Social and Personality Psychology Compass 3/4 (2009): 394–412, 10.1111/j.1751-9004.2009.00192.x

Masculinities, Femininities, Behaviour and Health

Antonia C. Lyons*
Massey University

Abstract

Using the notion that gender is performed in daily life and through daily activities, I review some of the health behaviour literature which employs ideas about masculinity and femininity. I argue that recent theorising about both masculinities (Connell & Messerschmidt, 2005) and femininities (Schippers, 2007) can be extremely useful in this field. I consider two specific health behaviours in light of this theorising, namely healthy eating and drinking alcohol, and explore how and which versions of masculinities and femininities are played out, which are problematic, and what they mean for gender hegemony. I argue that across both areas (and across other health behaviours), there are three specific issues that are important and require further conceptual development and empirical work: (1) the relationality of gender; (2) masculinities and femininities as embodied; and (3) the local, contingent and intersectional nature of masculinities and femininities. This conceptual framework and the aspects of relationality, embodiment and intersectionality have important implications not only for understanding health behaviours, but for any social psychological work theorising identities and everyday social practice.

Introduction

Sex and gender have long been linked to health behaviours. A vast amount of research consistently shows that men are more likely to engage in risky kinds of behaviours than women, while women engage in more positive health behaviours (Mahalik, Burns, & Syzdek, 2007). Observed sex differences in morbidity between men and women have been largely attributed to these everyday health practices of women and men (Lohan, 2007; Mahalik et al., 2007). However, examining sex differences in health behaviour does not tell us why or how such differences come about, nor explain variations in behaviour within men or within women. Using the notion that gender is performed in daily life and through daily activities, I review some of the health behaviour literature which employs ideas about masculinity and femininity, particularly around healthy eating and drinking alcohol. I argue that theories of masculinities and femininities can be extremely useful in this field, given that engaging in particular

forms of behaviour, including those to do with health and illness, are involved in the construction of gender identities. This has implications for our social psychological theorising on identities more generally.

Theorising Gender

Gender research has been criticised for using notions of gender that are too fixed and static (e.g., gender role theory), for ignoring variation within women and within men, and for failing to include power in its conceptualisations (Connell & Messerschmidt, 2005). Feminist theory and critical men's studies have influentially conceptualised gender as arising from practices within everyday life (Butler, 1993; Connell, 1995). Engaging in particular behaviours can be seen as a way of both producing and reproducing gender. Behaviours have cultural meanings that are associated with different versions of masculinity and femininity, and we enact varied gender identities by taking part in particular behaviours (Sellaeg & Chapman, 2008). In this sense, gender resides not only in the person but in social transactions and daily activities defined as gendered (Crawford, 1995), and is a continually negotiated and tenuous identity achieved through repeated (and shared) practices (Paechter, 2003). Furthermore, through engagement in these behaviours or practices, gender becomes accountable and assessed by others, and aspects of gendered identity become legitimated (West & Zimmerman, 1987).

Masculinity

A large body of scholarship on gender theory and research has occurred in the field of men's studies, particularly critical studies of men. Here masculinity is viewed as a social location, a set of practices and characteristics that are understood as 'masculine' which have effects on bodily experience, individuals, relationships and social structures (Connell, 1995; Schippers, 2007). Thus, instead 'of possessing or having masculinity, individuals move through and produce masculinity by engaging in masculine practices' (Schippers, 2007; p. 86). Hegemonic masculinity describes culturally dominant forms of masculinity (Connell, 1995; Connell & Messerschmidt, 2005) which influence men's identities and behaviours (e.g., being strong, aggressive, tough, independent, courageous, invulnerable). In Western societies, it is currently linked to heterosexual, white, middle-class status (Schippers, 2007). Hegemonic masculinity subordinates femininity, but also works by subordinating and marginalising other masculinities (e.g., gay men, men of lower social classes or racial/ethnic groups). Although few men actually attain the dominant hegemonic form of masculinity (e.g., celebrated athletes), many men aspire to it, benefit from it, and are 'complicit' in sustaining it (Connell, 1995; Gough, 2007). There are some masculine practices and characteristics that are hegemonic, and there are others that are not (Connell,

1995; Schippers, 2007). Furthermore, different masculinities are not necessarily linked to different groups of men; different masculinities are continuously being renegotiated through different practices and arise out of different social contexts (Connell, 1995). Empirical research examining the accomplishment of masculinity in everyday talk supports the notion of multiple and conflicting masculinities which are negotiated in different contexts (e.g., Edley & Wetherell, 1997; Gough, 2001; Robertson, 2006).

Femininity

The concept of hegemonic masculinity and Connell's (1995; 2000) groundbreaking work on multiple masculinities have been widely drawn on in gender theory and research. In contrast, there has been an undertheorisation of femininity, including notions of hegemonic femininity and multiple, hierarchical femininities (Schippers, 2007). Masculinity theorists have argued that research on hegemonic masculinity needs to pay much closer attention to 'the practices of women and to the historical interplay of femininities and masculinities' (Connell & Messerschmidt, 2005; p. 848). This is especially relevant as women, particularly young women, engage in new behaviours and configurations of identity that have an impact on gender hierarchies (Connell & Messerschmidt, 2005). Recently, Schippers (2007) has usefully developed the concepts of hegemonic femininity and multiple femininities based on the notion that these are central to male dominant gender relations. She explores how gender hegemony operates via masculinities and femininities, with men's dominance at the centre. The hegemonic significance of masculinity and femininity, Schipper argues, comes from the 'quality content' of the categories 'man' and 'woman'. Symbolic meanings are attached to each of these categories, defined in relation to each other, including the qualities that members of each gender category should possess. This includes, fundamentally, heterosexual desire. As Schippers points out:

> in contemporary Western societies, heterosexual desire is defined as an erotic attachment to difference, and as such, it does the hegemonic work of fusing masculinity and femininity together as complementary opposites. Thus, it is assumed that men have a natural attraction to women *because of their differences* and women have a natural attraction to men (p. 90).

There is more to masculinity and femininity than erotic desire, but this construction establishes the meaning of the relationship between masculinity and femininity in terms of difference and complementarity. Difference and complementarity do not constitute hegemony; however, gender hegemony arises from cultural constructions which define masculinity as dominant in relation to femininity.

Schippers defines hegemonic femininity as 'the characteristics defined as womanly that establish and legitimate a hierarchical and complementary

relationship to hegemonic masculinity and that, by doing so, guarantee the dominant position of men and the subordination of women' (p. 94). Ideal femininity in Western societies includes characteristics such as being nurturing, dependent, cooperative, weak, passive, submissive, cautious, vulnerable and virtuous. To be considered feminine, women are expected to engage and reproduce these hegemonic feminine ideals (O'Connor & Kelly, 2006). Femininity is a subordinate position to masculinity, but within this position, hegemonic femininity is valued over other femininities because it serves the interests of the gender order. This gender order constructs desire for the feminine object, physical strength and authority as the characteristics that differentiate men from women, and define their superiority over women, and it is these characteristics that then must be unavailable to women. When women do take on or enact such 'masculine' characteristics, they threaten the gender hegemony and must be contained via social sanctions, being defined as deviant or stigmatized (e.g., promiscuous women are labelled 'sluts' or 'cock-teasers'). Schippers argues that undesirable and non-normative versions of femininity cannot be seen as subordinate to an ideal femininity because femininity itself is subordinate to masculinity. However, they contaminate the relationship between masculinity and femininity, and therefore, Schippers calls them 'pariah femininities'. Men who embody and take on feminine characteristics (such as being attracted to other men, being weak) are also socially sanctioned; they also contaminate social relations. However, they are stigmatized as problematic but decidedly feminine, thus reinforcing the superiority of masculinity. Femininity is already inferior to masculinity and therefore can include stigmatization and contamination within it.

Masculinities, Femininities, and Health Behaviours

Decisions people make about what actions to engage in to 'be healthy' are infused by ideas about appropriate masculine and feminine behaviour, and as Saltonstall (1993) has influentially argued, 'this suggests that the doing of health is a form of doing gender' (p. 12). Engaging in health behaviours are themselves forms of social practice which construct the person; furthermore, social order is negotiated, produced and reproduced through such practices (Saltonstall, 1993). Men's and women's lives are socially organised in ways that affect their health behaviours through patterns in employment, social roles and activities, and economic resources (Bird & Rieker, 1999). Thus, health behaviour is a social practice through which gender identities and gender hegemony are continuously (re)constructed.

For men, hegemonic masculinity means that 'doing gender' frequently involves behaving in ways that puts their health at risk (Courtenay, 2000), such as consuming excessive amounts of alcohol (and drugs), being invulnerable, not seeking professional help, being violent and aggressive, and engaging in risky sexual and driving behaviour (Mahalik et al., 2007;

Noone & Stephens, 2008; Smith, Braunack-Mayer, & Wittert, 2006). Indeed, a recent experimental study found that unconscious priming of masculinity evoked faster driving in men, but priming of femininity did not (Mast, Sieverding, Esslen, Graber, & Jancke, 2008). Suicide behaviours are also gendered, with a recent review of the literature concluding that 'suicide-related behaviours, like health-behaviours more generally, are influenced by (and influence) demonstrations of masculinities and femininities' (Payne, Swami, & Stanistreet, 2008; p. 23). In sum, cultural understandings of masculinity influence men's health behaviours and these in turn function to situate them in the masculine arena (Mahalik et al., 2007).

Dominant forms of masculinity and femininity are constructed in opposition to one another, a dichotomy which is all-encompassing (Jay, 1981): if male is one thing, female is the opposite (e.g., hard/soft; light/dark; public/private; nature/nurture, mind/body). Therefore, being concerned about health is related to femininity; health protective behaviours have been linked to traditional notions of femininity (Lee & Owens, 2002). Performing ideal femininity involves viewing the body as vulnerable, attending to self-care, seeking professional health advice and help, and being concerned with diet and nutrition. Furthermore, femininity is linked to being the carers and custodians of other people's health (men, children, families) via women's 'natural' helping abilities (Lee, 1998; Lichtenstein, 2004; although evidence shows that these responsibilities have their own health costs: Doyal, 1995). Ideal femininity is not all good for health, however. The emphasis on beauty and slenderness and the pursuit of the 'thin ideal' (Bordo, 1993) have serious consequences for disordered eating patterns, including extreme dieting (Lee, 1998).

Overall, some non-traditional versions of masculinities and femininities for both men and women may enable greater practice of positive health behaviours, although some may not (e.g., excessive drinking among women; lack of exercise among men). Importantly, masculinities and femininities are negotiated within a neoliberal Western society where health has become one of its most salient features (Crawford, 1980), as well as the personal responsibility of the individual. Being healthy is now a moral obligation (Conrad, 1994). Viewing health care as a moral duty clearly privileges concern with health and wellbeing (feminine realm) over and above ignorance or avoidance of health and wellbeing issues (masculine realm), disrupting the gender order.

Below, I focus on two specific areas of behaviour that are related to health and identity, namely food, diet and healthy eating, as well as alcohol consumption and binge drinking. Engagement in, practice around, and meanings of these two behaviours have seen marked shifts in Western societies in recent years (see, e.g., Chamberlain, 2004 and Motluk, 2004). I consider these health behaviours using the gender framework outlined above, exploring how and which versions of masculinities and femininities are played out, which are problematic, and what they mean for gender

hegemony. I argue that across both areas (and across other health behaviours), there are three specific issues that are important for theorising identities in health and social psychology which require further conceptual development and empirical work: (1) the relationality of gender; (2) masculinities and femininities as embodied; and (3) the local, contingent and intersectional nature of masculinities and femininities.

Food, diet and healthy eating

A healthy diet is important for long term health and is related to the onset of so-called 'lifestyle' diseases (e.g., diabetes, obesity, heart disease, cancer). Research across a range of disciplines indicates that food and eating has meaning beyond providing the body with sustenance – it plays important roles in identity expression, communication, social interactions and constructing status and gender (Vartanian, Herman, & Polivy, 2007). Food and diet have traditionally been associated with femininity, as have activities that are related to food, such as shopping, cooking and eating (Roos, Prattala, & Koski, 2001). What type of food and how much we eat are gendered behaviours. Meat and alcohol are markers of masculinity in many cultures, and vegetables, fruits and sweet foods markers of femininity (Jensen & Holm, 1999). Eating smaller meals and eating 'healthy' foods are perceived as feminine behaviours, while eating larger meals and eating 'unhealthy' foods are perceived as masculine behaviours (Vartanian et al., 2007). Despite their increased participation in paid employment, women remain responsible for the majority of domestic food work (Lake et al., 2006; Hochschild, 2003) and demonstrate more familiarity with nutritional and dietary guidelines than men (Beardsworth et al., 2002).

A few studies have investigated the meanings men attach to food, highlighting how notions of hegemonic masculinity distance men from the feminised realm of healthy eating. For example, media representations of men, food and health in UK newspapers portrayed diet as a feminine domain and men as having narrow and unhealthy diets, knowing little about nutrition, and requiring 'hearty' food to fuel their bodies. Men's cooking practices were presented as special (e.g., novel, solitary, and selfish) and diet was trivialised and mocked, thereby undermining women's knowledge and reinforcing dominant hegemonic masculinities (Gough, 2007). Interviews with men about their food and eating practices show similar notions of food as fuel, the requirement of heavy food for manual labour, and routine and everyday cooking as women's work (Roos et al., 2001). However, men from higher social classes displayed more positive attitudes to vegetables and talked about food in terms of taste and pleasure, suggesting these men have 'negotiated new ways to be masculine and reformulated their definition of masculinity' (Roos et al., 2001; p. 54). Other research highlights how men in the United Kingdom reject healthy food because it is not substantial or tasty enough, although older men

took healthy eating more seriously, and middle-class men were more adventurous in their food habits (Gough & Conner, 2006). These men also displayed cynicism about governmental health messages (Gough & Conner, 2006), and as Sobal (2005) has noted, 'manly' eating frequently represents a way for men to enact 'independence' and 'autonomy' through refusing to allow others (governments, partners) tell them what to eat. Canadian men who live alone have also articulated more traditionally feminine ideals about food and healthy eating, yet they simultaneously linked ability to cook with traditionally masculine values of independence, self-sufficiency and impressing women. They also had low motivation to cook for themselves and their cooking focused more on entertainment and fun outside the domestic realm (Sellaeg & Chapman, 2008). As Sobal (2005) notes, men's cooking is often performed in hypermasculine ways: frequently outdoors (away from the domestic realm of the kitchen), being public and on display (rather than private and in isolation) and involving meat. This is also apparent in the vast number of male celebrity chefs who live in a glamorous, public world where cooking is far from routine and mundane.

In summary, while men's diets are typically seen as unhealthy, and men as lacking knowledge about healthy eating, the extent to which this is true for all men is currently unclear. It seems there are subgroups of men who are renegotiating how they 'do' masculinity with food and diet, and further research on other specific subgroups of men may well highlight the extent to which this occurs elsewhere. These men may have *masculinity insurance* (see Schippers, 2007); that is, men who embody other features of hegemonic masculinity that overshadow or change the meaning of their practices of cooking and food preparation (e.g., men of higher social classes, men who are physically strong and powerful, men who are top athletes). Or perhaps there are groups of men who are engaging in alternative versions of masculinity via their domestic cooking that research has yet to identify: men who are taking on board pleasures around food and cooking for others that enable them to provide healthy meals for their families. Such behaviour retains the some of the features of hegemonic masculinity (man as 'provider') but simultaneously allows them entry into 'carer' practices.

For women, there is much research and theory addressing disordered eating (e.g., Malson, 1998; Ogden, 2003), but relatively little research available on how food relates to constructions of hegemonic and alternative forms of femininities. Research demonstrates that women view food and cooking as a central activity in their lives and place value on meals with family and socialising (see Gustafsson & Sidenvall, 2002). Preparing and cooking for Christmas is seen by older women in New Zealand as an opportunity for self-affirmation and public recognition (Wright St Clair, Hocking, Bunrayong, Vittayakorn, & Rattakorn, 2005). However, health nutrition messages and the imperative to be thin in Western society can cause anxiety and guilt among women, including older women (Gustafsson & Sidenvall, 2002). The mundane, routine everyday nature of preparing

food and cooking for others is undertaken overwhelmingly by women and is located as a feminine practice in our social world. However, these routine behaviours are undervalued, as the hierarchical structuring of masculinity and femininity would suggest, and this is apparent in the academic literature. Little research explores how specific cooking and eating behaviours may produce different and non-hegemonic versions of femininity, and whether there are subgroups of women who are producing alternative femininities through their food-related behaviour, such as contemporary celebrity female chefs, or women who do not regularly cook for others.

Western health promotion guidelines attempt to increase people's consumption of those foods that are markers of femininity, and decrease those that are markers of masculinity (Jensen & Holm, 1999). This produces tension for the hierarchical ordering of gender in our society. Health promotion messages regarding diet and nutrition are often contradictory, complex and confusing (see Chamberlain, 2004) and may themselves be seen as aligned with stereotypes of femininity such as being fickle, contradictory and changing (in contrast to characteristics of masculinity as solid, dependable and consistent). Distancing oneself from this unstable knowledge may be more important in enacting hegemonic masculinity than engaging in the 'proper' behaviour of healthy eating. Additionally, while research has demonstrated that people who eat 'good' (healthy) food are perceived as being more attractive, intelligent and 'better' people than those who eat 'bad' food, those eating 'good' food are perceived as not very sociable and not much fun to be with (Vartanian et al., 2007). Thus, breaking the moral requirement to eat healthily may have social benefits (being seen as a more fun person) for various masculinities, and to a lesser extent, femininities. For women, knowledge about nutrition legitimates the pursuit of ideal femininity and slimness (Jensen & Holm, 1999), as well as caring for the health of the family, thus reinforcing the gender order.

Alcohol consumption

Drinking excessive amounts of alcohol, and binge drinking, is related to both short term and longer term health effects (Institute of Alcohol Studies, 2007). Drinking alcohol is a gendered activity. Cross-cultural research shows that men continue to drink more often and more heavily than women internationally (Rahav, Wilsnack, Bloomfield, Gmel, & Kuntsche, 2006) and young adult males drink more often than young adult females in almost every society (Ahlstrom & Osterberg, 2004/2005). Heavy drinking is a behaviour which is traditionally accepted and expected in men, and other characteristics of traditional masculinity, such as competitiveness, taking risks, and confronting pressures, may also prompt or support alcohol use among men (Van Gundy, Schieman, Kelley, & Rebellon, 2005). The mere act of consuming alcohol has been linked to the construction of traditional masculine identities (e.g., Kaminer & Dixon, 1995; Willott

& Griffin, 1997); drinking has been said to be male dominated, male identified and male centred (Capraro, 2000). However, within the act of consuming alcohol, behaviours are perceived as gendered, in terms of how much, what and where drinking occurs, with men traditionally expected to drink excessively, drink primarily beer, and drink in public. Having alcohol problems is viewed as unfeminine, whereas the inability to handle alcohol is viewed as unmasculine (Jakobsson, Hensing, & Spak, 2008).

A recent qualitative study conducted in Scotland suggests that the social contexts in which young men are drinking are changing rapidly, and masculinities are being redefined (Mullen, Watson, Swift, & Black, 2007). In this study, men were not necessarily using alcohol to assert a hegemonic masculinity; rather, pluralistic and more flexible masculinities were identified. However, these findings are inconsistent with other research. College men in the United States (particularly white men) have been found to use public drinking to communicate their hegemonic status to others (Peralta, 2007), while men in the United Kingdom have also been found to use alcohol to demonstrate hegemonic masculinity, although some men used alternative forms of competence to exhibit different versions of masculinity (e.g., sporting prowess; De Visser & Smith, 2007). Male drinking practices in rural pubs in New Zealand (NZ) have been found to persist because they are a site of male power and legitimacy in community life (Campbell, 2000). By drinking in the pub, men were literally performing masculinity, and dominant understandings of legitimate masculine behaviour were reinforced and defended, importantly always in relation to femininity. In comparison, young adults in an urban NZ setting have demonstrated greater manoeuvrability and flexibility in the enactment of masculinities through alcohol consumption, although some constraints on legitimate versions were apparent: men were expected to drink beer and to 'handle' excessive consumption (Willott & Lyons, forthcoming). In summary, initial research highlights that greater flexibility is available in versions of masculinities via alcohol consumption practices, although findings are inconsistent and may depend on local, national and cultural contexts. There remains a paucity of research into the multiple and complex ways that men are constructing their gender identities, particularly *in relation to* women and to recent increases in women's consumption.

Research examining how women perform gender through their drinking also identifies alternative versions of femininities, with women and men constructing women who drink as empowered, independent, pleasure-seeking social beings, which is linked to their changing positions in society (Lyons & Willott, 2008; Measham, 2002; see also Emslie & Hunt, 2008; Hutton, 2006). Women have been found to be regularly engaging in binge drinking, drinking (and liking) beer, drinking excessively for enjoyment, and drinking in public with friends, all traditionally hegemonic masculine gender performances (Lyons & Willott, 2008; Measham, 2004). However, they simultaneously feminized this behaviour (e.g., drinking wines and cocktails;

matching drinks with appearance). Thus, although engaging in traditionally masculine behaviour, they did so in ways that reaffirmed femininity and were in line with other hegemonic feminine ideals (see also Kraack, 1999; O'Connor & Kelly, 2006). Women may gain some credibility by appropriating hegemonic masculinity practices and in this way produce a version of femininity that is complicit with rather than subordinate to men (Kraack, 1999), suggesting some disruption in gender hegemony.

However, boundaries to women's excessive drinking were also identified. In NZ, some women are seen as engaging in 'unrespectable' behaviour when drinking; breaching ideal notions of femininity by losing control and being irresponsible by putting themselves at-risk of attack by men (Lyons & Willott, 2008). Older women were particularly viewed as deviant and breaking moral codes, perhaps because femininity continues to be equated with motherhood, which justifies scrutiny and moral panic (Day, Gough, & McFadden, 2004). Among undergraduate women in the United States, excessive drinking ('drinking like a guy') generated a sense of gender equality, although in reality it was more to do with emphasizing women's (hetero)sexuality and being attractive to men, thus reinforcing gender hegemony (Young, Morales, McCabe, Boyd, & D'Arcy, 2005). Other research has found that US college women 'do gender' by limiting the amount they drink so as not to breach gender boundaries and be seen as bad, promiscuous or masculine (Peralta, 2007). In the United Kingdom, young women have been found to drink heavily but show self-restraint and self-policing around intoxication for fear of social disapproval, ensuring they stay within the boundaries of traditional femininity (Measham, 2002). Jackson and Tinkler (2007) have argued that the most threatening aspect of women going out and drinking heavily in public is 'her disruption of dominant discourses on gender and on women as carer' (p. 264). This is likely to explain the double standards that continue to exist around what, when and how much drinking women should be engaging in (Lyons & Willott, 2008; Montemurro & McClure, 2005). Men and women might engage in the same behaviour for the same reason (e.g., binge drinking), but this plays out in very different ways for masculinities and femininities (see O'Connor & Kelly, 2006) and gender relations. Women's drinking generates concern because it is viewed as leading to problems for children, homes and our traditional moral order (Holmila & Raitasalo, 2005).

What are the implications of these constructions for addressing drinking behaviour? As Capraro (2000) has pointed out in the college context, 'nothing short of a radical reconstruction of masculinity' is likely to change men's drinking behaviour. He argues that drinking must be understood as a behaviour embedded in masculinity; linked to larger systems of attitudes, values and structures in men's lives that constitute masculinity and men's social position relative to women. For women, drinking must also be understood within broader (changing) social structures and gender relations, an understanding that is apparent in lay people's talk about

gender and health (Emslie & Hunt, 2008). Health promotion attempts to reduce binge drinking must tackle the complex issues around the functions of drinking for identities. Furthermore, as identity work becomes increasingly commodified via the marketing, purchasing and consumption of particular drinks (McCreanor, Greenaway, Barnes, Borell, & Gregory, 2005), we need to explore how men and women construct masculinities and femininities through the alcohol they consume, and how products are marketed to carve out apparently new and flexible versions of (commodified) masculinities and femininities (Willott & Lyons, forthcoming).

Considerations

This work on masculinities, femininities and health behaviour raises many complex issues, questions and implications for both research and practice. The three I concentrate on here concern the relationality of masculinities and femininities, the importance of including the body in theorising and research, and the local, contingent and intersectional nature of masculinities and femininities.

Masculinities and femininities as relational

Despite the vast amount of work exploring gender and health, there has been a lack of interest in the links between men and women, and a surprising separation between men's and women's worlds (Schofield, Connell, Walker, Wood, & Butland, 2000). Factors that influence the contexts in which we 'do gender' have largely been ignored (Johnston & Morrison, 2007) despite insistence that specific and historical constructions of masculinities and femininities cannot be dissociated from one another (Petersen, 2003). Individual health-related behaviours do not operate in a vacuum and acquire meaning only through their relationship with broader social practices (Lyons & Chamberlain, 2006; Mielewczyk & Willig, 2007). They need to be examined in the context of men's and women's interactions with each other, and within the larger structure of gender relations (Connell & Messerschmidt, 2005; Moynihan, 2002; Schofield et al., 2000). Recently, scholars have called for research examining the everyday lived experiences of *both* men and women, and how these are constructed as sets of gendered power relations (Smith & Robertson, 2008).

One important setting of gender interaction is families, where traditionally women are the caregivers who promote healthy behaviour and take responsibility for the health of others. Even in contemporary partnerships with dual careers, research suggests traditional roles in the family home remain intact (Hochschild, 2003), meaning women are doing the 'double-shift' of paid employment as well as household/family duties. This in turn leads to negative outcomes in their own lives (Schofield et al., 2000). Media representations portray women as the carers of, and responsible for, men's

health, representations which have few benefits for either women or men (Gough, 2007; Lyons & Willott, 1999). Marriage (and similar partnerships) seems to be particularly advantageous for men, offering caring, cooking and emotional and social integration (Payne et al., 2008). As men enter into such partnerships (as well as fatherhood), it has been found that they have less need to demonstrate hegemonic masculinity through risky behaviours, although they are more likely to enact other hegemonic ideals such as economic success, being a good breadwinner, and taking control (Payne et al., 2008; Robertson, 2006). It is not clear how much room for manoeuvre there is within families; taking on caring responsibilities is linked to 'sensitive' and 'new' masculinities, but we know little about how they operate in everyday life and what they mean for power asymmetry in gender relations. Masculinities and femininities need to be theorised and researched as processes that involve negotiation within situated contexts such as partnerships, families, and social activities, to gain insight into meanings and values associated with health-related behaviour and identity construction (see, for example, Seymour-Smith, & Wetherell, 2006).

Masculinities and femininities as embodied

Saltonstall's (1993) influential study on health in everyday life highlighted how participants saw health as about being embodied; and furthermore, saw the healthy body in markedly gendered ways. She thus argued that gender is central to the everyday lived experience of health. Men and women have different biological bodies, but these bodies are understood, produced and enacted in gendered ways. Masculine bodies are represented as hard, dry, invulnerable, strong, powerful, dominating and active (Bunton & Crawshaw, 2002; Saltonstall, 1993), while feminine bodies are represented as soft, leaky, vulnerable, weak, messy and passive (Shildrick, 1997; Young, 1990). The feminine body in the world is *not* open, active, bold and masterful, and to enact such behaviour has been said to invite objectification (Young, 1990) and possible stigmatisation. Ideas about masculinity and femininity influence how we use our bodies, which in turn influence conceptions of masculinity and femininity (Connell, 1995).

Bodies that are valued in contemporary Western culture are those that are 'lived', active, fit, young, sexually attractive and healthy looking (Monaghan, 2001). People engage in health-related behaviours, such as exercise and diet, to discipline their bodies to achieve this ideal. Indeed, food, health and the body are inseparable (Lupton, 1996). Significant changes in society have meant that men are increasingly becoming objects to be looked at, disrupting conventional gender patterns in which women are the object of the gaze (Gill, Henwood, & McLean, 2005). Men now also manage and discipline their bodies via behaviours that previously primarily women engaged in (Chamberlain, 2004). This has led to contradictions in current ideals of masculinity, which require that men manage

and discipline their bodies whilst simultaneously disavowing interest in their bodily appearance (Gill et al., 2005), and engage in risky health practices whilst simultaneously disciplining a body so it is fully capable of participating in society (Bunton & Crawshaw, 2002).

Theorising on the body has tended to emphasise illness, sickness and disability rather than 'vibrant physicality and associated embodied pleasures' (Monaghan, 2001; p. 331). Any work on health behaviour needs to include sensual bodies which desire and seek enjoyment and pleasure in everyday life. This is particularly salient given that transgression of moral messages around healthy living is itself pleasurable (Williams, 1998). Additionally, men and women have different biological, material, bodies which must also be included in our theorising about gender, health and behaviour (Birke, 2000; Kuhlmann & Babitsch, 2002). There has been a long history of viewing gender in terms of socially constructed bodies in contrast to material bodies, although this dichotomy (culture and nature) need not be absolute (Chapple & Ziebland, 2002): the social body and the biological body are mutually shaped and intertwined (see Lohan, 2007). We are neither one nor the other, but both simultaneously. Compared to embodiment research, there has been relatively little empirical research that has attempted to link the socially constructed body with embodied feelings and sensations (Cromby, 2004) nor with its physiological processes (Lyons & Cromby, forthcoming). Processes of identity negotiation in routine talk may be related to physiological processes, such as cardiovascular function (Lyons & Cromby, forthcoming; Lyons & Farquhar, 2002; Lyons, Spicer, Tuffin, & Chamberlain, 2000), an idea which could be extended to explore physiological processes involved in the (re)production of masculinities and femininities in everyday life.

The local, contingent and intersectional nature of masculinities and femininities

Those characteristics and practices that are idealised as masculine and feminine vary by context, group and society (Paechter, 2003; Schippers, 2007). Connell and Messerschmidt (2005) argue that hegemonies are constructed locally, in the face-to-face interaction of families, organisations and immediate communities. To explore such local interaction empirically, it would be worthwhile to access 'naturally occurring data' (Potter & Hepburn, 2005), and examine how speakers are using notions of masculinity and femininity in their talk with each other, and what this is achieving in terms of identity work (see Speer, 2001). This conversation analysis approach would allow theorists to explore how 'power and normativity is negotiated and constructed by participants in the course of their interaction' (Speer, 2001; p. 113). By keeping the analytic focus on the speakers' orientations and ways in which they categorise gender in their talk (Schegloff, 2007), we can identify which versions of masculinity and femininity are appropriate for specific local interactional contexts, including which versions are invoked, managed or resisted and when this is achieved during the talk.

Connell and Messerschmidt (2005) also argue that alongside the local, regional (culture or nation state) and global (world politics and transnational business and media) arenas are also important. So, versions of masculinities and femininities, including hegemonic versions, will vary by a range of social locations, positions and identities people occupy, including ethnicity, class, age, sexuality, employment, religion, geographic location, dis/ability and so on. There are infinite numbers of ways in which these factors can intersect, suggesting an arbitrariness about any identity construction which always entails some silencing of something (Petersen, 2003). Examining intersecting masculinities and femininities by other factors such as class, ethnicity or sexuality may run the risk of proposing so many versions that clarity is inhibited, generalizability is lessened, and analytical closure is precluded (Sobal, 2005). Multiple versions of masculinities and femininities are more useful when attached to a clear theory of power (Sobal, 2005), and when focused on specific outcomes and practices. For example, evidence on men's help-seeking behaviour concludes that occupational and socio-economic statuses are more important to consider in this field than gender alone (Galdas, Cheater, & Marshall, 2005). In the literature on suicide-related behaviour, Payne et al. (2008) point out that 'because traditional male status is more often dependent on relative socio-economic success and control over their work and environment, men may be more sensitive to deprivation, and more vulnerable to gender role distress as a result of not meeting expectations' (p. 32).

Associations between masculinities, femininities and health vary importantly across different social vectors, including by culture (e.g., health awareness in Mexican American men; Sobralske, 2006) and generation (e.g., smoking behaviour; Hunt, 2002). Yet, we currently do not know how specific versions of masculinities and femininities are themselves constructed differently across specific intersections. For example, historically ideal notions of femininity positioning women as passive and respectable have been promoted by privileged groups. Working class women were already positioned as 'other' in relation to this hegemonic femininity, so they did not have access to 'respectable' femininity (Skeggs, 1997). Day, Gough, and McFadden (2003) have drawn on these understandings to explore aggression and violence among working class women, and they conclude that this behaviour '"makes sense" in the light of local community values and practices. Moreover, such aggression could well be seen in terms of resistance to or rejection of dominant middle-class femininities defined as respectable' (p. 154).

Intersectionality has been a useful tool for feminist and anti-racist scholars, underscoring as it does the multidimensionality of marginalised individuals' lived experiences (Nash, 2008). It subverts race and gender binaries, makes theorising identity more complex, and highlights how some individuals are multiply-marginalised across different vectors of identity (Nash, 2008). It is important to realise that 'positions of dominance and

subordination work in complex and intersecting ways to constitute subjects' lived experiences of personhood' (Nash, 2008; p. 10).

Conclusion

Considering gender identities in terms of relationality, embodiment and intersectionality is central for all social psychologists interested in behaviour and identity as practice. Different versions of masculinities and femininities are being created and negotiated in relation to one another in everyday life via routine behaviours related to health. If we can empirically examine and deconstruct hegemonic versions of masculinity and femininity, we may be able to promote ways of 'doing gender' that are beneficial for both men and women, and have greater positive health consequences. We need to bear in mind that a gender relations approach is essential, and we cannot afford to focus on reconstructing masculinity along more healthy lines independently of femininity, or their interaction. Furthermore, in any reconstruction, we need to examine the intersections of social power, to avoid those that privilege only white, middle-class, employed men and women (see Gough, 2006). Changing people's health behaviours is not enough to enable substantial change for positive health outcomes unless the societal constructions of the behaviours are addressed and power structures that give rise to gender inequalities are deconstructed (Payne et al., 2008). We need to acknowledge the particularity of the current gender order and imagine possible alternatives.

Acknowledgements

I would like to thank Brendan Gough and two anonymous reviewers for their very helpful comments on earlier versions of this manuscript.

Short Biography

Dr Antonia Lyons is a Senior Lecturer at Massey University, Wellington. She has been involved in teaching both social and health psychology for the past 10 years, after completing a PhD in health psychology. Previously, Antonia has worked at the University of Birmingham, UK and Massey University, Albany. She is particularly interested in issues around gender, health and identity; the experience of illness; and the social contexts of health behaviours such as drinking alcohol. She has published widely in health psychology on experiences of, and psychosocial factors involved in, particular conditions and procedures (e.g. rheumatoid arthritis, congestive heart failure, cardiac catheterisation, puerperal psychosis, menopause, oral surgery), as well as on media representations of health and illness. She is also interested in issues of embodiment, particularly how social interaction and discourse relate to physiological functioning within and across

individuals. She employs both quantitative and qualitative methodologies in her research. Her co-authored textbook (*Health Psychology: A Critical Introduction* with Kerry Chamberlain) was published in 2006 by Cambridge University Press. Antonia is currently on the editorial boards of the *Journal of Health Psychology* and *Subjectivity,* and has recently joined a NZ National Strategy Group on Tertiary Student Drinking.

Endnote

* Correspondence address: School of Psychology, Private Box 756, Massey University, Wellington, New Zealand. Email: a.lyons@massey.ac.nz

References

Ahlstrom, S. K., & Osterberg, E. L. (2004). International perspectives on adolescent and young adult drinking. *Alcohol Research & Health*, **28**, 258–268.

Beardsworth, A., Bryman, A., Keil, T., Goode, J., Haslam, C., & Lancashire, E. (2002). Women, men and food: The significance of gender for nutritional attitudes and choices. *British Food Journal*, **104**, 470–491.

Bird, C. E., & Rieker, P. P. (1999). Gender matters: an integrated model for understanding men's and women's health. *Social Science and Medicine*, **48**, 745–755.

Birke, L. (2000). Sitting on the fence: Biology, feminism and gender-bending environments. *Womens Studies International Forum*, **23**, 587–599.

Bordo, S. (1993). *Unbearable Weight: Feminism, Western Culture and the Body*. Berkeley, CA: University of California Press.

Bunton, R., & Crawshaw, P. (2002). Consuming men's health: risk, ritual and ambivilence in men's lifestyle magazines. In S. Henderson & A. Petersen (Eds.), *Consuming Health: The Commodification of Health Care* (pp. 187–203). London, UK: Routlege.

Butler, J. (1993). *Bodies that Matter: On the Discursive Limits of 'Sex'*. London, UK: Routledge.

Campbell, H. (2000). The glass phallus: Pub(lic) masculinity and drinking in rural New Zealand. *Rural Society*, **65**, 562–581.

Capraro, R. L. (2000). Why college men drink: Alcohol, adventure, and the paradox of masculinity. *Journal of American College Health*, **48**, 307–315.

Chamberlain, K. (2004). Food and health: Expanding the agenda for health psychology. *Journal of Health Psychology*, **9**, 467–481.

Chapple, A., & Ziebland, S. (2002). Prostate cancer: embodied experience and perceptions of masculinity. *Sociology of Health & Illness*, **24**, 820–841.

Connell, R. W. (1995). *Masculinities*. Cambridge, UK: Polity Press.

Connell, R. W. (2000). *The Men and the Boys*. Berkeley, CA: University of California Press.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity – Rethinking the concept. *Gender & Society*, **19**, 829–859.

Conrad, P. (1994). Wellness as virture: Morality and the pursuit of health. *Culture, Medicine and Psychiatry*, **18**, 385–401.

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*, **50**, 1385–1401.

Crawford, M. (1995). *Talking Difference: On Gender and Language*. Thousand Oaks, CA: Sage.

Crawford, R. (1980). Healthism and the medicalisation of everyday life. *International Journal of Health Services*, **10**, 365–388.

Cromby, J. (2004). Between constructionism and neuroscience – The societal co-constitution of embodied subjectivity. *Theory & Psychology*, **14**, 797–821.

Day, K., Gough, B., & McFadden, M. (2003). Women who drink and fight: A discourse analysis of working-class women's talk. *Feminism & Psychology*, **13**, 141–158.

Day, K., Gough, B., & McFadden, M. (2004). 'Warning! Alcohol can seriously damage your

feminine health': A discourse analysis of recent British newspaper coverage of women and drinking. *Feminist Media Studies*, **4**, 165–183.
De Visser, R. O., & Smith, J. A. (2007). Alcohol consumption and masculine identity among young men. *Psychology & Health*, **22**, 595–614.
Doyal, L. (1995). *What Makes Women Sick: Gender and the Political Economy of Health*. London, UK: MacMillan Press Ltd.
Edley, N., & Wetherell, M. (1997). Jockeying for position: The construction of masculine identities. *Discourse & Society*, **8**, 203–217.
Emslie, C., & Hunt, K. (2008). The weaker sex? Exploring lay understandings of gender differences in life expectancy: A qualitative study. *Social Science & Medicine*, **67**, 808–816.
Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing*, **49**, 616–623.
Gill, R., Henwood, K., & McLean, C. (2005). Body projects and the regulation of normative masculinity. *Body & Society*, **11**, 37–62.
Gough, B. (2001). 'Biting your tongue': negotiating masculinities in contemporary Britain. *Journal of Gender Studies*, **10**, 169–185.
Gough, B. (2006). Try to be healthy, but don't forgo your masculinity: Deconstructing men's health discourse in the media. *Social Science & Medicine*, **63**, 2476–2488.
Gough, B. (2007). 'Real men don't diet': An analysis of contemporary newspaper representations of men, food and health. *Social Science & Medicine*, **64**, 326–337.
Gough, B., & Conner, M. T. (2006). Barriers to healthy eating amongst men: A qualitative analysis. *Social Science & Medicine*, **62**, 387–395.
Gustafsson, K., & Sidenvall, B. (2002). Food-related health perceptions and food habits among older women. *Journal of Advanced Nursing*, **39**, 164–173.
Hochschild, A. R. (2003). *The Commercialization of Intimate Life: Notes from Home and Work*. Berkeley, CA: University of California Press.
Holmila, M., & Raitasalo, K. (2005). Gender differences in drinking: Why do they still exist? *Addiction*, **100**, 1763–1769.
Hunt, K. (2002). A generation apart? Gender-related experiences and health in women in early and late mid-life. *Social Science & Medicine*, **54**, 663–676.
Hutton, F. (2006). *Risky Pleasures: Club Cultures and Feminine Identities*. Aldershot, UK: Ashgate.
Institute of Alcohol Studies. (2007). *Binge Drinking: Medical and Social Consequences. Fact Sheet*. Cambridge, UK: Institute of Alcohol Studies. Retrieved from http://www.ias.org.uk/resources/factsheets/binge_drinkingmed.pdf 30/10/08.
Jackson, C., & Tinkler, P. (2007). 'Ladettes' and 'modern girls': 'troublesome' young femininities. *Sociological Review*, **55**, 251–272.
Jakobsson, A., Hensing, G., & Spak, F. (2008). The role of gendered conceptions in treatment seeking for alcohol problems. *Scandinavian Journal of Caring Sciences*, **22**, 196–202.
Jay, N. (1981). Gender and dichotomy. *Feminist Studies*, **7**, 38–56.
Jensen, K. O., & Holm, L. (1999). Preferences, quantities and concerns: socio-cultural perspectives on the gendered consumption of foods. *European Journal of Clinical Nutrition*, **53**, 351–359.
Johnston, C. A. B., & Morrison, T. G. (2007). The presentation of masculinity in everyday life: Contextual variations in the masculine behaviour of young Irish men. *Sex Roles*, **57**, 661–674.
Kaminer, D., & Dixon, J. (1995). The reproduction of masculinity: A discourse analysis of men's drinking talk. *South African Journal of Psychology*, **25**, 168–174.
Kraack, A. (1999). It takes two to tango: The place of women in the construction of hegemonic masculinity in a student pub. In R. Law, H. Campbell, & J. Dolan (Eds.), *Masculinities in Aoteoroa/New Zealand* (pp. 153–165). Palmerston North, New Zealand: Dunmore Press.
Kuhlmann, E., & Babitsch, B. (2002). Bodies, health, gender – Bridging feminist theories and women's health. *Womens Studies International Forum*, **25**, 433–442.
Lake, A. A., Hyland, R. M., Mathers, J. C., Rugg-Gunn, A. J., Wood, C. E., & Adamson, A. J. (2006). Food shopping and preparation among the 30-somethings: whose job is it? (The ASH30 study). *British Food Journal*, **108**, 475–486.
Lee, C. (1998). *Women's Health*. London, UK: Sage.
Lee, C., & Owens, R. G. (2002). *The Psychology of Men's Health*. Buckingham, UK: Open University Press.

Lichtenstein, B. (2004). Caught at the clinic – African American men, stigma, and STI treatment in the deep south. *Gender & Society*, **18**, 369–388.
Lohan, M. (2007). How might we understand men's health better? Integrating explanations from critical studies on men and inequalities in health. *Social Science & Medicine*, **65**, 493–504.
Lupton, D. (1996). *Food, the Body and the Self*. London, UK: Sage.
Lyons, A. C., & Chamberlain, K. (2006). *Health Psychology: A Critical Introduction*. Cambridge, UK: Cambridge University Press.
Lyons, A. C., & Cromby, J. (in press). Social psychology and the empirical body: Rethinking the relationship. *Social and Personality Psychology Compass*.
Lyons, A. C., & Farquhar, C. (2002). Past disclosure and conversational experience: Effects on cardiovascular functioning while women talk. *Journal of Applied Social Psychology*, **32**, 2043–2066.
Lyons, A. C., & Willott, S. (1999). From suet pudding to superhero: Representations of men's health for women. *Health*, **3**, 283–302.
Lyons, A. C., Willott, S. A. (2008). Alcohol consumption, gender identities and women's changing social positions. *Sex Roles*, **59**, 694–712.
Lyons, A. C., Spicer, J., Tuffin, K., & Chamberlain, K. (2000). Does cardiovascular reactivity during speech reflect self-construction processes? *Psychology & Health*, **14**, 1123–1140.
Mahalik, J. R., Burns, S. M., & Syzdek, M. (2007). Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Social Science & Medicine*, **64**, 2201–2209.
Malson, H. (1998). *The Thin Women: Feminism, Post-structuralism and the Social Psychology of Anorexia Nervosa*. London, UK: Routledge.
Mast, M. S., Sieverding, M., Esslen, M., Graber, K., & Jancke, L. (2008). Masculinity causes speeding in young men. *Accident Analysis and Prevention*, **40**, 840–842.
McCreanor, T., Greenaway, A., Barnes, H. M., Borell, S., Gregory, A. (2005). Youth identity formation and contemporary alcohol marketing. *Critical Public Health*, **15**, 251–262.
Measham, F. (2002). 'Doing gender' – 'doing drugs': Conceptualizing the gendering of drugs cultures. *Contemporary Drug Problems*, **29**, 335–373.
Measham, F. C. (2004). 'Up for it, mad for it?' Women, drug use and participation in club scenes. *Health, Risk and Society*, **6**, 223–237.
Mielewczyk, F., & Willig, C. (2007). Old clothes and an older look – The case for a radical makeover in health behaviour research. *Theory & Psychology*, **17**, 811–837.
Monaghan, L. F. (2001). Looking good, feeling good: the embodied pleasures of vibrant physicality. *Sociology of Health & Illness*, **23**, 330–356.
Montemurro, B., & McClure, B. (2005). Changing gender norms for alcohol consumption: Social drinking and lowered inhibitions at bachelorette parties. *Sex Roles*, **52**, 279–288.
Motluk, A. (2004). Intemperate society. *New Scientist*, **183**, 28–33.
Moynihan, C. (2002). Men, women, gender and cancer. *European Journal of Cancer Care*, **11**, 166–172.
Mullen, K., Watson, J., Swift, J., & Black, D. (2007). Young men, masculinity and alcohol. *Drugs-Education Prevention and Policy*, **14**, 151–165.
Nash, J. C. (2008). Re-thinking intersectionality. *Feminist Review*, **89**, 1–15.
Noone, J. H., & Stephens, C. (2008). Men, masculine identities, and health care utilisation. *Sociology of Health & Illness*, **30**, 711–725.
O'Connor, C., Kelly, K. (2006). Auto theft and youth culture: a nexus of masculinities, femininities and car culture. *Journal of Youth Studies*, **9**, 247–267.
Ogden, J. (2003). *The Psychology of Eating: From Healthy to Unhealthy Behaviour*. Oxford, UK: Blackwell.
Paechter, C. (2003). Masculinities and femininities as communities of practice. *Women's Studies International Forum*, **26**, 69–77.
Payne, S., Swami, V., Stanistreet, D. L. (2008). The social construction of gender and its influnce on suicide: a review of the literature. *JMH*, **5**, 23–35.
Peralta, R. L. (2007). College alcohol use and the embodiment of hegemonic masculinity among European American men. *Sex Roles*, **56**, 741–756.
Petersen, A. (2003). Research on men and masculinities: some implications of recent theory for future work. *Men and Masculinities*, **6**, 54–69.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, **2**, 1–27.
Rahav, G., Wilsnack, R., Bloomfield, K., Gmel, G., & Kuntsche, S. (2006). The influence of societal level factors on men's and women's alcohol consumption and alcohol problems. *Alcohol and Alcoholism*, **41**, I47–I55.
Robertson, S. (2006). 'Not living life in too much of an excess': lay men understanding health and well-being. *Health*, **10**, 175–189.
Roos, G., Prattala, R., & Koski, K. (2001). Men, masculinity and food: interviews with Finnish carpenters and engineers. *Appetite*, **37**, 47–56.
Saltonstall, R. (1993). Healthy bodies, social bodies: men's and women's concepts and practices of health in everyday life. *Social Science & Medicine*, **36**, 7–14.
Schippers, M. (2007). Recovering the feminine other: masculinity, femininity, and gender hegemony. *Theory and Society*, **36**, 85–102.
Schegloff, E. A. (2007). *Sequence organization in interaction: a primer in conversation analysis*. Cambridge, UK: Cambridge University Press.
Schofield, T., Connell, R. W., Walker, L., Wood, J. F., & Butland, D. L. (2000). Understanding men's health and illness: A gender-relations approach to policy, research, and practice. *Journal of American College Health*, **48**, 247–256.
Sellaeg, K., & Chapman, G. E. (2008). Masculinity and food ideals of men who live alone. *Appetite*, **51**, 120–128.
Seymour-Smith, S., Wetherell, M. (2006). 'What he hasn't told you ...': Investigating the micro-politics of gendered support in heterosexual couples' co-constructed accounts of illness. *Feminism and Psychology*, **16**, 105–127.
Shildrick, M. (1997). *Leaky Bodies and Boundaries: Feminism, Postmodernism and (Bio)ethics*. London, UK: Routledge.
Skeggs, B. (1997). *Formations of Class and Gender*. London, UK: Sage.
Smith, J. A., & Robertson, S. (2008). Men's health promotion: a new frontier in Australia and the UK? *Health Promotion International*, **23**, 283–289.
Smith, J. A., Braunack-Mayer, A., & Wittert, G. (2006). What do we know about men's help-seeking and health service use? *Medical Journal of Australia*, **184**, 81–83.
Sobal, J. (2005). Men, meat, and marriage: models of masculinity. *Food & Foodways*, **13**, 135–158.
Sobralske, M. (2006). Machismo sustains health and illness beliefs of Mexican American men. *Journal of the American Academy of Nurse Practitioners*, **18**, 348–350.
Speer, S. A. (2001). Reconsidering the concept of hegemonic masculinity: Discursive psychology, conversation analysis and participants' orientations. *Feminism and Psychology*, **11**, 107–135.
Van Gundy, K., Schieman, S., Kelley, M., & Rebellon, C. J. (2005). Gender role orientations and alcohol use among Moscow and Toronto adults. *Social Science and Medicine*, **61** (11), 2317–2330.
Vartanian, L. R., Herman, C. P., & Polivy, J. (2007). Consumption stereotypes and impression management: How you are what you eat. *Appetite*, **48**, 265–277.
West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender and Society*, **1**, 125–151.
Williams, S. (1998). Health as moral performance: Ritual, transgression and taboo. *Health*, **2**, 435–457.
Willott, S., & Griffin, C. (1997). Wham bam, am I a man? Unemployed men talk about masculinities. *Feminism and Psychology*, **7**, 107–128.
Willott, S., & Lyons, A. C. (forthcoming). Consuming Male Identities: the social construction of masculine identities in relation to alcohol consumption in Aoteoroa New Zealand.
Wright St Clair, V., Hocking, C., Bunrayong, W., Vittayakorn, S., & Rattakorn, P. (2005). Older New Zealand women doing the work of Christmas: a recipe for identity formation. *Sociological Review*, **53**, 332–350.
Young, A. M., Morales, M., McCabe, S. E., Boyd, C. J., & D'Arcy, H. (2005). Drinking like a guy: Frequent binge drinking among undergraduate women. *Substance Use & Misuse*, **40**, 241–267.
Young, I. (1990). *Throwing Like a Girl*. Bloomington, IN: Indiana University Press.

