

From Type A man to the hardy man: masculinity and health

Elianne Riska

Department of Sociology, Åbo Akademi University, Finland

Abstract This article describes the transition in American 'stress' literature from a focus on 'Type A man' to the 'hardy man'. These two diagnostic categories were constructed in medical discourse and entailed certain notions of masculinity, class and health. The constructs explained the rise of unhealthy (coronary-prone) American middle-class white men in the 1950s and the emergence of healthy men in the same class, race and gender order in the 1970s. I show that the construction of Type A man rested on the medicalisation of the core values of traditional masculinity, while the term 'hardy man' demedicalised and legitimised these values.

Key words: Type A man, hardiness, gender, men's health

Introduction

During the past 50 years, the stresses of everyday life have been in focus in both lay vocabulary and medical research. Today, people talk openly about their 'stress level' or have succumbed to a chemical adaption to the anxieties and strains of work and family life, the latest attestation of which are the drugs of the new century – a new generation of antidepressants like Prozac (see Healy 1998, Luhrman 2000). In the beginning of the 1950s, and through the subsequent three decades, there was an earnest effort to understand the new cultural syndrome of stress, so prevalent in the post-World War II, work-oriented society. This syndrome became the concern of the North American medical community, which undertook to explore its complex character.

At issue were two simultaneous health problems in the United States in the 1950s: the high prevalence of stress and of coronary heart disease (CHD) among middle-class white-collar men. These syndromes were spotted by the medical community as the 'executive disease', as CHD was sometimes called then, and were attributed to the special lifestyle of these white middle-class men. The stress syndrome was also named 'hurry sickness' in some medical

circles (e.g. Friedman and Rosenman 1974: 70) to indicate the fast pace and drive of men holding the executive positions in mid-20th-century America. Soon a proper medical diagnosis was found: these were Type A men. Two American cardiologists, Meyer Friedman and Ray Rosenman, in their seminal article in *The Journal of the American Medical Association* in 1959 defined the type:

A person was adjudged as exhibiting completely developed behavior pattern A if he exhibited various signs we believed indicative of its presence, including excessively rapid body movements, tense facial and body musculature, explosive conversational intonations, hand or teeth clenching, excessive unconscious gesturing, and a general air of impatience, and if he admitted his sustained drive, competitiveness, and necessity to accelerate many activities and was aware of a chronic sense of urgency in daily living (1959: 1287).

The medical literature saw the health problems of Type A men in behavioural and psychological terms: the behavioural style and the psychological disposition of certain men made them prone to heart disease. Yet, these behaviours and characteristics were not randomly distributed in society. On the contrary, they were predominantly found among white middle-class men.

In the early 1950s, a classic in the sociological literature, *White Collar: the American Middle Classes* by C. Wright Mills (1951), alerted the scientific community to the unique social position and cultural disposition of the new postwar American middle class. As Mills suggested, the white-collared 'carry in a most revealing way, many of those psychological themes that characterize our epoch' (1951: iv). This social class was to be the target of sociological research for reasons Mills suggests:

We need to characterize American society of the mid-twentieth century in more psychological terms, for now the problems that concern us most border on the psychiatric. It is one great task of social studies today to describe the larger economic and political situation in terms of its meaning for the inner life and the external career of the individual, and in doing this to take into account how the individual often becomes falsely conscious and blinded. In the welter of the individual's daily experience the framework of modern society must be sought; within that framework the psychology of the little man must be formulated (1951: xx).

It was towards these 'new little Machiavellians' (Mills 1951: xii) that the medical community turned its medical gaze and found Type A man. But as I have shown (Riska 2000), this diagnostic category seemed to have lost its predictive power and scientific relevance by the late 1970s. By this time, a new construct enters medical knowledge via health psychology: a new personality disposition called 'hardiness'.

In this paper, I will describe the transition in the stress literature from a focus on Type A man to the hardy man. I will show that these concepts were constructed and translated in medical discourse and that they related to notions of masculinity, class and health. With the aid of the new construct, the transition of middle-class men from unhealthy Type A men to hardy and healthy middle-class men could be explained. At the same time, the construct added legitimacy to the core values of middle-class masculinity. In more sociological terms, hardiness became a key to re-evaluating the core features of traditional masculinity: men could be ambitious, compete, succeed, be in control and still be healthy.

How Type A man was supplanted by the hardy man

When feminists began to examine the medical knowledge about women's health in the 1970s, they found that men's health was used as the normative standard, which assumed the existence of a 'universal man'. They argued that the principle of the male-as-the-norm-by-default implied that the women's body was pathologised because it was different from men's (Chesler 1972, Ehrenreich and English 1978, Doyal 1983). Similarly, knowledge about men's health from male-only samples was extrapolated to apply automatically to women as well, in particular on issues related to work and health (Sorensen and Verbrugge 1987, Arber 1990, Annandale and Hunt 2000: 3–4). The concept of a universal man also in fact provided for men a biased and reductionist picture of men's health. This way of conceptualising men's health not only constructed men as a homogeneous group, but also took the 'naturalness' of this universal man for granted (Hearn 1998). The gender-neutral approach to men's health has made the gendered man invisible in most medical research. But just as knowledge about and discourses on women's health and body were socially constructed (*e.g.* Lorber 1997), so were those of men.

With the advent of men's studies came an interest in men's health (Harrison 1978, Harrison *et al.* 1989, Sabo and Gordon 1995, Helgeson 1995, Waldron 1995, Messner 1997, Courtney 2000). So far gender-sensitive research on men's health is scarce, although it is recognised that past uncritical research on men has examined 'universal man'.

But Type A man is a gendered man. Type A man captures the ideological construct of traditional masculinity prevalent in the US of the 1950s (Kimmel 1997). This behavioural type is based on a cultural concept that Connell (1987: 183) has called 'hegemonic masculinity' and others have called the 'hypermasculine construction' (Courtney 2000: 1391). This one-dimensional social category captures the dominant cultural ideals of masculinity, a traditional notion that serves, it is argued, the interest of dominant male groups (Connell 1987). More recently the 'health costs' of this stereotypic and narrow definition of masculinity have been pointed out (Messner 1997, Courtney

2000). In this respect, Type A man was a way of explaining the seemingly irrational behaviour of traditional masculinity, at least as regards health. The Type A man was constructed by medicalising traditional masculinity.

Type A man became a medical discourse that unveiled the scientific cause of coronary heart disease, a truth that had not been seen before but was constructed after World War II as the major cause of CHD (Helman 1987, Riska 2000). The emotional factors involved were seen, by two pioneers in the field, the cardiologists Friedman and Rosenman (1974), as inscribed in the surface of the body: a certain behaviour pattern, named pattern A, was the sign of those emotions. But both the behaviours and the related emotional components were not neutral to class, race or gender. At issue was a certain type of white middle-class masculinity that had up to then served as the norm for male behaviour: the behaviour of the hard-working, achievement-oriented and responsible male breadwinner. In economic terms, the behaviours and attributes of Type A man were those ideally required of ambitious and successful men in a competitive, capitalist industrial system.

But as a behavioural style and an economic behaviour, has the Type A man disappeared? Type A man and the coronary-prone personality were powerful representations of the plight of the middle-class man, images that became part of the medical folklore of the American middle class in the 1960s and 1970s. In retrospect, one can only speculate whether the mythology of the Type A man – the core of which was the coronary-prone personality – was the grand narrative and the essential image that was needed in order for these men to turn to a ‘healthy life style’ previously connected more with the rules governing women’s behaviour than with that of ‘real’ men. As others have suggested, masculinities have long been defined against positive health behaviours (see also Berrett 1997, Courtney 2000). Type A men were alerted to the unhealthy life they were living by the old epidemiology paradigm embraced by the pre- and post-Type-A-man epidemiologists who have all along suggested that smoking, sedentary habits, and fatty foods, not a certain personality, were the real culprits in the rising CHD rates among middle-class men.

A new discourse emerged in the late 1970s and explained the phenomenon by means of a new construct: ‘hardiness’. This personality predisposition is assumed to protect men from the deleterious effects of stress on their health. A new generation of middle-class men can look forward to a new relation between their social position and health: men can be real men, succeed and still be healthy. In contrast to Type A man, who was driven by a seemingly irrational passion to reach extrinsic goals and rewards, the hardy man is constructed as one who is driven by intrinsic motivation. Both personality structures seem to emphasise drive, involvement and goal striving.

The later construct – hardiness – was introduced in 1979 by Suzanne Kobasa, who developed it further in a couple of subsequent articles (Kobasa *et al.* 1982, 1983) and in a coauthored book entitled *The Hardy Executive:*

Health under Stress (Maddi and Kobasa 1984)¹. According to Kobasa, 'hardiness' is a personality characteristic: 'persons who experience high degrees of stress without falling ill have a personality structure differentiating them from persons who become sick under stress' (1979: 3). Kobasa views 'hardy persons' as sharing three characteristics: control, commitment and a sense that change is a personal challenge (1979: 3). By possessing these characteristics, a hardy person is able to remain healthy under stress. But 'the highly stressed persons who become ill are powerless, nihilistic, and low in motivation for achievement' (Kobasa 1979: 3).

To test the effect of hardiness, Kobasa examined a group of middle- and upper-level executives (N = 670) of a large public utility company, a homogeneous group preselected so that all were males, 40–49 years of age, married with two children, wife not working outside the home, usually Protestant, and attending religious services very or fairly often (1979: 5). The study aimed at exploring 'the importance of personality as a conditioner of the illness-provoking effects of stress' (1979: 1). Kobasa's hypotheses about hardiness were confirmed, and she concludes:

The mechanism whereby stressful life events produce illness is presumably physiological. Whatever this physiological response is, the personality characteristics of hardiness may cut into it, decreasing the likelihood of breakdown into illness (1979: 9).

In the discussion about the findings, Kobasa constructs a hypothetical 'hardy executive' who has to deal with a job transfer (1979: 9). The transfer is not envisaged as a threat for the hardy man but experienced as a challenge: 'The hardy executive does more than passively acquiesce to the job transfer' (1979: 9). The positive attitude allows the hypothetical executive to throw 'himself actively into the new situation, utilizing his inner resources to make it his own'. And Kobasa portrays the hardy executive and his less hardy counterpart in the following terms:

An *internal* (rather than *external*) locus of control allows the hardy executive to greet the transfer with the recognition that although it may have been initiated in an office above him, the actual course it takes is dependent upon how he handles it. For all these reasons, he is not just a victim of a threatening change but an active determinant of the consequences it brings about. In contrast, the executive low in hardiness will react to the transfer with less sense of personal resource, more acquiescence, more encroachments of meaninglessness, and a conviction that change has been externally determined with no possibility on his part. In this context, it is understandable that the hardy executive will also tend to perceive the transfer as less personally stressful than his less hardy counterpart (1979: 9).

In contrast to Type A man, the hardy executive is characterised by self-control, the very core of traditional masculine identity. The challenges awaiting the executive – whether hardy or not – are ‘learning to cope with new subordinates and supervisors, finding a new home, helping children and wife with a new school and neighborhood’ (Kobasa 1979: 5). A later prospective study of the same group confirms the hypothesis that ‘hardiness is a constellation of personality characteristics that function as a resistance resource in the encounter with stressful life events’ (Kobasa *et al.* 1982, see also 1983).

Although Kobasa in the first part of her presentation of the construct of hardiness uses only the terms ‘hardy personality’, ‘hardy persons’ and ‘hardy individuals’, both her sample of males and her example of the hardy executive indicate that the concept in question is male gendered.

The ‘hardy executive’ is the focus of an incisive examination in *The Hardy Executive*, in which Maddi and Kobasa (1984) provide in a more popular language, and in more detail, an overview of the background, methodology and findings of their study of a group of 259 middle- and upper-level male executives in a US company, Illinois Bell. For Maddi and Kobasa (1984: 31), hardiness is a personality style that evolves around ‘The BIG 3’: commitment rather than alienation, control rather than powerlessness, and challenge rather than threat. These characteristics, the reader is told, are moulded during childhood because a certain ‘family atmosphere breeds hardiness’. As Maddi and Kobasa (1984: 52) see it, the values underlying the primary (gender) socialisation are more important in breeding hardiness than the material conditions: ‘Atmosphere is something established for children by their parents, and it bears little or no relationship to economic and social advantage or disadvantage’. Nevertheless, hardiness, they suggest, can be learned at any time in life, and an executive can turn to ‘counseling for hardiness’ (which is the title of Chapter 6 of their book). With the aid of counselling, certain self-management techniques can be inculcated. In other words, the qualities of hardiness can be acquired through proper resocialisation of the male executive.

Hardiness is in the interest of the company because ‘health influences productivity, and this translates directly into profitability’ and ‘it makes sense, therefore, for companies to foster hardiness in their employees’ (Maddi and Kobasa 1984: 76): hardy executives constitute an economic asset for the company.

Hardy executives are especially effective because they are not passively compliant. This is yet another way in which hardiness seems to contribute to profitability (1984: 78).

And in harder times when the company faces the consequences of structural and economic change,

While nonhardy executives shrug their shoulders in the face of the recession and unemployment, for example, hardy managers are probably looking for ways of making the best of a difficult situation (1984: 92).

The hardy executive seems to have the kind of character that Richard Sennett (1998) thought had become 'corroded' under the conditions of prevailing capitalism. The hardy executive withstands the challenges of the flexibility and uncertainty that characterise the workplace and the labour market as Sennett depicts it.

'Hardiness' has become an established concept in medical research. From 1979 to 2000, of the 296 articles on hardiness listed in Medline, 226 were on hardiness as a health-protective factor (US National Library of Medicine 2001)². During the first five years, the research mainly studied white middle-class men, as had the early research on Type A man. But 10 years after the introduction of the concept of hardiness, it is used in portraying the hardy personality characteristics of those who can cope with stressful circumstances: how patients with chronic disease cope with illness, or how people subject to serious stress cope with their lives. An interesting genre, related to the latter theme, has been research on nurses and their coping with stress and burnout at work. Since 1985, this theme appears frequently in articles published in nursing journals (*e.g.* McCranie *et al.* 1987, Simoni and Paterson 1997).

But, more important, the construct of hardiness has penetrated the vocabulary of the American populace and has become, like Type A, a discourse that explains the relationship between personality, stress and health under current economic and social conditions.

The social construction of diagnostic categories

The rise of the 'epidemic' of heart disease in Britain was also related to the medical discovery of heart disease in the 1940s and was very much a product of a diffusion of postwar American influence in British heart-disease research (Bartley 1985: 303–4). As Bartley shows, heart disease was seen as a disease of affluence and the price paid for rising standards of living. Myocardial infarction and coronary heart disease became new terms in explaining the 'premature' death of middle-aged men in such circumstances. Bartley (1985) argues that these new diagnostic categories served the social organisation of death and dying in Britain: they were reductionist categories for the cause of death in cases in which an ambiguous heart-related health problem was in question. As Prior (1985) has shown, the medical causes of death, such as social class, have constituted reductionistic categories that are the product of a complex social organisation that polices and codes deaths.

While sociologists have pointed to the social construction of medical and diagnostic categories, this work has often moved at an abstract level. The Type A personality and the hardy personality provide concrete but individualised explanations for differences in health. In the two psychological

models, differences in health are explained by differences in individual dispositions, thereby making personality an individually-based risk factor for coronary heart disease. Although the two constructs valorise fixed personality characteristics and individual traits, both models examine men in certain social positions and social structures. A broader understanding of these middle-class men's health would have been achieved if the social contextual factors had been recognised. Such a level of analysis might have revealed a social patterning of health and the link between social conditions and individual wellbeing. For example, the early research on Type A man and on hardiness was conducted with white middle-class men (see Funk and Houston 1987, Funk 1992). While Type A men were preselected by social class and commitment to traditional masculinity as a trait, so were those examined for hardiness. Type A men were selected for their subgroup A vis-à-vis group B and group C on the basis of expressed masculinity as an overt individual behavioural style (Riska 2000). Similarly, hardy men were preselected on the basis of social class and behaviour fitting traditional, heterosexual masculinity: they all conformed to the nuclear-family pattern and male-breadwinner ideal.

The validity of the construct hardiness has been subject to serious criticism. The operationalisation of this construct is done by means of three separate concepts: control, commitment and acceptance of change as a challenge. An interesting methodological debate has been pursued over whether hardiness can be tapped by these three different characteristics (e.g. Hull *et al.* 1987, Funk 1992). Do the three characteristics have the same weight, or is one of them the crucial component? Furthermore, in the way that these three characteristics are operationalised, most scales measure the negative dimension of the phenomenon rather than the positive dimension that the whole concept is based upon. It is assumed, for example, that a low score on the measured dimensions of powerlessness, alienation and neuroticism are equivalent to a high propensity for the desired individual trait – hardiness (see Funk 1992). This is not necessarily the case, and the content validity of the measures are therefore questionable. In fact, criticism has also been directed at the use of different scales in the various studies, a methodological problem that makes it difficult to compare the results of the studies (Funk and Houston 1987, Funk 1992).

The measurement of personality dispositions in the Type A personality and hardy personality neglects the interference of certain values and attitudes. It is as likely that Type A men conformed to the unhealthy habits of the 1950s as that hardy men conformed to the healthism prevailing in the 1980s and 1990s. In that case, hardiness as a construct rests on another cultural tide – health as a value and individual asset among the middle class (Crawford 1980, Wagner 1997). The high CHD rates among middle-class men in the 1950s and the drop of the rates among the same class of men two decades later could be interpreted in this light (see also Wiebe and McCallum 1986, Waldron 1995).

Conclusion

In this paper, I have used what Armstrong (1990, see also Foucault 1975) has called the genealogical method, the purpose of which has been to trace the origin of the construct 'hardiness' as a way of making visible a new dimension of the health profile of modern (American) men. Hence, hardiness is a central concept in a medical and psychological discourse that aims to explain differences in health by making personality a risk factor for illness. The personality – whether Type A personality or the hardy personality – is conceptualised as the dominant male identity of the American middle class. The medical risk factor of Type A man seems to be that while he conforms to the ideal of achievement and hard work, he is not in control of his own life. By contrast, the hardy man is also achievement oriented, but he looks forward to his promotion and social mobility because he has a sense of self-control and purpose. Yet, as cultural idioms of respective decades – the 1950s and 1980s – the concepts capture the inner life of the two types of men who were the crucial economic actors of their society. They also capture the constraints and opportunities – both in economic and cultural terms – of these men during the respective decades. The construct of Type A man medicalises masculinity; the construct of hardiness demedicalises masculinity.

The construct of hardiness not only demedicalises male behaviour but, more importantly, legitimises traditional masculinity. Men can now have a comfortable sense of mastery of their stress level, or may reason that stress might even be good for them. Yet what the new construct of hardiness also did was to confirm that hard work, competitiveness and self-control were core values of heterosexual masculinity.

But both discourses – Type A man and the hardy man – individualise differences in health, although the concepts are based on social categories, especially the social positions of class and gender (see Umberson *et al.* 2000). The concept of hardiness diffuses the social character of masculinity: masculine behaviour is captured as an individual characteristic and personality disposition rather than as an institution and a set of structures that privilege a certain type of white middle-class male behaviour. It is in this sense that the Type A man and the hardy man are more than mere categories of individual identities. They capture the tacit power relations and hidden hierarchies of sub- and super-ordination based on class, race and gender.

The examination of the concept of hardiness in this paper does not question the approach of health psychology per se. On the contrary, the purpose has been to show that health psychology has problematised men's health and has integrated this insight into a new construct of hardiness. The narrow focus on individual personality structures did not do justice to the more profound revelation of the link between social structure and biography (Mills 1951, 1959): the Type A personality and the hardy personality are

not merely personality characteristics of individuals but social characters shaped by a social milieu. The categories Type A man and hardy man used by American medicine and health psychology have in fact indirectly suggested that stress and health inequality are related to men's position in the gender order and in the social hierarchy at work. The initial focus was on how much middle-class men felt a sense of control at work. Type A men were those who occupied positions of control, tried to control everything but felt the expected responsibility as an emotional burden, while in the early 21st century work-related stress connected to coronary heart disease is found in men and women who have little control at work (Marmot *et al.* 1997).

*Address for correspondence Elianne Riska, Department of Sociology, Åbo Akademi University, Gezeliusgatan 2 A, 20500 Åbo, Finland
e-mail: eriska@abo.fi*

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Notes

- 1 A North American reader might find the 'hardy man' an amusing and allusive concept. Early-20th-century American children's literature featured *The Hardy Boys*, a series invented in 1926 by Edward Stratemeyer – the promoter of a mass production of American juvenile literature. These books, the first dozen or so of which were written by Leslie McFarlane, told the adventures of two youngsters and amateur sleuths – Joe and Frank Hardy – brothers with hardy spirits. Revised versions of these adventure and mystery stories were brought out in the early 1960s by the Stratemeyer Syndicate, and another updating was done by Simon and Schuster in the early 1980s, when, incidentally, Kobasa's (1979) hardy man was introduced.
- 2 The rest of the articles chiefly deal with disease-resistant plants, insects and organisms.

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