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Chloe E. Bird and Patricia P. Rieker
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Introduction

Gender and Health is a book intended to improve health by informing both personal choices and policy decisions. It is designed for researchers, policymakers, and others who want to understand the ways in which both differences in women's and men's lives and in their physiology contribute to the paradoxical differences in their health.

The discrepancies are clear. Women live longer than men, yet they have higher morbidity rates. Men experience more life-threatening chronic diseases, whereas women have more nonfatal acute and chronic conditions. Furthermore, although the overall rate of serious mental illness is similar for men and women, the most common mental health disorders differ by gender. Most notably, women experience higher rates of depression and anxiety disorders, whereas men have higher rates of substance abuse and antisocial behavior disorders.

Are the factors underlying these health differences physiological, social, or both? Obviously, biological sex differences have health consequences. Yet biology is not destiny. In fact, even physiological differences in adult men and women may be socially acquired. Interactions between social and biological factors as well as those between mental and physical health further complicate the picture. For example, osteoporosis traditionally has been viewed as the product of hormonal deficiency as well as the lack of weight-bearing exercise and a poor diet, both of which are related to multiple social factors. In addition, recent research indicates that depression, which may be attributable to both social and biological factors, can also increase the risk of osteoporosis. Therefore, a combination of social

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and biological factors can influence gender differences in physical health both directly and indirectly.

In their landmark paper, Lois Verbrugge and Deborah Wingard (1987) argue that neither a strictly biomedical interpretation of the data nor one based on social factors adequately explains gender-based health disparities. They point to ample data documenting differentials in health and mortality, but add that "little research has been devoted to explaining those differentials" (Verbrugge & Wingard, 1987).

Two decades later, little has changed in our understanding of gender-based health disparities. Intuitively the answer lies neither in an exclusively biological nor an exclusively sociological vision of reality but in a combination of both. Many new studies have been published, but no new integrated explanations of the differences in men's and women's health have emerged. Why not?

A LACK OF COMMUNICATION AND COLLABORATION

From our perspective as sociologists, we contend that, although researchers study gender differences in health, there is generally little cross-disciplinary dialogue between the biomedical community and the social science community. We encounter scientists on both sides who ignore and often even disparage the views and work of those in other disciplines due to differences in their theories and methods. Competition for scarce research funding adds fuel to the distancing between the social and biomedical sciences.

In contrast, researchers from a wide range of disciplines within the two fields do undertake interdisciplinary studies to investigate the determinants of racial/ethnic and socioeconomic disparities in health. But for the most part, researchers remain entrenched in their own singular perspectives, however insightful, when explaining gender and health.

This level of specialization and intellectual parochialism frames existing debates about gender and health, limiting the range of questions asked, hypotheses tested, and outcomes considered (Bird & Rieker, 1999; Levine, 1995). Moreover, this situation diminishes possibilities for and interest in creatively integrating diverse theories and findings regarding men's and women's health. Consequently, no unifying framework

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exists that brings together the ideas of both social and biomedical scientists.

This research divide is somewhat perplexing. Perhaps the biomedical explanations of health disparities between men and women are so powerful that researchers believe social aspects of gender are not an issue that needs explaining. Sociologists, in turn, may feel that biomedical explanations will never address the fundamental social cause of gender disparities in health created by inequality. However, when we have presented our ideas regarding the gender paradox at health research conferences, we have met with two interesting reactions (Rieker & Bird, 2005). Many of our colleagues are surprised by the enduring nature of the paradoxical gender differences. Others familiar with the paradox confide that they do not pursue this line of research because they are stymied by the apparent contradictions in the patterns and the need to synthesize work from many disciplines.

Even confusion over terminology contributes to the lack of clarity regarding the relative contributions of social and biological factors to the paradoxical and perplexing differences in men's and women's health. Researchers from different fields use the terms "sex" and "gender" in different and often contradictory ways. The term "sex" is often used to refer to the chromosomal structure determined at the moment of conception and, more generally, to biological characteristics and their direct consequences. Social scientists introduced the term "gender" to refer to what society and culture make of those biological differences, and this term is frequently applied to the social characteristics and patterns distinguishing women's and men's lives. In fact, many if not most health-related differences between men and women may have both social and biological antecedents; thus, the distinction between sex and gender remains confounded.

In this book we limit our use of the term "sex" to those differences that are most clearly biological in origin. Rather than coining a third term for differences that clearly have both social and biological antecedents, we employ the term "gender" when referring to observed health differences between men and women, including those differences hypothesized to be purely social and those hypothesized to result from both social and biological factors.

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Sociological work demonstrates the profound influence that gender has on an individual's life experiences and why that influence is not reducible to chromosomal structures. The meaning, status, and implications of gender result from socially structured access to resources and opportunities and associated attitudes, behaviors, and values. Adding to the confusion, the term "gender" has rapidly replaced the term "sex" in medical research in recent decades. Unfortunately, this change in terminology has not helped clarify the contributions of social factors to men's and women's health. Instead, the term "gender differences" has frequently been misapplied to describe purely biological differences in human anatomy and to animal studies where the biological basis of such differences should be evident.

Even the structure of granting agencies fosters a research divide between the biomedical and social science communities. Clearly, the structure of the National Institutes of Health (NIH), the primary funder of health research, was not designed to impede interdisciplinary research. Rather, it resulted from the way science has evolved in this country with an emphasis on biomedical research and specialization. The NIH and other funding agencies did not foresee the growth and complexity of health-related research and the eventual need to bring sociological and biomedical researchers together to understand and address a wide range of health disparities, including gender differences in health. Over the past decade, the NIH and foundations have made increasing efforts to foster and fund interdisciplinary research to explain socioeconomic and racial/ethnic differences in health. At the same time, NIH has given relatively little attention to funding such cross-disciplinary work to better understand differences in men's and women's health. However, NIH's Office for Research on Women's Health created in 1990 has recently developed, implemented, and funded a group of interdisciplinary research centers and research training programs to ensure that women's health is part of the larger biomedical research agenda.

Our goal in writing this book is to move beyond the barriers that prevent us from a clear understanding of gender health differences. We hope that our synthesis of knowledge about social and biological determinants of health from diverse fields will lay the groundwork to replace current debates, exclusionary explanations, and narrow views with much-needed

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interdisciplinary dialogues. Only through an interdisciplinary approach that brings together both social and biological research can we hope to shed light on how and why gender differences in health occur. Such knowledge will most certainly alter the way we think about health, which in turn will create a new realm of possibilities for intervention and change.

A NEW FRAMEWORK FOR EXAMINING GENDER DIFFERENCES

We have developed an innovative sociological perspective to examine the complex antecedents of health differences between men and women and illuminate the ways in which men's and women's opportunities, and in turn their choices, are constrained. Our approach draws on the prevailing public health understanding of health disparities, which emphasizes the role of personal choices and health behaviors in enhancing or diminishing an individual's ability to live a long and healthy life. We argue that men's and women's opportunities and choices are to a certain extent constrained by decisions and actions taken by families, employers, communities, and governmental policies. In the long run, these choices can contribute to the observed patterns of gender-based health differences by creating, maintaining, or exacerbating underlying biological differences in health.

Our framework of constrained choice takes into account that an individual's decisions and even his or her allocation of resources reflect individual choices and preferences. We also recognize that the personal decisions involved are not isolated from the social forces that continually shape our lives. For example, the readiness and willingness to adopt positive and negative health behaviors are affected by social expectations and opportunities for both men and women. For instance, most Americans are aware that our culture and media images of ideal male and female bodies encourage young women to diet in unhealthy ways and lead some to anorexia and bulimia in an attempt to achieve thinness. However, few consider that, at the same time, young men are encouraged to increase muscle mass, leading some to abuse anabolic steroids, and, in the case of wrestlers, to dehydrate themselves to reduce their weight for competition, thereby increasing their risk of brain injury.

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Although many of the constraints and their consequences for individual choice are similar for men and women, the health impact will vary somewhat due to differences in both biology and life experiences. In other words, an individual's choices can influence and be influenced by biological processes (in a feedback loop). For example, constrained choices affect men's and women's stress levels as they experience competing demands on their time and other resources, which can in turn affect their psychological and physical responses to stress. Constrained choices may also have an impact on health behaviors and coping styles that affect both psychological and physical functioning. Consequently, we contend that gender differences in the constraints contribute to health disparities both directly and indirectly by affecting both men's and women's choices and their cumulative biological risk.

Some of the major pathways through which social factors affect individual physiology and health involve experiences of acute and chronic stress, which have been shown to cause wear and tear on multiple physiological regulatory systems, leading to more rapid aging, increased risk of disease, and earlier death (McEwen, 1998; Seeman, Singer, Rowe, & McEwen, 2001). Many of the factors that determine an individual's current and cumulative stress exposure are outside his or her control. These factors are the products of choices in which an individual may participate as part of a larger group (e.g., the household, the community, or society) and of social and environmental barriers to choosing health in which an individual may have little or no voice, such as air quality, the degree of demand and control in the workplace, or the nature and prevalence of discrimination. Thus, even those group-level choices in which the individual participates are based in large part on other priorities, such as balancing the budget, whether for a family or the nation.

Researchers and scholars from a wide range of disciplines have contributed to the understanding of the complex dynamics of women's and men's physical and mental health, providing insight into the social/economic and racial/ethnic differences among men and among women. Not surprisingly, as social and biomedical scientists focused their attention on health disparities, significant gaps in knowledge regarding substantial gender differences in health became apparent. For example, over recent decades it became clear that men's and women's cardiovascular disease symptoms and trajectories differ in clinically

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important ways. Similarly, researchers and clinicians began to recognize the need for gender comparisons to better understand disorders as far ranging as immune function, depression, and even substance use. These insights into both men's and women's health produced a new appreciation for the complexity of the paradoxical gender differences in health that challenges more singular notions of the disadvantage or advantage of either gender. Rather than focusing on the fact that women are sicker or that men die younger, our aim is to provide a balanced analysis of both men's and women's experiences and potential health consequences. We seek to further the dialogue across disciplines by acknowledging both the gender differences in health and the diversity among women and among men.

Scientific advances have created the possibility that people can live longer and healthier lives, if only they can figure out which advice to follow. This conundrum has generated public demand for change because people are frustrated both with the volume of new health information and the conflicting nature of the advice.[1] As a result of the information overload and an inability to evaluate each new piece of advice, individuals are uncertain about how to choose and combine strategies for maintaining and restoring health. These scientific and popular developments moved health to the forefront of a national debate on quality of life at the same time that the paradoxical differences in men's and women's health came to public attention. In many ways, the combination of public and scientific interest in these two topics has produced a strategic moment for a collaborative effort to examine the determinants of gender differences in health.

THE IMPACT OF HEALTH INFORMATION ON MEN'S AND WOMEN'S CHOICES

We assume that everyone is interested in having a healthy life and to varying degrees in obtaining knowledge and/or information that facilitates achieving that goal. It is commonly understood that women are

[1] One expression of this frustration is reflected in the widespread desire to increase control over one's own health and health care. We contend that one consequence of this desire is the growing demand for and use of complementary therapies. The coexistence of a vast self-care industry and an expanding market for high-tech preventive care and treatments represent another example.

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more familiar with health recommendations than are men, perhaps in part due to traditional gender roles of caring for the family and monitoring everyone's health. Consequently, gender differences in knowledge of current health information might also contribute to health disparities.

These gender differences aside, however, three major obstacles complicate the process of obtaining useful health knowledge for all of us. The first obstacle is that accurate and comprehensive information on how to lead a healthy life is not readily available. Although ample information exists on the potential benefits of engaging in health behaviors (such as exercise and diet) and avoiding health risks (such as poor air quality or chronic stress), the information is and always will be incomplete with regard to the wide array of choices that people make and the constraints they face throughout life. In fact, individuals lack the information to calculate – for example – what the actual cumulative health costs may be of living a harried and stressful life. Moreover, the information is not necessarily accessible or available in the form needed, either because it is not specific enough, the information cannot be found at the time it is needed, or it requires a relatively high level of education or even specialized knowledge to interpret and utilize. That would be enough of a challenge to impede most of us from choosing health, at least some of the time.

The second obstacle to obtaining health information is that the cumulative body of knowledge regarding the determinants of health and longevity is expanding at an unprecedented rate and involves an increasing number of specialized studies and findings, none of which simultaneously compares all of the factors that might be relevant to a given individual or family at a particular time. In reality, it is not possible to know everything that is known about health, and much of what is known includes either gaps in the information or what at this point appears to be directly conflicting information. Take, for example, the role of Omega-3 fatty acids and whether and how much fish to eat to benefit from these fatty acids without excessive exposure to mercury and other toxins. Even the most interested and avid reader of general and specialized health information is not able to stay current, and if he or she were able to keep up, there would not be enough time left in the day for the recommended amounts of exercise, sleep, and so on. In fact, many people find it

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extremely time consuming and stressful as they attempt to keep up with general health information or specialized knowledge related to their own known health conditions.

The third obstacle to obtaining useful health information is that until recently, the majority of health research focused on men, and less is known about how to prevent and treat many illnesses in women or whether the effectiveness of treatments varies by gender. Moreover, health information messages have been differentially targeted to men and women (and to other groups thought to be at risk for specific health conditions). For example, based on results from cardiovascular disease (CVD) prevention trials that included only men, it was assumed for years that women were at less risk for CVD. Because of this assumption, women were not advised (by physicians or the general media) to follow the same health advice as men. Consequently, women did not benefit equally even from what was known about preventing heart disease in men. In fact, numerous studies indicate that women were unaware of their substantial CVD risk, because most health messages targeted to women focused on breast cancer screening behaviors (Bassuk & Manson, 2004). During this same period, while health information for men focused on CVD, prostate cancer was virtually ignored, and yet it is another significant cause of male mortality.

In the end, making health a priority requires good information on the health effects of a tremendous array of choices, and this information is not easy to come by. Moreover, the health information that is available is not organized or presented in a form that allows men and women to use it in a meaningful way. For example, one cannot compare the health impacts of choosing a more stressful job over a less stressful one in the way one might compare their financial tradeoffs. Without specific information and a tool to project the long-term health consequences, there is no way for people to accurately assess the relative health effects of different everyday choices in order to incorporate that information into their decision-making process. Ironically, this type of information is also missing for policymakers as they consider the consequences of implementing or changing public policies, such as welfare, tax policies, and Social Security. Although they are not directly health related, such policies can nonetheless differentially affect men's and women's health.

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We contend that the interdisciplinary research we are calling for will not only improve our understanding of gender differences in health but will also provide the kind of information that individuals need to make health a priority and understand the health consequences of their everyday choices.

OVERVIEW OF *GENDER AND HEALTH*

The unique perspective of this book will give readers a new way to think about gender and health, as well as insight into a different way to conduct their lives. Therefore, *Gender and Health* begins with a review and discussion of the sex- and gender-based patterns of mental and physical health over the life course and the biological and social explanations of these patterns. We then present a model of constrained choice to illustrate both the possibility of and constraints on individual agency and to demonstrate that the social organization of men's and women's lives, as well as their biology, contributes to differences in their health. The subsequent chapters elaborate on the model of constrained choice and provide examples of the ways men's and women's lives alter their individual risk and exposure. In particular, we explore the connections among physiological mechanisms, social processes, and health. Finally, we identify opportunities for changes that could improve health and reduce disparities.

In Chapter 1, we examine gender differences and similarities in men's and women's physical and mental health and focus on four specific diseases or conditions selected because of their prevalence and substantial contribution to morbidity and mortality. For physical health, we include cardiovascular disease and the combination of immune function and immune disorders; for mental health, we consider depressive disorders and substance abuse disorders. We also synthesize recent findings from diverse literatures on the major social and biological explanations for the gender patterns in health and weigh their strength and limitations in order to shed light on the complexity of the issues at hand.

In Chapter 2, we introduce our model of constrained choice to illustrate both the possibility of and constraints on individual agency. Here we demonstrate how the social organization of men's and women's lives contributes to the paradoxical differences in their health. We explore

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