


# Aging Men's Health-Related Behaviors

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## Abstract

This conceptual review summarizes the current research on older men and their health-related behaviors with special attention given to the influence of the hegemonic masculinity framework over the life span. The authors consider whether masculinity precepts can be modified to enable men to alter their gendered morbidity/mortality factors and achieve healthier and longer lives. Also included is an overview of the gender-based research and health education efforts to persuade men to adopt more effective health-related behaviors or health practices earlier in the life span. Given the current attention being paid to men's health, for example, their higher risk of morbidity and mortality both generally and at younger ages, and the associated health care costs tied to those risks, the ethical and economic implications of this review may prove useful.

## Keywords

masculinity norms, aging men, men's health, men's health behaviors

This review discusses the research on men and their health-related behaviors or health practices with special attention given to the influence of the hegemonic masculinity framework on men generally and aging men particularly. Of specific interest is consideration of whether men's health-related behaviors adjust as they age. How do biological, social, psychological, and behavioral factors interact and does that interaction affect men's health practices (Courtenay, 2002)? Is it possible for aging men to adapt concepts of masculinity and related masculine gender scripts to better meet their changing health needs in later life and still fit within their personalized construct of masculinity? If so, what influences these actions? In her landmark discussion of gender and health, Verbrugge (1985) suggests three broad categories as possibly influential—biological risks related to illness and disease, acquired risks associated with work and play activities, and psychosocial factors that include gender-influenced responses to these risk categories as well as overarching constructs such as hegemonic masculinity. We conclude with a discussion of a selection of interventions that focus on improvement of men's health education and health-related behaviors as well as suggestions for areas of future research.

## Introduction

Compared with women, men appear to be at higher risk at younger ages of morbidity and mortality, and it seems that men with the strongest masculinity beliefs are at the highest risk and least likely to engage in preventive health care behaviors (Bird & Rieker, 2008; Garfield, Isacco, & Rogers, 2008; Rieker & Bird, 2005; Springer & Mouzon, 2011). Well-entrenched beliefs about the way men *should* behave may stand in the way of more effective health-related actions

and appropriate care. Indeed, it seems that “men are less likely than women to perceive themselves as being at risk for most health problems, even for problems that they are more likely than women to experience” (Courtenay, 2002, p. 2). Masculinity-derived beliefs either encourage men to engage in potentially harmful activities or to refrain from health-protective behaviors (Williams, 2003). These masculinity beliefs do not simply reflect the biological risks that men have higher mortality rates than women for just about every illness that affects both genders except Alzheimer's disease, they also reflect that men seem to be attracted to risky behaviors more than women (Courtenay, 2000; Creighton & Oliffe, 2010; Lohan, 2007). Men smoke and drink more than women, are more prone to violence, are more likely to engage in sports with high injury rates, and are less likely to wear protective gear (e.g., helmets, seat belts, condoms; Addis, 2011; Giovanni, 2013). In fact, “. . . men are more likely than women to engage in over 30 health risk behaviors that increase the risk of disease, injury, and death . . .” (Mahalik & Burns, 2011, p. 1; see also, Courtenay, 2000). Another potentially risky health behavior common among some men is to ignore routine health screenings and check-ups (Addis & Mahalik, 2003; McVittie & Willock, 2006; Meador & Linnan, 2006; Tudiver & Talbot, 1999). These bad-for-your-health behaviors are in line with masculine norms; norm-driven men associate health-promoting

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behaviors with femininity and that label is unacceptable (Addis, 2011).

### **Hegemonic Masculinity and Masculine Gender Scripts Promote Bad-for-You Health-Related Behavior**

Stereotypical male behavior that may negatively affect men's health is likely to be influenced by what is known as *hegemonic masculinity*, an idealized and norm-laden term. The key features of risky health-related behavior reflective of *hegemonic masculinity* are to ignore pain and other illness symptoms and to forego health care. Men demonstrate hegemonic masculinity when they adopt unhealthy health behaviors—to carry out more positive health behaviors requires that a man reject or modify these beliefs (Courtenay, 2009). Although there is a range of male response to hegemonic masculinity precepts, one hypothesis is that characteristics such as age, level of education, sexual orientation, ethnicity, marital status, or occupation might influence that response (Sabo & Gordon, 1995; Williams & Umberson, 2004). The effect on male health-related behavior or health practices is difficult to predict and likely to vary depending on the social construction of individual life circumstances and life course stage (Sabo & Gordon, 1995; Williams & Umberson, 2004). For example, in research with Latino men, Peak and colleagues reported acceptance of positive health-related behaviors among men as long as the goal was to be a good provider for one's family, which fits within the masculinity framework (Peak, Gast, & Ahlstrom, 2010). As Robertson (2006) states, men's notions of "acceptable" and "unacceptable" health practices can be modified by their unique and subjective experiences through the life span.

An unexpected effect on health behavior related to social class is discussed by several authors including Springer and Mouzon (2011) and O'Brien, Hunt, and Hart (2005) who found that men holding blue-collar-type jobs were *more* likely to seek preventive health care than those in higher status occupations; this is interesting because health and education are thought to be positively correlated, and thus, one might expect those in higher status occupations to have both more education and higher health care usage. These authors, as well as several others, hypothesized that the masculinity threat of not being able to work and provide for one's family might outweigh any other negative considerations associated with health care seeking (Gast & Peak, 2013; O'Brien et al., 2005; Peak et al., 2010; Springer & Mouzon, 2011). Other acceptable motivators that allow men to seek health care include the ability to exert control over one's life, to keep fit, and to maintain an active sex life, all of which fit within the masculinity framework (Addis & Mahalik, 2003). It appears that positive health-related behaviors can be "acceptable" if they fit within the masculinity framework but "not acceptable" if considered femininity-associated behaviors such as attending to emotional issues (Bennett, 2007; Farrimond,

2011). Interestingly, as noted in a study with African American men, some men may downplay their own health needs when balanced against other obligations such as family, work, and community responsibilities, obligations that, in this study, deterred the men from engaging in potentially healthful physical activity (Griffith, Gunter, & Allen, 2011).

Initially, *hegemonic masculinity* was understood to refer to patterns of practice "that institutionalize men's dominance over women" (Connell, 1987, p. 185). This concept of hegemonic masculinity as an idealized description of manhood reached wide acceptance in the late 20th century. Professor R. W. Connell (1987) popularized the term; a six page description appeared in *Gender and Power* and "became the most cited source for the concept of hegemonic masculinity" (Connell & Messerschmidt, 2005, p. 831). Over time, the discussion of hegemonic masculinity evolved from a general description of social roles and men's dominance over women, power relations between genders, and the characteristics associated with hegemonic masculinity, into a discussion of the behaviors that might be associated with the concept, and then to the possible consequences associated with those behaviors. The end result is likely to be multiple masculinities (Springer & Mouzon, 2011) as men strive to be masculine in ways that are negotiated and renegotiated in a dynamic process dependent on context, culture, and changing life circumstances (O'Brien, Hart, & Hunt, 2007; Sabo, 2000; Sabo & Gordon, 1995). Despite the fact that few men actually live the idealized hegemonic masculine life, its influence is far-reaching and is especially visible in men's health-related behaviors.

We may see the precepts of hegemonic masculinity enacted in men's lives through the vehicle of *masculine gender scripts*. Burns and Mahalik (2007) define masculine gender scripts as ways of acting, feeling, and thinking based on socially prescribed norms of masculinity. Many men learn how to be masculine from watching other men behave both in the real world and as portrayed in various media and infer appropriate male behavior from these received gender socialization messages (Sabo & Gordon, 1995). Masculine gender scripts that guide male behavior are constructed from these observations as well as societal feedback.

Masculine gender scripts may also promote a gendered response to health issues (Sabo, 2000). For example, men may adopt unhealthy behaviors such as smoking or drinking to excess or engaging in unprotected sexual activity because, according to scripted socialization messages, those behaviors demonstrate idealized masculinity (Courtenay, 2011; Fleming, Lee, & Dworkin, 2014; Sabo & Gordon, 1995). Tracking the influence of these masculinity-themed health messages might provide a useful way to modify men's health-related behaviors—it would be relatively easy to incorporate more health-appropriate masculine gender scripts into health education and health-promotion programs and then evaluate their impact on health outcomes (Gast & Peak, 2013; Thompson, 2008).

From this gendered perspective, doing health means doing gender: “Decisions that men and women take to be healthy are influenced by [their] understandings of what constitutes appropriate masculine and feminine behavior” (Thompson, Reeder, & Abel, 2011, p. 238). Many men express a strong desire to avoid health care encounters in traditional settings and will participate in health-prevention activities if they are disguised as in comfortable community settings such as barbershops or bars (Garfield et al., 2008; McVittie & Willock, 2006) or if responding to targeted messages that affirm gendered stereotypes (Fleming et al., 2014). In these male-associated community settings, participation in health-promotion programs is okay because they are consistent with masculinity-scripted activities. Another example of an acceptable gendered health activity is for a man to use some form of technology—for example, wearing some type of biometric assessment instrument that uploads data to a computerized tracking system—because technology mastery is a desirable male behavior (e.g., Men’s Health Network, n.d.; Porche, 2013). Similarly, health activity that is sports related is acceptable because sports activities are masculine-identified behaviors (Tudiver & Talbot, 1999). Certainly paying attention to one’s physical health through exercise or diet to improve sports participation fits within the masculinity framework (Garfield et al., 2008; Thompson et al., 2011). Interestingly, the range of acceptable male behavior connected to physical condition appears to be more limited than the range of acceptable female behavior; if there is a comparable hegemonic femininity framework, few can agree on its structure and composition (Connell, 1987). Despite what one might assume about men’s spirit of adventure and willingness to think outside the box, “. . . men appear more constrained than women by gender ideologies” (Evans, Blye, Oliffe, & Gregory, 2011, p. 8).

### The Influence of Age on Masculinity and Men’s Health-Related Behaviors

Interpretations of hegemonic masculinity vary for individual men at different stages/ages in their lives, refined by context, culture, and life circumstances. Hegemonic masculinity is not one consistent message, there is no one-size-fits-all definition. Multiple forms of masculinity are socially constructed and modified over the life course; each man makes his own adjustment (Sabo & Gordon, 1995; Thompson et al., 2011). Depending on what they have learned from their life experiences, older men may see the need and have the ability to repackage and reconstruct hegemonic masculinity messages to be less constraining; age-associated wisdom or the knowledge gained from life-altering circumstances such as widowhood might be used to modify traditional masculine beliefs and permit more effective health-related behaviors (Bennett, 2007; Springer & Mouzon, 2011).

There is a growing body of research on masculinity and its effects on men’s health-related actions generally but not

as much that specifically addresses whether age tempers health-related actions driven by hegemonic masculinity. Yet, over the life course, as men age, they may be more willing to readjust their views on masculinity in general and masculinity-associated health behaviors specifically. Verbrugge (1985) says that a combination of biological risks, acquired risks, and psychosocial factors helps explain health-related behaviors and psychosocial factors are more influential for women than for men. For example, women are more likely to feel psychological distress (e.g., guilt over conflicting demands, depression, and anxiety) but also are more willing to express those feelings and to seek help coping with them (e.g., social support). Taylor et al. (2000) state that, over time, women have evolved a more successful stress response of *tend-and-befriend* that builds social support networks and that women are more likely to rely on female friends as opposed to spouses for needed assistance. Although women may provide help to both men and women in their social networks, they ask for and receive help more often from their female friends (Taylor et al., 2000). In comparison, the male stress response of *fight-or-flight* does not build a social support network and produces less instrumental help in times of need. *Fight-or-flight* is associated with the hegemonic masculinity ideals that are suggested to shape men’s health-related behaviors (Taylor et al., 2000; Verbrugge, 1985). Is it possible for older men to add the more health-useful *tend-and-befriend* stress response to their behavioral repertoire? A broader range of behavioral responses might enhance the support options available to older men later in life. For instance, in work with older widowed men in England, Bennett (2007) found some older widowers managed to reconstruct masculinity-derived emotional self-control and allow emotional expression by changing the behavior categorization from “sissy stuff” to a demonstration of “the sturdy oak” (Brannon, 1976). Given the growth in our aging population and rising health care costs associated with aging, any improvement in men’s health-related behaviors that might produce cost savings takes on new importance (Springer & Mouzon, 2011).

Is it possible for aging men to transcend the bad-for-your-health behaviors associated with hegemonic masculinity? Can older men assume more effective age-appropriate—or health-appropriate—models of masculinity? Springer and Mouzon (2011) and others suggest that older men who are retired or in poor health might be more willing to do so because they have already lost the idealized sense of masculinity tied to occupational success and robust health (Calasanti, 2004; Calasanti & King, 2005). Widowhood too can be a motivator for change because wives are potential health-promoting agents. In a recent study of the effect of spousal loss on multiple dimensions of health for both genders, negative health behaviors were reported to be consistently more likely among men after losing a spouse (Das, 2012). The role adjustments associated with common events of older age, for example, retirement or widowhood, may

create opportunities for men to assume more effective health-related behaviors. In the case of widowhood, for example, given how often wives are the traditional health-behavior motivators for their husbands, if older men want to assume better health behavior without their health-promoting wives, figuring out new routes to achieve that goal is a necessity, and in some cases, as Bennett (2007) has found, does occur. (Note that although older women are more likely to be widowed in later life, women are more active health seekers and better at recruiting needed social support throughout their life span and typically do not need to adjust their health behaviors after spousal loss.)

Can men use their older age to modify their social construction of masculinity, from a normative to a more pragmatic embodiment of masculinity (Robertson, 2006)? Robertson, Sheikh, and Moore (2010) suggest the possibility of a linkage between the gendered nature of embodiment and more effective health practices. The intersection of gender, health, and aging and the relative weight of each in regulating behavior over the life course are fluid and may incorporate partnership status as well as factors related to economic and social class (Arber et al. 2005; Rieker & Bird, 2005). Will older men allow themselves to reinterpret the meaning of masculinity messages if a health threat calls for more effective behaviors that do not fit within hegemonic masculinity precepts? Tannenbaum and Frank (2011) explored this theme in a qualitative focus group study with 48 community-dwelling older men and then in a second study, a mail survey of 2,000 men aged 55 to 97. The focus group results in the first study indicate that health status can be used to permit more effective health-related behavior, even if that behavior is a threat to the stereotypical masculinity messages. The survey results in the second study specify age, even more than scores on a standardized masculinity index, for its ability to predict the acceptance of health-related behaviors. Both studies support the hypothesis that

with age men will succeed in incorporating actions into their daily lives in a way that does not conflict with their perceived resilience to frailty and weakness, even if such actions involve seeking help for illness or adopting healthier lifestyle behaviors. (Tannenbaum & Frank, 2011, p. 243)

This may mean that the ability of aging men to adjust health-related behavior is simply unpredictable given the range of possible masculinity modifications, including those associated with retirement or spousal loss (Evans et al., 2011).

There is some evidence that age *does* temper health behavior and that an individual's interpretation of masculinity precepts can be modified to be more pragmatic. In a study of 107 older adults in Florida, McGinty, Dark-Freudeman, and West (2012) compared younger (aged 50s-60s) and older (70s-80s) adults in terms of attitudes toward health behaviors and reported that age did affect some health-related behaviors. In this sample, the younger older adults were more

focused on health-improvement goals, whereas health-maintenance goals seemed more important to the older cohort. Respondents in both age categories appeared motivated more by health fears rather than health hopes in terms of health behaviors, but the younger older adults seemed more likely to believe that positive health behavior actions taken now could potentially improve future health, whereas the older group seemed satisfied with maintaining current health levels (McGinty et al., 2012).

Robertson et al. (2010), in their study of male cardiac patients, found a range of behavioral responses as the men struggled to adopt more effective health practices. Men appeared to feel more comfortable using age to explain their cardiac event as opposed to a gendered explanation that incorporates the notion of poor health. The use of age in this way maintains masculine capital. Another study that looked at whether health beliefs can be tempered for older adults was undertaken by Stephan, Chalabaev, Kotter-Gruhn, and Jaconelli (2013) who describe how negative stereotypical views of aging actually improved when positive feedback was provided to the older participants. Working with a group of 49 older adults (ages 52-91), Stephan and his team were able to successfully manipulate these older adults to feel younger after the team communicated positive performance messages about results of a handgrip test that induced the older participants to compare themselves favorably with younger peers (Stephan et al., 2013). After hearing these positive messages, the older adult participants improved their handgrip strength simply because they *felt* younger, although no physical indicator had changed. Communicating positive messages may be a promising strategy that could be used "to enhance physical functioning and health-related outcomes among older adults" (Stephan et al., 2013, p. 6).

Levy (2003) also described attempts to manipulate aging and gender stereotypes and suggested that the stereotyping process starts early in life when we internalize the negative aging messages we see and hear communicated around us. We accept these negative views about aging as valid and, over time, the messages evolve into negative self-stereotypes that affect our behavior when we actually are older (Kotter-Gruhn & Hess, 2012; Levy, 2003). Levy held four focus groups with a volunteer sample of men ( $N = 32$ ), all Caucasian, and an age range of 21 to 68 ( $M = 42.65$ ). Levy was particularly interested in how masculine gender scripts affect men's views of their own aging. The focus group results indicated that (a) men recognize that their bodies change as they age, (b) masculine gender scripts have an impact on their views on aging, (c) men need to and will rethink what masculinity means when faced with the challenges of aging, and (d) men think of aging in terms of capacity for physical activity (Levy, 2003). A particular contribution of this study is the acknowledgment that negative stereotypes of both aging and gender are internalized at an early age, then reinforced throughout the life span and enacted in later life.

Because there is a range of male response to masculinity-generated messages, it is likely that any individualized interpretation of masculinity beliefs will differentially affect men's health-related behaviors as well (Springer & Mouzon, 2011). It is okay for employed men to have flu shots if this insures they will remain in good enough health to provide for their families because being a good provider is in accord with masculine ideals, but what is the acceptable motivation for older men who are no longer in the workforce? Older non-working men need an alternate interpretation that supports maintaining good physical health when it is not connected to being a good provider. Acceptable masculinity-scripted reasons for older non-working men to maintain good physical health might include ensuring independence and autonomy because "real men" strive to avoid dependence on others (Calasanti, 2004; O'Brien et al., 2007). Avoidance of physical dependence might allow a routine physical exam but not a visit to a mental health professional because mental illness carries more negative stigma for men. A prostate exam is acceptable because part of the definition of being a "real man" is the ability to maintain an active sex life (Kontula & Haavio-Mannila, 2009; Matthias, Lubben, Atchison, & Schweitzer, 1997; Smith, Braunack-Mayer, Wittert, & Warin, 2007).

Tannenbaum and Frank (2011), the researchers who described findings from the qualitative and quantitative studies cited above, identified age, as opposed to scores on a masculinity index, as the better predictor of older men's health-related behaviors (e.g., wearing seat belts, exercise, eating well, getting an annual physical), which fits within the hypothesis that age does temper male health-related behavior. Participants in these two studies were 55 and older and, at least in the qualitative focus group findings, able to transcend the pull of hegemonic masculinity-driven behavior of "self-reliance, resilience, and toughness" (Tannenbaum & Frank, 2011, p. 247). Some of the respondents mentioned that engagement in good-for-you health behaviors demonstrated that they were in control of their health and, of course, personal autonomy fits within the hegemonic masculinity framework. For these men, witnessing friends vulnerable to aging-related health problems was a motivator to find an alternate solution, especially if that alternate solution promoted personal autonomy and fit the hegemonic "real men" masculinity model. Attempts to modify stereotypical thinking about the consequences of aging seem to have been successful in the studies cited here and are worth exploring further. It appears possible under conditions of sufficient motivation (e.g., after observing vulnerable friends), or if the definition of acceptable health-related behavior expands beyond being a good provider, as it might with non-working men, that older men can adjust their health-related behaviors.

### **Marital Status and Men's Health-Related Behavior**

It is widely accepted that being male is a potential risk factor for health; in some cases, health care professionals actually

expect poor health-related behavior from their male patients. Several studies report that health practitioners assume women will be the health care supervisors, overseers, and promoters of men's health care decision making (Seymour-Smith, Wetherell, & Phoenix, 2002; Thompson et al., 2011; Tudiver & Talbot, 1999); in some health practices, patient-reminder postcards and health-promotion messages are sent to patient partners (Stepnick, 2003). The underlying assumption is that a woman's intervention transforms a man's health care visit from "not going to happen" to "ok, make me an appointment," because his goal of wife-appeasement converts the health care visit to an acceptable masculine behavior—"my wife made me come" is all he is required to say (Gast & Peak, 2011; Seymour-Smith et al., 2002).

Marriage is known to provide both physical and mental health benefits for men that are different from those benefits women receive (Gast & Peak, 2011; Peak et al., 2010; Schoenborn, 2004). Markey, Markey, Schneider, and Brownlee (2005) describe how married men engage in more health-promoting behaviors and fewer health risk-taking behaviors when compared with single, divorced, and widowed men. They report that married men are significantly more likely than single men to undergo colorectal cancer screenings, cholesterol screenings, and prostate exams, even after controlling for age (Markey et al., 2005). Men also benefit from marriage through spousal management of daily hassles (Greenstein, 2000), provision of social support (Umberson, Chen, House, Hopkins, & Slaten, 1996), encouragement of health-promoting behaviors, and discouragement of health-harming behaviors (Umberson, 1987). It is important to note, however, that research has found a relationship between marital strain, aging, and health for both men and women (Umberson, Williams, Powers, Liu, & Needham, 2006). Umberson and colleagues (2006) noted that "the negative aspects of marriage appear to become more consequential for health as individuals age" (p. 13).

Some men voice gratitude for the potential health benefits found in marriage. For example, in a recent focus group study with married men between the ages of 20 and 89 (Arnell, 2014), participants reported less of a need to display traditional masculine traits and specifically noted reduced risk-taking behavior after marriage. These men also cited appreciation for spousal health-related social support and social control. Many respondents remarked that they avoided health care because (a) their fathers avoided health care, (b) they felt men should wait out an illness rather than seek health care, and (c) to spend time and money on health care was perceived as taking these resources away from their families. Some men learned not to tell their wives of injuries or illnesses to avoid the spousal social control strategies that would be used to pressure them. Although several participants reported less of a desire to adhere to conventional gender scripts after marriage, others felt that once they married, their time-honored breadwinner role placed a heavier burden on them. Respondents also stated that they maintained masculine identities through being a good provider and avoided

health care unless it was an emergency or interfered with their ability to work. Overall, these men did not feel that spousal social control was a masculinity threat but developed individual strategies to avoid marital conflict around health care behavior (Arnell, 2014).

Other research has linked marital status and men's health-related behavior to masculinity-related beliefs. Wives often encourage healthy behaviors through social control especially when a partner is unwilling to make a health behavior change on his own (Franks et al., 2006). Umberson (1992) reported that 80% of men named a spouse as the primary source of social control, and August and Sorokin (2010) stated that married men received social control messages more often than unmarried men. In a focus group study with Caucasian men, participants described seeking health care because of spousal pressure as opposed to severity of symptoms (Gast & Peak, 2011). Conversely, some research noted that social control efforts by spouses can be ineffective in promoting health behavior change and suggested that those efforts might undercut the confidence of the receiving spouse in his own ability to improve unhealthy behaviors and might increase psychological distress (Fekete, Stephens, Druley, & Greene, 2006; Franks et al., 2006; Helgeson, Novak, Lepore, & Eton, 2004; Rook, 1990). Very little research has specifically looked at spousal control, aging, and men's health.

Taken together, this body of research provides inconsistent messages about the value of spousal social control on men's health behaviors. The presence of a wife may result in better health-related behaviors for some men, but it is not clear which men benefit from spousal intervention and which are capable of self-directed health care. It is important to understand the beneficial aspects of spousal social control if one wants to improve older men's health-related behaviors. In the case of widowhood, is a substitute for absent spousal control the appropriate goal or should the preferred goal be encouragement for self-directed health-related behavior earlier in life so that all men, not just older men, become better independent actors with regard to their own health care behavior? Improving men's health-related decision making earlier in the life span might result in improved morbidity as well as mortality. The following section describes several promising interventions that attempt to do just that.

## Interventions That Help Men Modify Health-Related Behaviors

There has been an upsurge in attention to men's health, as can be seen, in part, in the inception of the Men's Health Network and Men's Health Month, which may underlie some of the current interest in interventions directed at men's health-related behaviors. Garfield et al. (2008) described a wide array of options in their excellent overview of this topic—several promising examples are discussed below. In addition, Courtenay, in *Dying to be Men* (2011) devoted a significant portion of his book to an analysis of why men

behave as they do in relation to their health and highlights possible interventions practitioners might try to effect change in men's health-related behaviors. Courtenay strongly supports that men and women “require different interventions, and that failure to tailor interventions to these specific needs significantly reduces the chance of behavioral change” (Courtenay, 2011, p. 289).

It seems likely that marketing male-specific health-related information and health services in settings in which masculine behaviors are supported (McVittie & Willock, 2006) will be more effective in overcoming men's reluctance to seek help as compared with the assumption that all health education efforts are equally effective with everyone. Even college-aged men benefit from messages tailored to their specific age-appropriate needs and learning styles, as Courtenay described in *Dying to be Men* (2011). Some of the techniques mentioned, such as utilizing representatives of the target group to help formulate health education plans, as well as trying something out of the ordinary to reach those considered resistant to health education, could work well with a male population of any age (Courtenay, 2011).

We see one example of an attempt to target messages appropriately to men in the Men's Health Network (MHN; [www.menshealthnetwork.com](http://www.menshealthnetwork.com)), a non-profit educational organization created to improve men's health, which offers health information that fits within the hegemonic masculinity perspective (Giovanni, 2013). The MHN website is a portal to an array of health education options that try to appeal to a wide range of men; the photographs used on the site show men engaged in a variety of manly activities. One MHN suggestion for more effective health behavior is to label a checkup a *Well-Man consultation*, which removes negative illness stigma; it is a checklist of typical health needs all men have, any health actions that result are considered routine, although men are encouraged to be proactive instead of reactive ([www.menshealth-network.org](http://www.menshealth-network.org)).

The Men Health Center in Baltimore is a male-friendly health clinic that tailors health services to men using research-based techniques on male health-related behaviors (Garfield et al., 2008). One male-friendly adaptation is that on arrival at the clinic, men write down their health concern on a piece of paper and hand that to the receptionist rather than openly voice the concern where others might overhear, thus averting possible embarrassment. The clinic uses community outreach to inform both men and women about their services. The information is marketed to men in settings where men gather (e.g., at work sites or at a barbershop); women receive positive feedback for their roles in encouraging men to seek appropriate health care (Garfield et al., 2008). Work sites are also a potential male-friendly setting; Peak et al. (2010) in their focus group study with Latino men found those respondents favored health-promotion programming at the work-site. If they are no longer working, older men may be responsive to health education services provided in alternate male-friendly community settings such as coffee shops or barbershops instead.

The National Institute of Mental Health's (NIMH) *Real Men Real Depression* outreach is an example of targeted education (Rochlen, Whilde, & Hoyer, 2005). In this campaign, NIMH provides basic information about mental health issues and treatment options using men from a range of age groups and backgrounds ([www.nimh.nih.gov/health/topics/depression/men-and-depression](http://www.nimh.nih.gov/health/topics/depression/men-and-depression)). North Carolina's version of PRECEDE (Green & Kreuter, 2005) is a planning model that incorporates health interventions designed to improve men's utilization of preventive health services (Meador & Linnan, 2006). Following their PRECEDE model, North Carolina started with a diagnosis of the problem—men's underutilization of preventive health services—and incorporated services to address what they determined to be “key behaviors that contribute to underutilization of preventive care services: delaying or avoiding care, lack of a regular physician, and concealing vulnerability” (Meador & Linnan, 2006, p. 190).

An outreach effort for a specific subset of African American men utilized a barber-based intervention to screen for hypertension at 16 African American owned barbershops in Texas (Victor et al., 2009). In a general discussion of the efficacy of using barbershops, Li and Linnan (2011) reported that their survey of barbershop owners indicated respondents “were very receptive about promoting health in the barbershop and are already discussing many important health topics with customers” (p. 207).

Any of these examples of targeting and marketing specifically to men can easily be adapted to reach older men as well although if health education efforts were more successful earlier in the life span, it might not be necessary to educate older men later in life. It seems that we are finally cognizant of the need to adapt *how* something is provided to best appeal to the group it is supposed to reach and that this might result in better health outcomes for the target group. If information is offered in user-friendly, non-intimidating settings, adjusting the message to match the audience, while emphasizing the acceptable masculinity attributes of good health (e.g., being a good provider and a competent sex partner, avoiding dependence, and maintaining autonomy), all men—older men too—can maintain their sense of masculinity and their good health.

## Discussion and Suggestions for Future Research

The three leading causes of death for both sexes are heart disease, cancer, and stroke (Bird & Rieker, 2008; Rieker & Bird, 2005; Verbrugge, 1985). Although the causes of death may be the same for both sexes, there are differences related to age at illness onset as well as illness response and trajectory. Those gendered differences reflect a variety of influences that change over the life span and about which there is incomplete agreement. Verbrugge (1985) suggests that men

and women respond differently to the biological risks of illness and disease as well as the acquired risks of work and play, that both categories interact with psychosocial factors, and that it might be that psychosocial factors have the most influence on health behavior change. For example, women may be better at health management tasks because they are more likely to seek help and typically maintain stronger emotional ties with others, whereas men are more likely to engage in a variety of masculinity-scripted activities such as substance abuse and dangerous sports in response to distress (Verbrugge, 1985).

Bird and Rieker (2008) put forward a model of *constrained choice* in which individual decisions about health behavior reflect not just personal preferences but also the social forces that regulate our lives and that this constrained choice model will help account for what has been missing in other discussions of gender differences in health. They say that “although many of the constraints and their consequences for individual choice are similar for men and women, the health impact will vary somewhat due to differences in both biology and life experiences” (Bird & Rieker, 2008, p. 6). Taylor and colleagues (2000) speculate it is the gendered distinction in stress response that underlies health behavior differences. They say the female stress response of *tend-and-befriend* is more health instrumental than the male response of *fight-or-flight* as it allows women to seek health care and to request and accept needed support (Taylor et al., 2000). Clearly, there is agreement that health behaviors are affected by gender even as there is a range of opinion about the mechanism.

This is a fascinating and timely topic. Any improvement in morbidity and mortality outcomes or reductions in health costs is highly desirable for both ethical and economic reasons (Thorpe, Richard, Bowie, LaVeist, & Gaskin, 2013). We suggest more research is needed to tease out answers to questions that remain unresolved. Can older men successfully adapt (if not reject) masculinity-driven health behavior? Do health behaviors and responses to masculinity ideals vary by subgroup—sexual orientation, urban versus rural, socioeconomic status (SES), race/ethnicity, or illness category? Future researchers might also examine masculinity ideals from a life span perspective and compare health behaviors for younger, middle, and older age men as they age. We need to learn from empirically driven health programs that focus on improving the health behaviors for all men to achieve better health outcomes for older men.

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