emotionality" and "expressiveness," that are every bit as mythologising but perhaps not as constricting in times of illness.[2 5]

There is, however, a dynamic element to this process. Men told me how male clinicians often attempted to "smooth troubled waters" (address dramatic existential crises) by referring to infertility as, for example, "shooting blanks," and the loss of a testicle and the fear of potential sexual problems as nothing more than "a plane flying on one engine and landing safely" or that "one cylinder is as good as two." This kind of language reinforces the way in which many men think about their bodies as machines, controllable and controlled. Indeed it highlights the way that a Cartesian dualism between mind and body is recreated, leaving men feeling separate and estranged from their somatic experiences.[21]

Men's "natural" qualities merge with social theories of men as they constantly invent and reinvent themselves as people with "stiff upper lips," as "boys who don't cry," not in a vacuum, but in an interactive process. By looking at gender rather than sex, constructivist theories can suggest practical changes in doctor-patient interactions and illuminate problems in medical research and practice that need further investigation. But just as a positivist approach ascribes innate "masculine" traits to men, interpretive constructivist theories also fix stereotypes of gender on to the body. Gender continues to be perceived as a "thing."

A man may have a range of traits. The ones he will express will be affected by the context he is in. For example, men in hospital often feel they have to rein in their emotions, but on the football pitch men cry and hug their team mates.

Postmodern theory

Postmodern theory continues to reinforce a social constructivist stance that breaks loose of any given definitions of those uncertain "things" called sex and gender.[22] We live in kaleidoscopes of fragmented and differing realities. A man may cry in one encounter and stoically withdraw in another, or do both. He may hold his teddy bear for comfort while refusing psychotropic drugs for fear of losing control. A weight lifter may lift up to 180 kg in health and be unable to hold a spoon in illness.

Gender as a floating signifier may be a puzzling concept for a medical profession trained to think definitively. Yet if we accept ambiguity and masculinities as constructed, complex, and fluid states we may see more clearly that men are treated differently from women, possibly because both doctors and patients hold fixed theories of sex/gender. A recognition of the complexities of gender may explain why prestigious doctors, who epitomise masculine achievement and power, can reassure some patients but may intimidate and even emasculate others. If doctors constantly have to live up to stereotypical expectations of gender in institutions that are imbued with images of male stereotypes, internal conflict will be inevitable,[23] and clearly this is not conducive to optimum patient care.

Alternative theories of masculinity, as opposed to "traditional" ones, help us to recognise when research is skewed and health care is sabotaged. Men die younger; some underreport their symptoms and refuse interventions. But if both doctors and patients are locked together in perpetuating male gender myths based on sexual difference and expectation, they will never be able to talk honestly in times of illness and in health. Health is inextricably tied up with the image of the perfect man, signifying strength and control, but attempts to be the perfect man in illness can mean a loss of masculinity. Anxiety, sadness, and untold fear are likely to ensue.

1 Steingart RM, Packer M, Hamm P, Coglianese ME, Gersh B, Geltman EM, et al. Sex differences in the management of coronary artery disease. *N Engl J Med* 1991;325:226-30.
2 Edley N, Wetherell M. *Men in perspective: practice, power and identity.* London: Prentice Hall Harvester Wheatsheaf, 1995.
3 Verbrugge L. Gender and health: an update on hypotheses and evidence. *J Health Soc Behav* 1985;26:1156-1182.
4 Thompson N. Masculinity and Loss. In: Field D, Hockey J, Small N, eds. *Death, gender and ethnicity.* London: Routledge, 1997:76-88.
5 Kilmartin CT. *The masculine self.* New York: Macmillan, 1994.
6 Mechanic D. Sex, illness, illness behaviour and the use of health services. *Soc Sci Med* 1978;12B:207-14.

7 Sinnot JD. *Sex roles and aging: theory and research from a systems perspective.* London: Karger, 1986.
8 Annandale E, Hunt K. Masculinity, femininity and sex: an exploration of their relative contribution to explaining gender differences in health. *Sociol Health Illness* 1990;12:24-46.
9 Macintyre S, Hunt K, Sweeting H. Gender differences in health: are things really as simple as they seem? *Soc Sci Med* 1996;42:617-24.
10 King D. Gender blending. Medical perspectives and technology. In: Ekins R, King D, eds. *Blending genders.* London: Routledge, 1996:79-98.
11 Allison KR, Adlaf EM. Age and sex differences in physical inactivity among Ontario teenagers. *Can J Public Health* 1997;88:177-80.
12 Moynihan C, Bliss J, Davidson J, Burchell L, Horwich A. Evaluation of adjuvant psychological therapy in patients with testicular cancer: randomised controlled trial. *BMJ* 1998;316:429-35.
13 Kaplan M, Marks G. Appraisal of health risks: the roles of masculinity, femininity and sex. *Sociol Health Illness* 1995;17:206-21.
14 Hearn J. Research in men and masculinities: some sociological issues and possibilities. *Aust N Z J Sociol* 1994;30:47-70.
15 Bem S. The measurement of psychological androgyny. *J Clin Psychol* 1974;42):155-62.
16 Mitchel C. Relationship of femininity, masculinity and gender to attribution of responsibility. *Sex Roles* 1987;16:151-63.
17 Korzenny F. AIDS communication, beliefs and behaviours. Symposium on science communication: environmental and health research, University of Southern California, Los Angeles, 1988.
18 Stoltenberg J. *Refusing to be a man: essays on sex and justice.* Portland, OR: Breitenbush, 1989.
19 Moynihan C. Testicular cancer: the psychosocial problems of patients and their relatives. *Cancer Surv* 1987;6:477-510.
20 Seidler VJ. Men, heterosexualities and emotional life. In: Pile S, Thrift N, eds. *Mapping the subject: geographies of cultural transformation.* London: Routledge, 1995:170-91.
21 Seidler VJ. *Unreasonable men.* London, New York: Routledge, 1994.
22 Docherty T. *Postmodernism: a reader.* London: Harvester Wheatsheaf, 1993.
23 Ramirez A, Graham J, Richards M. Mental health of hospital consultants: the effects of stress and satisfaction of work. *Lancet* 1996;347:724-8.

Understanding controlled trials

What outcomes should be measured?

Martin Roland, David Torgerson

Many types of clinical, patient related, and economic outcomes can be measured in trials. The choice of one or more outcomes will depend on the nature of the study and the question it is trying to answer. Objectives can relate to different levels of observation and analysis, from the individual to the family, the community, and society as a whole.

If a trial is "explanatory"[1] then a single main measure of clinical outcome may be appropriate. For example, if a trial is designed to determine which of two antihypertensive agents is more effective at lowering blood pressure then hypertensive control will be the main outcome. Traditionally, clinical trials have used physiological or biomedical outcomes, but these may not be well related to clinical outcomes. One example of a surrogate outcome measure which misled investigators was the CD4 count in AIDS trials: this turned out to be a poor predictor of survival.[2] Thus the use of physiological surrogates which are not clearly related to health outcomes must be viewed with caution.

A range of health status measures have been developed to address the poor relation which may exist between clinical outcomes and outcomes that are important to patients. These attempt to capture the patient's experience using valid and reliable quantitative scales.[3 4] They generally aim to quantify the extent to which an illness affects a patient's ability to carry out a range of normal activities. They may be related to abilities across a wide range of activities or targeted at problems associated with specific diseases. A common approach is to use both a general and a disease specific measure within one trial.

In pragmatic trials a single outcome measure may be inadequate for clinicians and other healthcare decision makers to weigh up the risks, costs, and benefits of a given intervention. Several outcome measures are therefore commonly included. For example, in trials of back pain, the Cochrane Collaboration recommends that outcomes should include pain, functional status, ability to work, and satisfaction with treatment.[5] In another example a recent trial sought to compare evening and night care given by doctors from commercial deputising services with that given by a doctor from the patient's own practice; the outcomes included whether the patient was actually visited, what prescriptions were given, whether there was any difference in health outcome for patients, and whether care from one type of doctor was more likely to increase subsequent use of health services.[6 7] The use of a wide range of outcomes is likely to be more informative for decision makers than a single outcome measure.

The impact of a disease may extend beyond the individual to the family or carers—for example, in dementia[8]—so the outcomes measured might need to be extended to a wider group. Similarly, at a societal level, if an aim of the study is to influence resource allocation between different types of treatment then economic outcomes will need to be included.[9]

Although it is often advisable to use several different outcome measures, some have advocated that the very large trials needed to answer certain types of clinical problem should focus on a small number of very simple outcomes.[10] There is also a statistical drawback to using multiple outcome measures. Increasing the number of measures in a trial increases the probability that one will reach statistical significance on the basis of chance alone. When a research question requires that several separate outcomes should be separately assessed, this needs to be taken into account in the sample size calculation. In general, more subjects are needed when several outcomes are being measured.

National Primary Care Research and Development Centre, University of Manchester, Manchester M13 6PL
Martin Roland, *director of research and development*
Centre for Health Economics, University of York, York YO1 5DD
David Torgerson, *senior research fellow*
Correspondence to Dr Roland

BMJ 1998;317:1075

1 Roland MO, Torgerson DJ. What is a pragmatic trial? *BMJ* 1998;316;285.
2 Fleming TR, DeMets DL. Surrogate end points in clinical trials: are we being misled? *Ann Intern Med* 1996;125:605-13.
3 Wilkin D, Hallam L, Doggett MA. *Measures of need and outcome for primary health care.* Oxford: Oxford University Press, 1992.
4 Bowling A. *Measuring disease: a review of disease specific quality of life measurement scales.* Buckingham: Open University Press, 1994.
5 Van Tulder MW, Assendelft WW, Koes BW, Bouter LM and the Cochrane Back Pain Editorial Board. Method guidelines for systematic reviews in the Cochrane Back Review Group for Spinal Disorders. *Spine* 1997;20:2323-30.
6 Cragg D, McKinley R, Roland M, Campbell S,Van F, Hastings A, et al. Comparison of out of hours care provided by patients' own general practitioners and commercial deputising services: a randomised controlled trial. 1. The process of care. *BMJ* 1997;314:187-9.
7 McKinley R, Cragg D, Campbell S, Hastings A, Roland M, French D, et al. Comparison of out of hours care provided by patients' own general practitioners and commercial deputising services: a randomised controlled trial. 2. The outcome of care. *BMJ* 1997;314:190-2.
8 O'Connor DW, Pollitt PA, Roth M, Brook CP, Reiss BB. Problems reported by relatives in a community study of dementia. *BMJ* 1990;156:835-41.
9 Torgerson DJ, Raftery J. Measuring outcomes in economic evaluations. *BMJ* 1998 (in press).
10 Peto R, Collins R, Gray R. Large scale randomised evidence: large, simple trials and overviews of trials. *J Clin Epidemiol* 1995;48:23-40.