Introduction

Medicalized Masculinities: The Missing Link?

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A funny thing happened on the way to theorizing medicalization: men's bodies were ignored. This seems a startling statement, given the sheer number of articles and books written on the medicalization of—well, everything, it would appear. But with the exception of a few scattered but important pieces (see Ehrenreich 1983; Tiefer 1994; Potts 2000; Riska 2002, 2004; Mumford 1997), most of which are very recent, medicalization research has focused on genderless or female bodies. In medicalization research, as in most social-scientific research, gender seems to mean womanhood.

This is not to say that the male body is absent in social scientific research. It is clearly present in work on the body and in masculinity studies, both relatively recent strains of research, but neither of which considers male bodies as having been medicalized. It is also present in work on men and health, which often actively applies medical reasoning to male health, pathologizing masculinity as a health risk rather than commenting on its medicalization. Are we to assume that, of all the things that have been medicalized (from sexuality to reproduction to emotions to deviance to the family and caregiving to aging to race to femininity), masculinity has somehow managed to elude medical definition and regulation? And if it hasn't, how do we account for this gap in

the literature? The substantive chapters in this volume will address the first question; the second we try to answer here. In this chapter, we trace the history of work on medicalization (which failed to consider masculinity as an object of medical definition and regulation) on the one hand and of several other substantive social-scientific traditions (which considered masculinity but not its medicalization) on the other to consider why they functioned in practical isolation from each other. This will be a somewhat tricky business—it is, of course, far easier to explain why something did happen than it is to explain why it did not. But we suggest several causal factors here. First, the answer lies in habits established during the 1970s and 1980s, when (a) feminist work on the medicalization of femininity was taken to represent a one-to-one correlation between the two as regards gender, (b) the heavy focus on the medical control of underrepresented groups effectively excluded men from the picture, and (c) the masculinities literature's pathologizing of masculinity as a health risk limited its ability to recognize that medicine might be pathologizing men. Second, over the last twenty years, the sociology of the body's Foucauldian emphasis on the surveillance and discipline of bodies failed to intersect with an emergent focus on the embodiment of everyday life.

Medicalization: A Brief History

Medicalization emerged as both a concept and a theoretical tradition in the 1970s. The power of medicine to define and regulate social action was introduced by Talcott Parsons, who, in 1951, wrote about medicine's role in controlling deviance and, in the process (in true functionalist fashion), reproducing and strengthening the social order by holding the sick accountable to dominant social norms of productivity—a function that was beneficial to all. In 1970, Elliot Freidson provided an alternative to the functionalist view of medicine as a beneficent and politically neutral institution by depicting it as composed of actors devoted to monopolizing the production of health knowledge to achieve professional autonomy.

The medicalization thesis introduced by Irving Zola in 1972 accepted this vision of medicine as an agency of social control motivated by a quest for professional power, but deepened extant understandings of medicine's power by establishing that this was beginning to expand beyond its original goals by defining and controlling an increasingly wide array of human troubles—in short, by expanding its practices and authority into areas of life previously outside its purview. Medical agents did this by redefining social problems as medical ones and claiming that

their own expertise was the most appropriate one to cure them. While Freidson situated medicine's growing power in its own professional agenda, Zola pointed to the increasingly technical and bureaucratic nature of Western society as the engine behind the "medicalization of society"—the exponential labeling of aspects of everyday life as medical in nature by medical agents. According to Zola, processes external to medicine potentiated its galloping control over everyday life—while medicine certainly benefited from medicalization, its desire for power would not have resulted in medicalization had not the larger social context's desire for technical solutions to social troubles accommodated medicine's tactics and tendencies.

Thus, areas that had previously been seen as social problems, usually centered in or involving human bodies (i.e., homosexuality and alcoholism), and exclusively handled by the church and the state, were now seen as medical ones. Following on the heels of sociological critiques of psychiatry and working within a social constructionist perspective, Zola (1972) and Freidson (1970) depicted medicine as an agency of social control whose authority was partially due to its expanding power to define and regulate deviant behavior. Viewed within this frame, diagnoses (and diagnostic categories) are not neutral "discoveries" so much as highly subjective interpretations, and a number of studies published in the 1970s and 1980s (see, e.g., Schneider 1978; Conrad 1975; Conrad and Schneider 1980) traced the shift in interpretation of deviant behavior from moral to medical deficit, or "badness to sickness" (nested in the secularization and rationalization of Western society—see Turner 1984; Conrad and Schneider 1980. For more current work in this vein, see Rimke and Hunt 2002.) Indeed, that medicalization is primarily a matter of defining already-problematic behaviors in medical terms is central to this tradition: according to Peter Conrad (2000, 322), medicalization "consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it. Medicalization occurs when a medical frame or definition has been applied in an attempt to understand or manage a problem." As we'll see, this has led to an antagonistic relationship between medicalization scholars and Foucauldian ones.

These early (and subsequent) studies uncovered the explicitly political nature of medicalization—and, by extension, of science itself (see Knorr-Cetina and Mulkay 1983; Lynch 1997; Latour 1999 and 2000; Clarke and Fujimura 1992). Medicine is not above politics but deeply embedded in them, as can be seen in its control and regulation of politically disenfranchised populations such as women, children, the poor,

sexual nonconformists, members of racial minorities, and the aged. Through the medicalization of abortion,[1] reproduction (see below), menstruation (see Pugliesi 1992), childbirth,[2] childhood (see Halpern 1990; Pawluch 1983, 2003) and childhood behavior such as attention deficit disorder and juvenile delinquency,[3] welfare seeking (Schram 2000; Blackwell 1999), homosexuality,[4] race[5] and racism (Wellman 2000), aging[6] and the life course (Rosenfeld and Gallagher 2002), medicine not only expands its own powers, but limits the political power of already subject populations while claiming to protect them.

Thus, as an institution with increasing power to define deviance in medical terms (see Melick, Steadman, and Cocozza 1979; Robbins and Anthony 1982; Rosencrance 1985; Morrow 1982), medicine's self-styled and popular status as a scientifically neutral, even beneficent, institution was challenged by those who saw it as engaging in the social construction of medical "conditions" and "problems"—and, of course, in the production of medically suspect populations, albeit ones that participated, often eagerly, in their own medicalized identities (see, e.g., Schneider 1978; Markens 1996). The expanding market of services and treatments made medicine a profitable industry and bolstered its new status as a source of social control, as medicine was depicted as strengthening both the mechanism and the ideology of capitalism (see Waitzkin 1991). Moreover, medicalization was depicted as inherently political in that it helped to regulate populations, defined acceptable behavior, and individualized and decontextualized political issues.

While rooted in a concern with the medicalization of deviance, this body of work also examined the medicalization of areas of life that had not originally been seen as deviant, primarily life processes. The shift in focus from the medicalization of deviance to the medicalization of everyday life produced an explosion of studies on the medical definition and control of female reproduction (see Leavitt 1989; Becker and Nachtigall 1992; Sievert 2003; Barker 1998), death (see Kozak 1994), menopause (see Bell 1987 and 1990; Lock 1988; Worcester and Whatley 1992; Friedan 1993; Oudshoorn 1994; McCrae 1983), the family (see Donzelot 1979; Finkler 2000, 2001; Finkler, Skrzynia, and Evans 2003; Wolf 2002) and caregiving (see Lock 1984; Chappell 1999; Abel 2000; Binney, Estes, and Ingman 1990), and emotions (see Lock 1987; Pugliesi 1992)—and indeed, it was evident that these studies were not merely the product of an analytical shift, but the product of a growing recognition that medicalization was proceeding, apparently unchecked, to gain control over everyday lives, including healthy ones. These did not represent a shift from the state as an agency of social control to medicine as

its central agent; rather, they signaled a more complex shift toward a risk and surveillance society.

Biomedicalization and the Risk Society

According to Adele Clarke and colleagues (2003, 1), medicalization (again, the control by medicine over the definition and regulation of social problems) transformed into the more micropolitical biomedicalization: the definition and regulation of bodily processes themselves, mainly through "such technoscientific innovations as molecular biology, biotechnologies, genomization, transplant medicine, and new medical technologies." The seeds of biomedicalization were sown in the 1970s, when aspects of life that had not been seen as social problems (e.g., PTSD, PMS, and physical stigmas) began to be framed in medical terms. In 1985 this process accelerated, riding the shift from modernity (which focused on controlling external nature) to postmodernity (which focused on transforming the internal nature of humans and other creatures through, for example, the genome project). Computer and information technologies are central to this process, which occurred through the emergence of what the authors call "the Biomedical TechnoService Complex, Inc."—a fast-growing biomedical sector that is at once sociopolitical, cultural, and increasingly technological.

Biomedicalization is more widely dispersed throughout society than is medicalization, expressing its power through technological innovations and the production of "risk groups" that are both self-governing and governed by medical agents and agencies. These "technologies of the self" (Foucault 1988) take up an increasing amount of time and energy in actors' everyday lives and help to shape new identities and experiences.

Key to biomedicalization is the commodification of health itself. As Robert Crawford noted in 1985, social actors are becoming morally obligated to be healthy, just as Parsons's social actors are obliged to strive to overcome sickness. Health thus becomes a project rather than a taken-for-granted state; people are exhorted to adopt healthy "lifestyles" and to be open to health "promotion" messages. These messages and directives inhere in innumerable sites outside of the traditional clinical setting—indeed, they have become part of our culture and are embedded in key institutions such as school and the workplace.[7] Depicting health as constantly endangered by a myriad of decisions and contexts renders all actors medically problematic. Because "they create standard models against which objects and actions are judged," risk technologies are normalizing and give rise to distinctive types of surveillance. These use the results of risk assessments "that take epidemiological risk statistics, ostensibly meaningful only at the population level, and transform

them into risk factors that are deemed meaningful at the individual level" (Clarke et al. 2003, 8–9). That social actors embrace this discourse themselves makes health both more biomedicalized (by virtue of self-surveillance techniques applied at home) and less medicalized (by virtue of the social actor's increasing responsibility for her own health and a lessening of the power the doctor holds over it).

Thus, biomedicalization expands the range of medicine in everyday life from merely controlling bodies to actually changing them to conform to new health standards and identities (see Haraway 1991 on cyborgian bodies). Through preventive health messages that entail "lifestyle" changes, biomedicalization produces new identities, anxieties, and mundane practices. This clearly resonates with the recent risk society thesis that was itself inspired by the Foucauldian tradition.

According to Lupton (1999), the theoretical perspectives on risk that have emerged since the 1980s (the cultural anthropological approach, the work of Ulrich Beck and Anthony Giddens, and Foucauldian work on governmentality that explores how governmental structures "manage and regulate populations via risk discourses and strategies"—Lupton 1999: 1) all see risk as those working in the area of the social construction of social problems view social problems: as the product of claims makers rather than as objective phenomena and as serving social and political purposes. Clearly, then, research on risk shares much with research on medicalization. Of these three strains of research, however, the Foucaldian governmentality perspective is the most mindful of the social construction of risk, focusing not on the "nature of risk itself, but rather the forms of knowledge, the dominant discourses and expert techniques and institutions that serve to render risk calculable and knowable, bringing it into being" (Lupton 1999, 6).

Foucault held that over the past four centuries, "the modern system of liberal government, with its emphasis on rule and the maintenance of order through voluntary self-discipline rather than via coercive or violent means" (Lupton 1999, 4) fashioned an increasingly wide array of interlocking bodies of expertise and a plethora of institutions and mechanisms for their production, distribution, and use. To those working within the Foucauldian tradition, risk is just one of a number of disciplinary techniques that the government uses to survey and control populations. Epidemiological knowledge is used to construct a standard of health and health practices, against which individuals are judged, and those who deviate from this norm are categorized as at risk of any number of health dangers. "To be designated as 'at risk,' therefore, is to be positioned within a network of factors drawn from the observation of others" (Lupton 1999, 4–5).

Despite the resonance of the risk society approach with work on medicalization and social control, however, tensions exist between the two. As Lupton (1997, 94) states,

> the writings of Foucault and his followers, while not necessarily using the term 'medicalisation' or adhering to the versions of power relations usually presented by proponents of the orthodox medicalisation critique, tend to present a consonant vision of a world in which individuals' lives are profoundly experienced and understood through the discourses and practices of medicine and the allied professions.

Lupton writes that supporters of the medicalization thesis (those who adopt a feminist, Marxist, or consumerist approach to medicine) see medicalization in wholly negative terms and thus as something that should be resisted or escaped. To these supporters, medicalization "deflect[s] questions of social inequality into the realm of illness and disease, there to be treated inappropriately by drugs and other medical therapies" (1997, 96). This is particularly damaging to powerless groups, who are both more medicated than the powerful and the most likely to suffer the effects of inequality in the first place. The solution, say these scholars, is, again, escape or resistance through "demedicalization." According to Foucauldians, however, this is both oversimplistic and naive: the first because it elides the potentially beneficial aspects of medicalization, and the second because it assumes that medical power can be undermined through a process of redefinition alone.

The key difference between these two approaches centers on their different definitions of power itself. To Foucault, medical (and all other forms of) power exists not only in local sites and in the definition and control of a particular trouble (these are expressions of power) but in overarching disciplinary discourses and practices. Because power informs all social relations, it cannot be considered the possession of particular power groups, nor can power be transferred from one group to another. Medical agents are actors in a web of power relations and of discourses that exist independent of their situated deployment. For proponents of the medicalization thesis, however, power *is* the possession of powerful groups (here, medical agents) who actively and motivatedly work to secure power over populations (here, patients). In Conrad's (1992, 216) words,

> the social control that medicine gains through expanding its domain comes from its power to define that domain by defining human behavior and characteristics as medical in nature. Implemented by medical agents and strengthened by medical technology, it is nonetheless the definitional power that medicine holds that legitimates its control and

> that allows for medical agents to apply medical technologies in the first place.

For Foucauldian scholars, however, thinking of medical power as located in the hands of particular agents and agencies rather than in "a series of loosely linked assemblages, each with different rationalities" (Lupton 1997, 100) is misguided. Moreover, medicine is not omnipotent, clashing as it does with state and other agencies. This, then, is the third Foucauldian critique: medicalization scholars oversimplify the terrain in which the medical gaze works and assume that medicine's political and financial ambitions drive its expanding powers.

Gender and Medicalization

Riska (2003) identifies three phases that the medicalization thesis underwent in its consideration of gender. (The third, which she calls a "return to reductionism," is essentially a new wave in the medicalization of masculinity). The first, fashioned by Zola and Freidson, disregarded gender entirely, although research on the medicalization of deviance tended to concentrate on troubles that were assumed to exclusively affect males (e.g., hyperactivity and alcoholism). The second wave began in the mid-1970s, when feminists identified modern medicine's control of women as part of its central logic, pointing to the replacement of traditional women healers by male doctors in the nineteenth century and portraying women as the victims of medicine (see Ehrenreich and English 1973, 1974). Scientific medicine was depicted as an imposition of "abstract male knowledge" on women's previously reflexive awareness of the workings of their own bodies:

> There was a common assumption shared by various branches of the women's movement that women's health had been medicalized in the past, and that gender-biased medical knowledge and diagnoses and treatments decided by biased male physicians had resulted in the over treatment of women documented in high surgery rates for hysterectomies and mastectomies, and overuse of drugs, especially psychotropics. (Riska 2003: 66–67)

Feminists called for a reevaluation of women's bodies as healthy rather than as unhealthy when compared to the dominant male standard of health and for the demystification of women's bodies to be achieved by women learning about their own bodies.[8]

Thus, although the concept of medicalization was not inherently linked to gender, this era—and strain of research—inspired a deluge of pieces on, *inter alia*, the medicalization of the life course and all aspects

of women's reproductive lives (cited above). In concert with the burgeoning feminist writing on women's bodies and their regulation (see Boston Women's Health Collective 1973), women's bodies took center stage in much medicalization research. Indeed, many scholars asserted that women are more vulnerable to medicalization than are men. Reissman (2003 [1983] 58), for example, cited the greater external visibility of women's bodily processes in relation to men's (i.e., pregnancy, menstruation, and birth), the fact that women's social roles (i.e., as caregivers) bring them in more contact with medical agents than do men's, women's tendency to devote more time and energy to self-care than do men, and "women's structural subordination to men" as reasons for women's status as "especially appropriate markets for the expansion of medicine." While occupational medicine and stress management programs have tended to examine men's bodies rather than women's, and while "medicine has focused on childhood hyperactivity and the adult addictions—problems more common in males than females" (Reissman 2003 [1983], 57), Reissman argues, it is women's *ordinary* physical and psychological functions that have been medicalized, as opposed to men's exclusively *deviant* ones. (The exception Reissman notes is male impotence, which had begun to be medically scrutinized in the 1980s, but she states that male hormones and the male climacteric had not—a claim that no one would make today.)

Riska notes correctly that this exclusion of men's bodies and behaviors from the medicalization thesis is only beginning to be critiqued by scholars who write that the medical assumption that men's bodies properly function as the "prototype" for all human bodies ignores the gendered nature of men's bodies and health; again, while women's natural functions are pathologized by medicine, men's are not. Indeed, Judith Lorber (1997) and Vicki Meyer (2001) uncover just one of many contradictions in medical approaches to health. As Riska (2003, 71) writes, "chronic diseases in women are attributed to 'failed ovaries' and 'hormone deficiency,' which put women at risk, while lifestyle and physiological processes associated with aging are presented as primary risks for men." These and other insights into the hitherto ignored medicalization of men have just begun to be voiced in the last four years. Examples are work on the medicalization of masculinity in the context of coronary heart disease (Riska 2002—although Ehrenreich raised this as early as 1983) and recent work on the medicalization of male sexual "fitness" (Bordo 2000, Potts 2000, Marshall and Katz 2002)—according to Hartley (2003), an interesting, and rare, case of men's sexual problems having been medicalized before women's (but see Maines 1998). But the sense that women are more prone to medicalization than are

men endures; despite medicine's recent focus on men's bodies, Conrad (2000, 221–222) agreed with Reissman that "it is abundantly clear that women's natural life processes (especially concerning reproduction) are much more likely to be medicalized than men's" and cited Zola's claim that, since most elders are female, "it is likely aging and gender issues will continue to converge."

Until the twenty-first century, then, despite the significant concern with gender in much medicalization research, this was exclusively explored in the context of women's lives. While men were included (indeed, took center stage) in historical studies about the medicalization of homosexuality, it was their sexuality rather than their sex that was examined as the object of medicalization. (The same applies to studies about the medicalization of AIDS—see, e.g., Epstein 1988; for an exception, see Etzioni 2000.) While gender emerges as an object of medicalization in the context of the medicalization of the family, it is the medical definition and constraint of mothers, not fathers, that is documented (see Litt 2000; Donzelot 1979—but see Williams and Umberson 1997). Many studies of the medicalization of aging treat elders as though they were sexless, and while there is abundant work on the medicalization of female menopause, there is little on the medicalization of male aging *per se* (but see Marshall and Katz 2002; Hepworth and Featherstone 1998). Men's voices appear in work on chronic illness (see Charmaz 1995), but as objects of physical suffering rather than of medicalization. The sociology of mental illness considers the medicalization of female emotions into hysteria (see King 1989; Orr 2000; Zavirsek 2000; Briggs 2000),[9] but while there is certainly work on men's emotions and emotion work (see Umberson et. al. 2003; Gaia 2002; Scheff 2001; Katz 1988), there is little on the medicalization of male emotions (but see Cancian 1986 on the feminization of love). Work on the medicalization of race and ethnicity has concentrated on entire racial and ethnic groups and on minority women (see Roberts 1997; Kaw 2003) rather than on the medicalization of, say, African American masculinity (see Saint-Aubin 2002 for a strong exception). Thus, at the intersection of gender and medicalization, femininity has prevailed. Nascent in the research into medicalization are the seeds for considering the medicalization of masculinity (e.g., male menopause, criminality, homosexuality, the feminization of emotions and therapy), but with few exceptions already described here, these have been neither nurtured nor harvested. Indeed, with the exception of Riska's (2002) analysis, the few works on the medicalization of masculinity that have appeared over the past several years have concentrated on its most obvious instances—the medicalization of male aging and sexuality—rather

than on the myriad other aspects of masculinity cited above. This is due to the equation of gender with femininity in the context of medicalization, which is itself rooted in the assumption, brought about by the discovery of medicine as an agency of social control, that only underrepresented groups are medicalized.

Masculinities

The masculinity studies of the last three decades were inspired by the insight that while men had previously been studied as social actors of historical, political, cultural, and scientific significance, they had not been considered as gendered beings in the same way that women had—as actors whose gender mattered in the course of their daily lives and actions. Grounded in and ideologically affiliated with the second-wave feminism of the early 1970s, most of these studies have been explicitly feminist (or, in these studies' local argot, profeminist, given its claim that only women can be feminists). As had women, men involved in the Men's Liberation movement who were positively influenced by feminism began to question and politically contextualize their lives. Writing on masculinity in this era was both popular (e.g., the 1977 anthology *A Book of Writings for Men against Sexism*) and academic, with sociology, psychology, and social psychology showing the most interest in the area. Moreover, issues surrounding male homosexuality arose almost immediately, given the number of gay and bisexual men involved in Men's Liberation, some of whom drew connections between homophobia and sexism.

Early masculinity studies (e.g., Fasteau 1974 and Farrell 1975) challenged functionalist approaches to sex role theory, still dominant in the 1960s and present in the 1970s, which normalized the existing gender order. They stated that masculine roles, while assuring men political and economic power over women, were nonetheless damaging to men's physical and emotional health as well as to their social relationships. Thus, from the outset, this research tradition not only sought to problematize masculinity, but to pathologize and frame it in medical terms as well. The 1970s saw the release of a number of feminist books on masculinity that listed both the benefits of male power and privilege and the physical and emotional costs associated with traditional masculinity (see David and Brannon 1976; Pleck and Sawyer 1974; Pleck and Pleck 1980). While some of these feminist publications were written by women who critiqued masculinity as an essential aspect of patriarchy, others were written by men who used men's liberation to escape restrictive sex roles, and academic studies, mostly produced by men, approached masculinity

as a problematic amalgam of sex roles that were damaging to both sexes. A key example of the latter is Pleck's *The Myth of Masculinity* (1981), which argued that the male sex role model failed to capture the actual experiences of men and proposed a "male sex-role strain" model that sought to capture the costs of conforming to traditional masculine expectations. This book was a pivotal one, shifting the focus from sex roles to power and oppression (which in turn led to an emphasis on the multiplicity of masculinities and the importance of socialization in their development—masculinity studies' third wave). Clearly situated in the larger critique of functionalism, these early works critiqued sex-role theory for eliding the role of power in male-female relations, drew on conflict theory to call for masculinity studies' consideration of men's patriarchal roles, and demanded a systematic and structural approach to the topic.

The central challenge became to understand men's lives as embedded in systems of power and control while appreciating the fact that men may also be victims of those very systems. In the writings of the late 1980s and early 1990s, the answer lay in masculinity's own precarious status: men may be disempowered relative to other male groups, and men of all socioeconomic-political statuses rely on others to validate their masculinity (see Pleck 1992 and Kaufman 1987). Masculinity, with all its benefits, is thus socially constructed and fragile, requiring interactional reproduction and reassurance. This new focus on masculine practices and its interpersonal accomplishment led to a concern with how boys are socialized into masculinity (e.g., Kivel 1999), claiming that masculinity was a limiting (and, as we'll see below, unhealthy) set of practices. Masculine socialization limited the parameters of acceptable gendered behavior and severely punished deviations from them. While this research focused on the classroom, the gendered use of space, the role of parents, and cultural assumptions (e.g., McGuffey and Rich 1999; Connell 1996; Kenway 1996) as forces of social control, however, it failed to consider the role of medicine in defining and regulating masculinity. Rather than intersect with other work on social control (i.e., medicalization), the masculinities literature of the 1990s veered toward an engagement with issues of diversity within masculine culture and lives, as profeminist scholars studying men argued against accepting one type of masculinity as normative while labeling others deviant. Following the multiracial focus of feminism, the differences between men that received the most attention were identical to those that differentiate women: race, class, sexuality, age, and disability (see Gerschick 2000 and Gerschick and Miller 2004 on disabled men; Majors and Gordon 1994 on black men; Chen 1999 on Asian American men; Fine et al. 1997 and

Karen Pyke 1996 on working-class men and class more generally; and Connell 1992 and Levine 1998 on gay men).

The dual foci on diversity among men on the one hand and on the power that men hold on the other converged in Connell's well-known theoretical work, which sought to balance an understanding of masculinity as part of a tool kit subordinating women (and, in his later writings—see Carrigan, Connell, and Lee 1985—subordinated men such as homosexuals and marginalized men such as the poor and men of color) with an appreciation for the different ways that men actually define and enact it. In 1995, Connell defined masculinity as "simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and structure,"[10] and defined hegemonic masculinity as "the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy" (Connell 1995, 77). These definitions allow for the agentic male practice of distancing the self from a dominant (and historically variable) traditional masculinity while retaining the latter's centrality to the gendered social order under patriarchy. Despite some criticism,[11] the concept of hegemonic masculinity is widely used in current work.

Thus, the relatively new area of masculinity studies that emerged in the 1970s and picked up steam in the 1980s and 1990s bypassed issues of medicalization for issues of socialization, gender roles, and the role of masculinities in pitting men against each other as men are pitted against women. This tradition's explicitly feminist agenda[12] led it to follow the same theoretical trajectory as had feminism and to echo feminism's condemnation of masculinity as a source of power and of damage to men and women alike.[13] These scholars depicted the reproduction of hegemonic masculine gender roles and men's use of their superior political and economic locations as the central means of subjugation by men. This encouraged a structural focus that nonetheless ignored the existence of medicine as an institution that controlled men, and the pathologizing of masculinity as damaging to health meshed with medicine's tendencies to normatively rank certain behaviors through the lens of health. Despite Whitehead and Barrett's (2001, 1) claim that "today there are no areas of men's activities that have not been subject to some research and debate by both men and women," the result of these emphases was a body of work that, while useful in certain ways, fails to recognize the significance of medicine for the production and control of masculinity, despite its feminist allies having documented the medicalization of femininity throughout the years that masculinity studies developed.

Masculinity and Men's Health

With few exceptions, both masculinities and epidemiological studies pathologize masculinity as a health risk and thus take an active role in the construction of the risk society rather than adopt a critical stance towards it. The central argument is that traditional masculinity—comprised of sexual difference from women, superiority (and superior power over others), independence, aggressiveness, competition, and physical strength—leads men to (1) engage in risk-taking behavior such as excessive drinking, fast and risky driving, risky physical endeavors, and violence, all of which allegedly account for higher accidental or homicidal deaths, (2) suppress their emotions to act overambitiously in the pursuit of power (which, in the unimaginative epidemiological logic embraced by this strain of work, leads to coronary heart disease [CHD]), and (3) deny their pain and its significance, which leads to a failure to seek medical treatment. As we've seen, the men's movement of the 1970s depicted men as victims of the same gender order that victimized women, although not in the same way and not to the same degree. Current men's studies scholars continue to assert that "health seems to be one of the most clear-cut areas in which the damaging aspects of traditional masculinity are evident" (Sabo and Gordon 1995, 17), although they locate these behaviors in the gender order rather than in any innate male tendencies. Indeed, Harrison, Chin, and Ficarrotto (1992: 282) wrote that

> it is time that men especially begin to comprehend that the price paid for belief in the male role is shorter life expectancy. The male sex-role will become less hazardous to our health only insofar as it ceases to be defined as opposite to the female role, and comes to be defined as a genuinely human way to live.

(Given many men's studies scholars' assertion that masculinity is, by definition, a rejection of the feminine, this would be a neat trick indeed.)

The product of this reasoning was a causal link between masculinity, specifically "traditional white middle-class male sex-role characteristics" (Riska 2003, 74), and ill health. These were constructed as health risks because they cast men in the role of the primary breadwinner of the family—a major health burden. Men became an endangered species, threatened "by the operative effects of the male mystique: men's own self-destructive and risky behavior to prove their heterosexual male identity" (Riska 2003, 74–75).

A similar discursive process has occurred in regards to men's limited health-seeking behaviors and use of medical resources relative to

women's, which have been cited as causal factors in men's higher mortality rates and lower life expectancies. Just as women have traditionally been held up to the standard of men's bodies, men are now being held up to the standard of women's health behaviors; in short, men's health behaviors are now depicted as deficient by using women's health behaviors as the gold standard for health practices (Riska 2003, 77). Given that men's relatively light use of medical resources has been attributed to their masculinity, this results in once again positing masculinity itself as a cause of ill health: a discursively medicalizing move (in Foucauldian terms, becoming one of the assemblages of governmentality).

Embedded in the construction of masculinity as a health risk is a wholesale adoption of the medical model's dogma that CHD is caused by poor diet and emotional inadequacies and that early medical surveillance and intervention prevents and/or cures disease. In short, it reproduces and elaborates the risk behaviors argument that dominates medical, epidemiological and popular thinking. (The clearest example of this is the construction of the type A man whose stereotypically masculine commitment to success is a risk factor for CHD—see Ehrenreich 1983, Riska 2002.[14]) That constructing a set of behaviors as risk factors "detracts from the possibility that we will recognize and rectify social circumstances that impact people's health" (Segal, Demos, and Kronenfeld 2003) makes this construction eerily reminiscent of medicalization, which individualizes and decontexualizes political issues. Gendering these alleged risks has placed men in a subservient role with respect to health, as men's higher mortality rates and lower life expectancies in the West are attributed to their own behaviors, albeit behaviors that originate in the larger socioeconomic, political, and gender systems. Thus, rather than critically uncover the medicalization of masculinity that, as this volume's chapters demonstrate, is occurring, epidemiology and men's studies are seemingly unaware of it, albeit for different reasons: epidemiology because of its essentially medical vision of human health, and men's studies because of its tendency to pathologize masculinity as damaging to men and women.

The Sociology of the Body

While the last fifteen years have seen an explosion of sociological and historical studies of the body, this focus has a long, if only recently recognized, history in the social sciences. Indeed, a concern with the body as a social rather than merely biological entity is deeply embedded in classical theory. Karl Marx ([1867] 1954), for example, wrote that capitalism's survival depended upon the continual reproduction of

human bodies, and Friedrich Engels (1987 [1854]) documented capitalism's disastrous impact on the working-class body. As Williams and Bendelow (1998) show, Emile Durkheim (1960 [1912]) established the body-soul relationship as central to the distinction between the sacred and profane, and the ascetic body is key to Max Weber's (1958) argument in *The Protestant Ethic and the Spirit of Capitalism*. Norbert Elias's work on the civilizing process (1978 [1939] and 1982 [1939]) traced the historical shaping of the human body from an impulsive and unrestrained vehicle of a volatile medieval personality to a calculating, rationalized, pacified, and repressed entity—a process characterized by the replacement of external restraints on the body to internal ones (an insight that resonates with Foucault's work on repression) and which he considered ongoing and perhaps endless.

This sociological concern with the body remained dormant until it was awakened by the work of Michel Foucault and, to a lesser degree, Erving Goffman, who is ironically considered more of a symbolic interactionist than a sociologist of the body. Foucault's work (1973, 1977, 1978) uncovered a new form of bodily discipline, beginning with the production of the clinical body that was reduced to its anatomical parts and processes and regulated through the medical gaze and practices and made compliant through such other key institutions of social control as the school and the prison. Foucault's work documented the body as an entity under increased surveillance and regulation designed to monitor it and fashion it into a productive tool, and spawned a new sociological and historical perspective on the body as a socially and politically constructed and, as we've seen, increasingly self-regulating entity—a theme taken up by Bryan Turner in later years (see Turner 1984). Goffman's work on stigma (1963a), impression management (1959, 1967), and relations in public (1963b) highlighted the body as a vehicle for social identity and interaction and, indeed, for the "interaction order" itself.

There things rested until 1984, when Turner's (1984) seminal work, *The Body and Society*, reminded scholars that the body is, in sociological terms, an "unfinished entity" bound within institutional discourses that constantly form and reform it as an experiential one (Gubrium and Holstein 2003; Shilling 1993). Turner's text led to further breakthrough works on the body from Pasi Falk (1994), Chris Shilling (1993), Emily Martin (1987), and the 1995 debut of the journal *Body & Society*. In a few short years, the sociology of the body had emerged as a topic of great debate and discussion—a state in which it remains today, as this substantive focus engages new areas of discussion, from somnolence (Taylor 1993; Hislop and Arber 2003) to the body postmortem (Freiden 2003). Indeed, having critiqued the Foucaldian approach for its ironically

disembodied approach to the human body wrought by its emphasis on discursive power, a new strain of work has called for an examination of the body as an everyday, active entity, not as simply the inarticulate construction of disciplinary forces, à la Foucault. To quote Loic Wauquant (1995, 3), "One of the paradoxical features of recent social studies of the body is how rarely one encounters in them actual living bodies of flesh and blood. The books that have appeared in recent years on the topic . . . typically offer precious few insights into the actual practices and representations that constitute the human body as an 'ongoing practical achievement'."

Three recent edited volumes alert us to this shift—Nettleton and Watson's (1998) *The Body in Everyday Life,* Williams and Bendelow's (1998) *The Lived Body*, and Faircloth's (2003) *Aging Bodies: Images and Everyday Experience*. As Nettleton and Watson (1998, 2) note, daily lives are embodied. We wake up, brush our teeth, drive to work, trip on the sidewalk, have sex, and so on. These are all *bodily* functions. To quote the authors, "Everyday life is therefore fundamentally about the production and reproduction of bodies." More and more research recognizes the body as a central entity in its own right that engages ordinary men and women as they make their daily rounds. The result is a growing appreciation for the body as a "thing" experienced in daily life (Nettleton and Watson 1998) as well as a passive, docile object (Foucault 1977), an entity subject to its own government (Turner 1984), a civilizing presence (Elias 1978 [1939]), and both consumer and consumed (Falk 1994; Featherstone 1991).

The body is also, of course, both gendered and sexualized in a range of discourses and encounters, as several scholars have shown (Butler 1993; Backett-Millburn and McKie 2001; Jackson and Scott 2001). In addition to the feminist work on female bodies that began in the 1970s (see above), a new wave of feminist work has considered the construction and depiction of the female body. Judith Butler (1993), for example, provides us with an intriguing example of how the body has been gendered in Western society. Following Turner (1995), Butler suggests that the body is represented in terms of a patriarchal definition that explicitly constructs the body in terms of gender and sexuality, departing from a philosophical concern with the "Other." Faircloth (2003, 6) summarizes Simon Williams and Gillian Bendelow's argument, appearing in their book *The Lived Body: Sociological Themes, Embodied Issues* (1998), that dualisms that form the basis of our culture (mind/body, subject/object, nature/culture) are transferred to women in the forms of "reproduction/production, family/state, and individual/social." The result, Butler argues, is the female body's construction within ropes of

hegemonic culture. While this sheds some insight into the female body's location between "natural entity" and cultural construct, Butler has been critiqued for having fallen victim to the Foucauldian tendency to focus on the cultural discipline of the body through interwoven tendrils of surveillance while ignoring everyday practice. Nonetheless, her work attests to the ongoing relevance of gender to the study of the body.

Despite the burgeoning work on the body, however, the medicalization of masculinity has gone unconsidered in this promising new tradition as well. Falling into two broad and seemingly mutually exclusive areas—the Foucauldian surveillance and disciplining of bodies on the one hand, and the embodiment of daily life on the other—the medicalization of the body itself has been omitted in the interests of capturing macro-level discursive impacts on the body and the embodiment of everyday life. Sociologists of gender who include embodiment in their fields of vision have focused on such matters as lived experience, gender, sports, and, of greatest significance to this volume, the impact of chronic illness on the body rather than its medicalization. If one reads what is perhaps the predominant journal in medical sociology, *Sociology of Health and Illness*, one is overwhelmed by articles on the everyday experience of illness, of birth, the impact of risk, and so on, but one searches in vain for an article that focuses on the actual medicalization of everyday life. By focusing on the experience of illness rather than its construction, medical sociology and the sociology of health and illness (the most obvious venues for the sociological consideration of the body) treat illness as a practical and moral exigency challenging the individual rather than as a social and cultural by-product of medicalization. Thus, while Williams and Bendelow (1998, 19) argue that "the male body has become increasingly prominent as an explicit topic of investigation for theorists and empirical researchers alike," this work has focused on discounting the traditional epistemological status of men's bodies as the standard against which women's bodies are measured, on calling for a theorizing of male embodiment, and on challenging the "tendency to see men and masculinity as separate, such as 'minds' using 'bodies,' " rather than on the intersection of male bodies and medical discourses and regimes.

The fact that the medicalization of masculinity has gone unrecognized (except as it is evident in Viagra and CHD) can be explained by reference to a number of factors. One of them may very well be that the masculinity aspect of medicalization is so subtle that it is almost imperceptible. After all, the prototypical examples of medicalization that tend to be cited are deviance and female reproduction, and since masculinity has not traditionally been seen as deviant and male reproduction has

not been medicalized (although there is some anxiety about sperm count these days—see Halwell 1999), the medicalization of masculinity evaded the medical sociological imagination. Another factor is that once medicalization was discovered to be a source of social control, scholars focused on powerless groups (e.g., the poor, elders, women, racial minorities, and children) to the exclusion of other groups, such as men. Foucauldian scholars distanced themselves from the medicalization thesis, viewing its treatment of power and regulation as simplistic and naively reformist; why they failed to appreciate the increasing medical control of masculinity in particular, however, is particularly mysterious given their immunity from the medicalization critique's exclusive focus on allegedly "powerless groups" (a term hardly in keeping with Foucault's conception of power as a dynamic social resource shared by all). The early feminist argument that male medicine pathologized and medicalized women's bodies effectively precluded recognition of the medical control of men, and, for reasons cited above, the medicalization of masculinity has gone unnoticed by feminists and pro-feminists who pathologize masculinity themselves. Finally, the sociology of the body is split into two broad camps: the Foucauldian one that focuses on surveillance and discipline and the camp that has challenged it to consider everyday embodiment. Given the Foucauldian sense that the medicalization thesis is overly simplistic and the proponents of the latter's emphasis upon daily experience to the exclusion of the social and political construction of the fields in which embodiment unfolds, the medicalization of masculinity falls outside of either camp's purview. Despite this effective exclusion of men from research on medicalization, however, the social sciences have recently begun to recognize that male bodies may no longer be exempt from medical definition and regulation—if, indeed, they ever were. Partly inspired by the introduction of Viagra and other sexual technologies, by the reduction of male sexuality to hormonal imbalances (mirroring the discourse on female sexuality), and by the immense marketing possibilities this reductionistic interpretation offers, this work has yet to find either a focused voice or a publication venue.

This book provides both, covering new sexual technologies and the medicalization of male aging, masculinity in the context of medical anatomy and therapy sessions, black masculinity, and underdeveloped male socialization. Given the vast array of areas of everyday life in which the medicalization of masculinity continues to unfold, however, a myriad of other case studies suggest themselves. These include the medicalization of masculinity through the construction and regulation of prostate and testicular cancer, sexual offenses (and offenders), homosexuality,

female masculinity, and male aggression and criminality (through, for example, the "discovery" and attribution of causal significance to the XYY chromosome). We hope that the chapters contained in this volume will inspire others to expand the scope of current work on the medicalization of sexuality to include masculinity and thus to fashion a more sophisticated understanding of the intersections between medicine, gender, bodies, sexualities, and health.