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Hegemonic Masculinity in Men with Schizophrenia: Complicity and Strategic Performance

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HEGEMONIC MASCULINITY IN MEN WITH SCHIZOPHRENIA: COMPLICITY AND STRATEGIC PERFORMANCE

by

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Under the Direction of Eric R. Wright, PhD

ABSTRACT

Using secondary analysis of in-depth interviews of men with schizophrenia (N=59), in this thesis I explore the interplay between the performance of hegemonic masculinity and the treatment career of men with serious mental illness (SMI), and in doing so begin a conversation about how mental health providers can better address issues of masculinity. My findings are that significant barriers to masculinity performance are caused by the diagnosis and treatment of SMI, leading to roll loss, subsequent stress, and strategic modification of masculinity performance to attain hegemonic complicity. I identify six emergent themes and three masculinities within the data, and offer a theoretical framework with recommendations for application and future research.

INDEX WORDS: Masculinity, Hegemonic Masculinity, Gender, Mental Health, Mental Illness, Role Loss, Interviews, Qualitative Coding, MaxQDA.

A QUALITATIVE EXAMINATION OF MASCULINITY PERFORMANCE IN MEN WITH SERIOUS MENTAL ILLNESS

by

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DEDICATION

This thesis is dedicated to Christina Collandra, Jessica Stansel, and Chris Rockhill, who inspired, supported and encouraged me throughout its production. Your love has given me the courage to decide what kind of man I want to be, and I hope this work helps others do the same.

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1 INTRODUCTION

For men in Western societies, proper performance of masculinity is one of the most rigid norms in everyday life, with strict rules that carry serious social sanctions if violated (Connell 2005). The current dominant masculinity, known as hegemonic masculinity, is that which dominates all other incarnations of masculinity and justifies the domination of women (Connell 2005). Achieving hegemonic masculinity, or at least remaining complicit to its ideals, is of utmost importance for men, affecting their likelihood for success in virtually all aspects of life. Understanding the performance of masculine standards is crucial to deciphering any social interaction where men are present, especially when the context limits or disallows the enactment of normative masculine traits. For men seeking the hegemonic ideal, afflictions of serious mental illnesses (SMI), and the treatment of such illnesses, are likely to limit the performance of hegemonic ideals. As such, men with SMI could be defined as a marginalized masculinity – those men for whom a fundamental aspect of social identity are kept from achieving the hegemonic ideal in all but rare circumstances (Connell 2005). Widely accepted masculine norms such as financial independence, social autonomy, being desired by women, and the ability to provide for one's family are all threatened by SMI. Despite this crucial conflict between gender norms and mental illness, little attention has been paid to the performance of masculinity in men with SMI.

Much like gender, the sexuality of mental health patients was unaddressed by academics and treatment professionals until recently. This refusal to confront and accept the sexual lives of patients caused many problems for individual patients as well as for entire treatment communities, and only recently have mental health treatment providers recognized the importance of sexual expression in the lives of patients (Buckley 1999; Buckley and Wiechers

1999; Deegan 1999; Perry and Wright 2006; Wright et al. 2007). Since sociological research shed light on the drawbacks of ignoring sexuality, improvements have been made in policies and procedures regarding patient sexuality (Welch, Clements, and Moreau 1999). The role of normative gender performance within the mental health treatment setting, however, has yet to be explored theoretically or empirically.

In this thesis I seek to fill this gap in knowledge through a secondary qualitative examination of 59 in-depth interviews conducted with men diagnosed with schizophrenia who were receiving care at community mental health centers (CMHC) in the Indianapolis area. Participants answered open ended questions about their sex lives, romantic relationships, and knowledge of HIV, creating a fertile context for spontaneous expressions of masculinity. Through secondary analysis of this data, I explore the role masculinity plays in the treatment of men with SMI and attempt to determine whether treatment would benefit from policies and practices that address masculine norms and their performance. While exploratory in nature, my thesis intends to answer the following questions:

- What role does masculinity performance play in the lives of men with SMI?
- Does SMI and its treatment limit performance of masculinity, thus relegating these men to marginalized masculinity?
- Does the limiting of masculinity performance hinder treatment of and recovery from SMI?
- Do mental health providers take direct or indirect action that limits the expression of masculinity?

By answering these questions, my thesis seeks to accomplish the following goals: to develop a theoretical framework that describes the interactions of masculinity and SMI as a

guide for further research; to serve as a catalyst for further research, launching an academic dialogue among mental health providers, psychologists, and sociologists regarding treatment and gender performance; and to determine if men with SMI are precluded from claims to hegemonic masculinity, thus adding to the literature on marginalized masculinities more generally.

Vulnerable populations often propose a paradoxical challenge. Inductive, qualitative research is often difficult to justify with a population such as people with SMI. Regulatory organizations are reticent to allow access for research unless there is a clear need, such as a public health crisis reported by mental health providers. While these protections are justified, those of us concerned with these populations are often left to speculate as to the nuanced workings of less obviously urgent social relations, our hands tied to make observations and develop theories that intend to improve the circumstances of these vulnerable populations. In this thesis I utilize a wealth of data – nearly 900 pages of transcribed interviews about sex, relationships and HIV – to develop a robust theoretical framework regarding hegemonic masculinity and men with SMI, despite the lack of direct access to participants. It is my hope that these findings and my resulting theory will inspire and justify research where direct access to participants is allowed by regulatory agencies and invited by mental health providers.

Mental health treatment is constantly evolving, and in recent years many mental health care providers have moved toward a holistic treatment approach. Providers developed many mental health practices and policies in the middle decades of the 20th century when many ideologies – especially those surrounding marriage, sex and gender – differed drastically from today (Buckley 1999). As a result, policies and procedures desperately need reform to match new societal norms. Policy makers and providers have addressed some issues, such as the systematic closing of large total institutions in favor of community based mental health clinics.

And, as previously stated, research has identified sexuality as an important part of patients' identities, prompting providers to address sexuality during the treatment process. In this thesis I show that masculinity plays an important, and, until now, unrecognized role in the treatment process of men with SMI. I position hegemonic gender performance as an important area of cross-disciplinary academic inquiry, and the recognition of gender as the next site of reform for the institution of mental health care.

Outside the realm of mental health research, policy and treatment, this thesis contributes to the ongoing body of sociological research on marginalized masculinity. Social traits such as race, sexual identity, nationality, and physical characteristics can limit a man's ability to enact hegemonic masculinity (Connell 2005). This thesis positions mental health status and the stigma surrounding it as an important addition to this academic dialogue, identifying men with SMI as a marginalized masculinity.

Mental health treatment is important for financial, political and, most importantly, ethical reasons. How we care for those who have been afflicted with mental disorder says a great deal about our society, and I assert that an understanding of the role that gender performance plays in mental health treatment is a crucial step in improving our standards of care. Many mental health professionals recognize the ethical imperative and therapeutic value of treating those in their care as complete persons, addressing not only their mental disorder, but all aspects of who they are (William Anthony et al. 2002). As gender is one of the most fundamental aspects of identity in our society, it is surprising that more focus has not been placed on its performance during mental health treatment.

2 LITERATURE REVIEW

2.1 Overview

Major ethical concerns arise when a group of people are subject to the authority of another more privileged class, have restricted autonomy, and are widely stigmatized as inherently incapable or flawed. Such groups require special justification to include in research on human subjects, and are referred to as vulnerable populations (Ruof 2004). No group fits so many of the features of vulnerability as people afflicted with SMI. People with SMI are often at the mercy of the mental health system, and historically have been subjected to a wide range of horrible abuses (Deegan 1999). Not only do mental health professionals often completely control the daily lives of those with SMI, but knowledge produced by the psychiatric community defines much of their existence. Additionally, those afflicted with SMI are widely stigmatized by the general culture which portrays the mentally ill as a frightening, alien, and dangerous other (Pescosolido 2013). Social structures that arise from this stigma limit opportunity and thus autonomy. In the worst cases, the stigma is internalized by those suffering from SMI, crippling their sense of self (Goffman 1962).

In recent times the vulnerability of those afflicted with mental illness has been recognized by the psychological community, resulting in reform of the most overtly harmful practices and procedures (Grob 1994; Mechanic 1999; Morrissey, Goldman, and Klerman 1980). Unfortunately, old views and the societal stigma surrounding mental illness still influence many policies and, as such, those policies resist change (Dowdall 1996; NAS Committee 2016; New Freedom Commission on Mental Health 2003; U.S. Department of Health and Human Services 1999). A critical, outside view is important to continuing reform, especially when it incorporates the voices of mental health consumers, but gaining access is difficult for social research (Cook

and Wright 1995). Even when controlling agencies allow empirical research and that research shows that change in the mental health system is needed, real change manifests slowly (Mechanic 1999; Morrissey et al. 1980; New Freedom Commission on Mental Health 2003). Old ideology, prejudice, poor funding, and bureaucratic inertia can all stand in the way of change (NAS Committee 2016; U.S. Department of Health and Human Services 1999).

In this thesis I examine the role that masculinity plays in the lives and treatment careers of men with SMI, an area of inquiry that has received very limited attention in the sociological or psychological communities. Indeed, the subject of masculinity in psychology journals is almost exclusively employed as a predictor of help seeking, drug abuse, or violence. Due to this absence of literature that directly addresses the subject at hand, the texts assembled here are eclectic, may appear dated, and at times only tangentially related to the direct topic of study. Despite these limitations, they provide a sound theoretical and contextual framework for this study.

2.2 **Identity and Masculinity**

Perhaps the most influential and widely referenced works discussing the sociology of mental health is Erving Goffman's *Asylums*. Based on three years of observations made in mental wards in the late 50's, Goffman discusses many aspects of mental health care of the time. *Asylums* may appear dated for modern application; during the time of Goffman's observations complete institutionalization was the standard for mental health care, and therefore, it may seem of limited use. However, it is not his focus on the concept of the total institution that is relevant, but rather his exploration of the change in identity that comes with being labeled as mentally ill. Goffman explores at length the mental processes of the patient, including the loss of roles the

patients suffered upon placement into care (Goffman 1962). The use of role loss when studying gender may seem in conflict with current standards; gender is such a pervasive aspect of our lives that it is "done" regardless of context, as opposed to a role that can be assumed or abandoned (West and Zimmerman 1987). However, my framework does not conceptualize gender as a role in this manner. Rather, I assert that certain ways of doing gender – especially those that produce the culturally ideal forms of masculinity – are accessed through social roles (provider, husband, sex partner). These social roles, which can be lost or gained, serve as sites for the production of particular aspects of masculinity, and the way gender is done at these sites is unique to that site. For instance, one cannot do gender in a way that produces the masculine norm of financial autonomy if employment is impossible due to SMI. Therefore, role loss becomes crucial to the study of masculinity within the context of men with SMI.

Goffman's thoughts on the life course self-view are also of value for my analysis, giving some expectation to how changes in identity from SMI may manifest within the interviews:

> Given the stage that any person has reached in a career, one typically finds that he constructs an image of his life course – past, present, and future – which selects, abstracts, and distorts in such a way as to provide him with a view of himself that he can usefully expound in current situations. Quite generally, the person's line concerning self defensively brings him to an appropriate alignment with the basic values of his society, and so may be called an apologia. (Goffman 1962:150)

This tendency to develop a distorted self-view that aligns with the current norms of society is crucial when examining issues of masculinity, the proper performance of which is paramount for normative acceptance psychically and socially. Based on Goffman's writings, we should expect a desire within these patients to project a normative masculinity toward the interviewer.

Asylums was not limited in scope to the patients, however, as Goffman was also studying the mechanisms at work in the institutions and staff. One of my research goals is to explore how

mental health care providers may limit the performance of masculinity. Goffman highlights the lack of objectivity among staff in *Asylums,* describing at great length how the stigma and presupposed ideas about individual patients are reinforced in staff meetings, sympathies for patients are quelled by other staff, and new staff are "brought up to speed" by other workers on the current patients so as to prevent conflicting ideas about their state of mental health (1962). The way that staff may construct the identity and recovery progress of a patient to other providers is crucial in the light of prejudice toward people with SMI. For instance, staff may reify stereotypes of black patients as inherently prone to violence or hyper sexuality. Since these traits are linked to a particular masculinity, perceptions and attitudes of the staff may impact masculinity identity and performance. These observations about mental health providers will guide my inquiry to their effect on masculinity performance.

In order to observe expressions of masculinity within the dataset, I must specify how exactly I will define these expressions. To accomplish this I utilize the theoretical constructions of masculinity laid out by Connell in *Masculinities.* Central to Connell's framework is the assertion that there are multiple masculinities, and they vie for dominance over one another (Connell 2005). Hegemonic masculinity is the current dominant masculinity at any given point, serving two functions: to legitimate the system of patriarchy within the current social and historical context and to dominate other forms of masculinity, such as that of homosexual men, working class men, and men of color (Connell 2005). Hegemonic masculinity is commonly misinterpreted as a static set of ideals, but this belies the fluidity of gender relations and systems of dominance - we must remember that hegemonic masculinity is defined by its effectiveness in the given context (Connell and Messerschmidt 2005). Therefore, the current hegemonic ideals – those behaviors that exemplify the current manifestation of hegemonic masculinity – must be

identified in each unique context. To do this, I utilize Connell's conceptualization of masculinities combined with a grounded theory approach to establish a flexible framework for identifying expressions of masculinity within the data[1], rather than having a static list of signifiers to code for. In doing this, I focused on Connell's concept of masculinities that are complicit with hegemonic masculinity – meaning men whose construction and performance of masculinity does not achieve the hegemonic ideal, but rather "realize the patriarchal dividend without the tensions or risks of being front-line troops of patriarchy" (Connell 2005). Since the majority of men do not embody hegemonic masculinity entirely, but are complicit with its hierarchy and thus reap benefits from it, my research focuses on this complicity.

In *Hegemonic Masculinity: Rethinking the Concept* (2005), Connell and Messerschmidt examine the first two decades of research utilizing Connell's theory and refine its tenets. Several concepts emerge here that are salient to this thesis. First, hegemonic masculinity varies across and can be analyzed at three distinct levels: local, regional, and global (Connell and Messerschmidt 2005). Hegemonic masculinity at a local level, while influenced by regional and global hegemony, is often distinct to that location and constructed through face to face interactions within organizations (Connell and Messerschmidt 2005), making this thesis an example of local hegemonic analysis. Second, masculinity is discursive in that men adopt it strategically based on their locality and context in order to "help them ward off anxiety and avoid feelings of powerlessness" and "promote self-respect in the face of discredit" (Connell and Messerschmidt 2005). This strategic adoption in response to disgrace echoes Goffman's apologia, and is certain to be of import for the examination at hand. Finally, this piece offers the insight that while hegemonic masculinities may vary and thus must never be conceptualized as a static set of behaviors, they consistently serve the purpose of providing a way to relate to women

[1] For a list of the final codes see appendix A.

and give solutions to issues of gender relations by strategically adapting to current context (Connell and Messerschmidt 2005). These points allow me to clearly conceptualize hegemonic masculinity in the local context of the mental health treatment of men with SMI, and develop codes that focus on strategic complicity with hegemonic ideals.

2.3 **Sexuality Reform**

Mental health care providers have recently reformed their policies and procedures regarding the sexuality of consumers. Due to the strong cultural link between sex and gender identity, the studies that prompted these reforms can give insights into patient views and institutional responses to the sensitive issue of gender in mental health care. A major element to dealing with any issue in an institutional setting is establishing a rudimentary policy that addresses it, but even the most fundamental policy regarding sexuality violates the assumption that people with SMI are asexual (Buckley and Wiechers 1999). Until recently, mental health care facilities refused to acknowledge the sexuality of consumers in their care. In their survey of 53 hospitals, Buckley and Wiechers found that only 25% had a policy in place dealing with the sexuality of mental health patients and only 12.5% had a sexual education program in place (Buckley and Wiechers 1999). The authors attribute the lack of policy to the assumption that mental health patients are mostly asexual and, when not, their sex is violent - only 3.9% of the hospitals saw sexuality among patients as a frequent problem and the most regularly reported concern was that of sexual assault (Buckley and Wiechers 1999). While the sample for this study was limited in size as well as geography (all the hospitals were in Ohio), it offers insight into the reticence of health administrators to address issues of sexuality before consumer efforts and research pushed for reform surrounding patient sexuality. If mental health care providers are

also ignoring issues of gender expression there could be hindrance to patient progress due to frustration with role loss (Goffman 1962).

In *Human Sexuality and Mental Illness: Consumer Viewpoints and Recovery Principles* (1999), Patricia Deegan also details health care providers' resistance to addressing sexuality of consumers. In her interview with a group of mental health consumers, inconsistent policy and mixed messages were a major frustration, such as being told the official policy was that sex was disallowed and then being provided with condoms (Deegan 1999). Deegan also exposed some possible links to gender performance as some participants discussed role loss when they were denied the opportunity for romantic partnership, and sexual dysfunction due to medications were a major concern for participants (Deegan 1999). Both of these are unique sites for doing gender, especially in regard to hegemonic masculinity. The treatment environment limits or makes impossible many manifestations of masculinity performance, such as independence, employment, ambition, and fulfilling the provider role. Romantic relationships and positive sexuality could be one of the few remaining healthy places to express masculine norms – sexual virility and the ability to physically please a partner are key masculine expressions (Connell and Messerschmidt 2005). Despite her small sample size, Deegan's data is rich, and her analysis exposes many themes that proved useful in my current endeavor.

Stigma and the Sexual Isolation of People with Serious Mental Illness (Wright et al. 2007) thoroughly details restrictions on relationships and sexuality due to SMI and its treatment. The authors analyze 261 in-depth interviews of patients afflicted with SMI who were receiving treatment in a variety of settings. The interviews were part of a larger dataset, and consisted of all participants who reported no current sexual activity. The authors analyzed the participant's reasons for not having sexual partners, and discovered several major themes including lack of

access to partners, sexual dysfunction, fear of disease or pregnancy (due partially to lack of available protection), sexually restrictive treatment culture and settings, the everyday issues caused by mental illness, and a general feeling of being devalued (Wright et al. 2007). In addition to offering insight to the sexuality of people with SMI, many of these themes conflict directly with the performance of masculine norms, pointing to systematic restrictions on masculinity.

2.4 **Masculinity & Help Seeking**

With the exception to its correlation with help seeking, physiological research does not regularly address masculinity performance. Participants examined for my thesis are already in treatment and have been for some time, but examining the relationship between masculinities and help seeking may offer insights to the greater context of mental health treatment, especially when other variables are introduced for examination. Joseph Hammer and his colleagues, utilizing data from a web survey with 4,748 respondents, found interesting connections between adherence to masculine norms, self-imposed stigma for seeking psychological treatment, and attitudes toward mental health services (Hammer, Vogel, and Heimerdinger-Edwards 2013). While web surveys are often ungeneralizable due to selection bias, in the original data collection researchers put links to the survey on a variety of listservs and websites that attract diverse categories of men. They found that the three index variables were linked in all demographic subgroups, but certain subgroups had strong trends that suggested cultural narratives (Hammer et al. 2013). Men living in rural areas showed the strongest link between masculine norms and self-stigma. In addition, rural men had less favorable attitudes toward mental health services than suburban or urban men. The authors attribute these trends to the cultural importance of

masculinity in rural areas and the lack of access to services (Hammer et al. 2013). Educational level also had an impact, as men with graduate education had significantly better attitudes toward mental health services due to their ability to reconcile treatment with their personal masculine identity (Hammer et al. 2013). These findings confirm an overall antagonistic relationship between masculinity performance and mental illness.

In addition to confirming the link between masculine norms and reluctance to seek help, Berger and his colleagues found a correlation between adherence to hegemonic masculinity and two nuances of help seeking: type of help sought and the source of the help (Berger et al. 2013). The authors conducted 85 interviews with men who responded to a newspaper ad, and utilized the Response to Mental Health Rating System (RMHRS) and the Articulated Thoughts in Simulated Situations (ATSS) paradigm to rate participants' reactions to mental health topics and sources of help seeking advice (Berger et al. 2013). They not only found the expected negative relationship between adherence to masculine norms and help seeking in general, but correlations between particular masculine norms and attitudes toward the source of help (Berger et al. 2013). Men who adhered to the norm of pursuing women – a trait tied closely to hegemonic masculinity – were least likely to respond positively to the suggestion of treatment by a romantic partner (Berger et al. 2013). While the authors do not use a random sample, they show that their sample is more diverse than previous studies on help seeking – many of which use convenience samples consisting of college students (Berger et al. 2013).

2.5 **Marginalized Masculinity**

As I examined the data, one of my research questions was if men with SMI can be positioned as a marginalized masculinity. For this reason I sought out research on populations

with marginalized masculinity and their interactions with the mental health institution. The literature I found was largely focused on black masculinity, which is constructed as hyper-aggressive, overly sexual, and dangerous (Connell 2005). This intersection of mental health status, gender and race required my attention during analysis considering a significant proportion of the participants in the sample are black.

In *Masculinity and Emasculation for Black Men in Modern Mental Health Care,* McKeown et al. examine the responses black men had to mental health treatment. Part of a larger study, the data consisted of telephone surveys with 52 advocacy organizations, focus groups of black men who had received treatment, and three case studies of advocacy provision. The first major issue uncovered for black men was a medicalization of their masculinity; participants reported higher doses of medications than white patients and a lack of non-pharmaceutical treatments such as psychotherapy (McKeown et al. 2008). Other differences in care were more frequent physical restraint, staff acting as though black patients were more aggressive, greater involvement of the criminal justice system and the police, and higher likelihood of detention in secure units (McKeown et al. 2008). The resulting web of racialized care is overwhelming for many respondents:

> Evidence here shows that this stigma can be heightened when mental health service intervention carries connotations linked to slavery and the concomitant abuse of controlling power. When psycho-social feelings of impotency are combined with medication that can create physical impotency the potential for total emasculation of black men within mental health services can become complete. (McKeown et al. 2008)

Since the data for this study come from reports given by advocacy organizations and former patients, rather than direct observation, they could raise concerns of inaccuracy or bias. However, it is not the accuracy of the claims made in the report that is relevant for the purpose of

this thesis, but rather the perceptions of men constrained to a marginalized performance of masculinity. Even if the claims of racialized care are exaggerated (although unlikely) the widely reported perception of discrimination certainly would affect the behavior of men receiving care, including the performance of masculinity.

In *The Protest Psychosis*, Jonathan Metzl builds a compelling argument that schizophrenia was constructed diagnostically and culturally to match the attitudes and behaviors of black militant protesters. His argument includes a broad historical and cultural analysis of documents spanning most of the 20th century, and a collection of relevant quantitative data. He highlights changes to the *Diagnostic and Statistical Manual* (DSM) in 1968 at the height of the black power movement and a trend in psychological research to link schizophrenia with black men (Metzl 2009). This racialization of the DSM caused a divergence between the biological occurrence of schizophrenia and its subjective diagnosis (Metzl 2009). According to Metzl, schizophrenia is shown by genetic research to have a very predictable 1% occurrence rate, regardless of virtually any demographic or ethnic variation, yet blacks are reportedly diagnosed with the disorder four to seven times as often as whites (2009). Additionally, due to the racialization of diagnostic materials the process of diagnosis is hindered, even when the patient and provider are the same race (Metzl 2009). In summary, Metzl exposes the lengthy historical interaction between race, gender and mental health. While racial difference is not central to my analysis, 42.4% of my sample is black, making his work is important to my analysis should any racial variation emerge. In addition, *The Protest Psychosis* links one existing marginalized masculinity, that of black men (Connell 2005), with the masculinity of men with SMI.

2.6 **Application**

Finally I consider how the clinical implications of my thesis may take shape in mental health care policy and training. In "Dissemination and Adoption of Social Skills Training: Social Validation of an Evidence-based Treatment for the Mentally Disabled", Robert Liberman examines the widespread adoption of the UCLA modules for training social and independent living skills (SILS). Based on inventories of programs and individual practitioners, as well as reports of external training on the modules, mental health providers and organizations implement the SILS training all over the U.S. and in over 30 other countries (Liberman 2007). Providers use these social skills modules to teach normative social interactions to patients with SMI, and as such the SILS training is a vehicle for normative socialization. The SILS training is, in effect, an institutional manifestation of Goffman's process of the life course self-view, directing the patients in exactly how to envision the narrative of their future self (Goffman 1962). Greater knowledge of how masculinity affects treatment and recovery could improve these modules, and they in turn could serve as a mechanism for teaching healthy expressions of masculinity. Such a project should be taken on with great care, however, as to ensure that the encouraged gender constructions do not reify gender inequalities, sexism, or misogyny.

This thesis crosses many disciplinary borders – sociology, psychology, and public health all have bearing. I selected the above literature for its ability to weave the common thread of masculinity, as defined by Connell, through a varied base of knowledge that prepared me for the analysis that follows. This body of work defines a theoretic framework for my thesis, gives it context, and provides examples of other research resembling my focus.

This literature expands and clarifies the questions this thesis, while maintaining its inductive nature. First I will document the distinct expressions of masculinity in men with SMI,

and organize these expressions into themes showing patterns of gendered behavior and attitudes. Second, I will identify specific masculinities enacted by the men in the sample and how those masculinities strategically lay claim to, or secure complicity with, hegemonic ideals. Finally, I will show how these patterns of expression and masculinities are impacted by the presence of SMI and the treatment career. In addition, the literature suggests how the findings of this thesis may be implemented to improve the standards of care, both through systematic training that builds awareness among providers, and policy changes that recognizes the importance of gender.

3 RESEARCH DESIGN

3.1 Overview

Gender certainly touches every part of our lives, influencing how we are seen by others as well as our self-image, and the normative performance of gender is crucial to acceptance and often self-worth. It is my assertion that gender plays a dramatic role in the lives of men with serious mental illness, shaping how they respond to diagnosis, treatment, and recovery. In this research I explore how the unique context of mental health treatment limits and modifies localized hegemonic and complicit masculinity. Since the performance of masculinity is an elusive subject, and researchers have produced little to no sociological examination of masculinity in the context of SMI, a qualitative analysis is the logical choice to produce initial theories (DiCicco-Bloom and Crabtree 2006). Considering patients with SMI are a vulnerable and protected population, I chose a secondary analysis, circumventing the need to access the population directly. To this end, I have selected a rich data set (detailed in full in the next section) of in-depth interviews of men with SMI. In the interviews the men were asked how

their illness and treatment had affected their romantic and sexual relationships – attributes directly tied to the performance of masculinity. To analyze the data, I developed a coding system through an open coding process guided by theories of hegemonic masculinity and complicity. Due to the fluid nature of hegemonic masculinity, I utilized a grounded theory approach to identify specific masculine expressions and analyzed patterns in the codes to locate emergent themes and masculinities.

3.2 **Data Set**

In order to answer my research questions I needed a dataset where the respondents had ample time to become comfortable with the interviewer, discussing at length the elements of their life that involved masculinity. As evidenced by the literature on help seeking, masculinity and mental health care are at odds (Berger et al. 2013; Hammer et al. 2013), indicating that men would be reticent to admit they are struggling with feeling masculine. To simply ask about the performance of masculinity outright might yield canned answers - in Goffman's terms they would offer their apologia (1962). Therefore, indirect questioning is an ideal approach, teasing out sensitive information that may be uncomfortable to discuss directly (Singleton and Straits 2005). Having a large sample size was important since the experiences of men with SMI vary greatly by attributes such as class, race, and social support structure. Collecting such a wealth of data would have taken years, and access to a protected population such as this would be difficult to attain, further supporting the decision for a secondary analysis.

I selected data from the Indiana Mental Health Services and HIV Risk Study (Wright, Gayman, and Perry 2003), which sought to examine the effects of mental illness and treatment

on the historic and current romantic and sexual relationships[2] of patients with SMI, as well as to assess their knowledge of HIV and AIDS. This line of questioning was conducive to the spontaneous discussion of masculinity. Sexual virility and conquest are central to hegemonic masculinity (Connell and Messerschmidt 2005), and questions about romantic relationships can lead to subjects such as ambition, employment, respect, and the fulfillment of the provider role. The 401 interviews took a team of several researchers three years to collect and they achieved a response rate of 73.9%. Due to the commitment of the original research team to visit patients multiple times (should a patient become disorganized, fatigued, or anxious during the interview) most of the responses were quite verbose.

Participants for the original data collection were recruited from Indiana state hospitals and CMHC's. The requirements were that they had to be diagnosed with a serious mental illness, be age 18 to 60, and have been in treatment for at least two years. At two hospitals and one CMHC, every eligible patient was invited to participate, and the remaining participants were randomly sampled from lists of eligible patients at two other CMHCs, producing a large sample with diverse demographics. The investigators had a close relationship with state officials who oversaw these institutions, easing access to the target population of patients with SMI.

In order to narrow the focus of the study, ensure suitable social context of participants, and reduce the data set to a manageable volume, I chose to restrict my subsample to men diagnosed with schizophrenia who were receiving treatment at community mental health centers. While women can enact masculinity, through this work I aim to improve the treatment of men

[2] It is important to note that due to the concern with HIV awareness, the original line of questioning did focus on sexual relationships – participants would be discouraged from discussing relationships that did not have a sexual component. However, several questions in the interview guide simply ask for details about the participant's "most important relationship." Most respondents discussed romantic relationships in these sections of the interviews. In short, the intent of the data collection to focus on relationships with a sexual component did not prevent verbose discussion of non-sexual relationship elements. The original interview guides and survey instruments are available from the principle investigator.

with SMI, so including female masculinity performance would be counterproductive. The choice to limit the participants to those with schizophrenia comes from the cultural association between schizophrenia and hypermasculinity – particularly violence. Men with schizophrenia are highly stigmatized as dangerous and unpredictable, likely leading to severe role loss and hindrance on masculinity performance. The overt and pervasive nature of this stigma led me to speculate that they may be more vocal about their frustrations surrounding masculinity than men with other disorders. In addition, selecting men with schizophrenia allows for a follow-up examination that compares men with a different disorder. Finally, I chose to use only patients who were receiving treatment at community mental health centers for two reasons. First, participants would be more stable and thus their interviews would be more coherent - hospital stays are often short term, focusing on stabilization of a crisis period. Second, these participants are living their day to day lives among general society, and as such are subject to the norms of masculinity performance and the stigma of failing to perform masculinity. These criteria resulted in a subsample of 63 men. My initial examination of the transcripts showed three participants who were highly unresponsive or combative, producing almost no content of analytic value. In addition, one spoke little English and no translator was present for his interview. Choosing to remove these four cases left a final sample of 59 interviews for the purpose of my analysis – a robust yet manageable amount of data at just under 900 pages of transcription.

The unit of analysis for this study is the interviews with single patients; even when the interviews took multiple sessions to complete those sessions were combined to a single unit of analysis. Even though the original data collection took approximately three years, it is cross-sectional in that each participant completed one whole interview (even if that interview required

several sessions to complete). Longitudinal data could prove incredibly valuable for examining how the performance of masculinity varies over the course of the treatment career, but the purpose of this study was to generate initial theory – theory that could inform such a future longitudinal investigation.

Unfortunately, the dataset does have some major limitations, especially in regard to generalizability. First, since the participants are all in treatment, this analysis can offer limited insight into the functioning of masculinity in men who are never diagnosed or refuse treatment. While the workings of masculinity in men with undiagnosed or untreated mental illness is an interesting and important topic that deserves attention, it is ultimately beyond the scope of this data set or my research questions. Second, the restriction to state funded institutions did limit the sample frame, omitting patients with the resources to seek treatment in private institutions. Masculinities are tied to class (Connell 2005; Connell and Messerschmidt 2005), and men who can afford private treatment are not only likely to construct their masculinity differently, but also have resources available to overcome barriers and retain roles that serve as sites for hegemonic masculinity. However the pieces may differ, the pressures of masculinity performance are present regardless of class, making this analysis a valuable reference point for men of greater means receiving private care. Furthermore, given that higher class men have more options for retaining masculinity in the face of SMI, I argue that producing insights that address the needs of the most vulnerable patients is the most ethical starting point for the larger conversation of masculinity and mental illness.

The other major limitation with this data comes from the nature of secondary analysis. The original line of questioning, with its emphasis on sex and relationships, has a great impact on which masculine expressions emerge from the data. While this limitation is a serious one, non-

sexual expressions of masculinity did emerge regularly in the interviews, offering invaluable insights. Furthermore, the coding system I developed has the advantage of capturing the nuances of how these men presented their sexuality – especially in relation to aggression, misogyny, and alternative expressions of masculinity. While this limitation is unfortunate, and some expressions of masculinity were no doubt limited or excluded, this simply serves as an avenue for further inquiry using primary data. Ultimately, all conversations must start somewhere, and while this data set carries the expected limitations inherent to all qualitative interview research (DiCicco-Bloom and Crabtree 2006; Dunbar, Rodriguez, and Parker 2003), the purpose of qualitative inquiry is not to answer all our questions, but to tell us which questions we should be asking.

3.3 **Measurement**

To measure the expressions of masculinity in the interviews, I developed codes with a grounded theory approach, allowing the expressions of hegemonic and complicit masculinity present in the data to inform the development of codes in an inductive manner (Singleton and Straits 2005). These initial "base codes" (as I will refer to them from here on) were focused on precise, narrow expressions of masculine norms, and could be positive expressions of masculinity (sexual prowess) or statements that expressed limitations on masculinity (sexual dysfunction). My strategy for this technique was to be as precise and discreet as possible with base codes with the intent that themes would emerge between them allowing for collapse into groups. For instance, three base codes were "lack of potential sexual or romantic partners" (meaning no social exposure to people with which to partner), "partnering hindered by SMI" (when a potential partner is identified but the SMI interferes directly), and "stigma prevents

partnering" (when potential partners are present but refuse involvement with respondent specifically due to stigma). These three codes, while similar, express nuanced variations on the effect of SMI on romance, and along with other codes were collapsed into a group code of "romantic relationships."

In addition to the aspect of masculinity being expressed in the base codes, I tagged each individual code for three distinct features to allow for additional analysis. First, I tagged codes dichotomously as either overt expressions of hegemonic masculinity or as merely complicit to hegemonic ideals. I identified overt expressions as having a clear relational dominance toward either women or other men. I tagged codes as complicit to hegemonic masculinity when they did not directly show domination of women or other men, but were compliant with the hegemonic gender hierarchy. Expressions of overt hegemonic masculinity require separate analysis because they are arguably problematic - they often set unrealistic expectations for men (especially those who carry stigma), recreate gender inequality, and foster misogyny. Second, I tagged codes for the presence of disorganized behaviors. As noted above, when eliminating participants from the subsample only the most combative or unresponsive participants were removed due to a lack of usable content in their transcriptions. Many subjects remained who report information that clearly deviates from a cohesive sense of reality. Since identifying disorganization is an entirely subjective assessment, I was conservative with my allocation of this tag. I limited the tag to the most obvious examples of disorganization, such as the respondent referencing something that was a clear departure from reality, exhibiting stressed patterns of speech like stammering or excessive repeating, and when the respondent would fade off and lose track of the conversation. Finally, I tagged base codes for overt reference to role loss or role reinstatement, allowing

analysis of how sites for doing gender are stripped and reinstated over the treatment career (Goffman 1962).

In addition to coding for masculinity in the respondents and their lives, I coded for several other elements of interest for this thesis that are related to gender politics. The first set of these additional codes marked instances of staff involvement with the performance of masculinity, such as recommendations or limitations on opportunities for masculine performance (to not have sex or father children) and the participants' responses to these interactions - such as resistance, frustration, or acceptance. Also, upon realizing that there was some interplay between religion and the masculinities of many respondents I coded for expressions of religious devotion. Finally, I coded statements that directly reflected upon and rejected hegemonic masculinity. While these anti-hegemonic sentiments were few, I felt they deserved noting.

One major unforeseen complication did arise during the coding process: many respondents were highly repetitive during their interviews, espousing the same sentiments many times and often in rapid succession. Upon noticing this trend, I realized that this repetition could cause several problems. First, within single interviews a participant may make a statement so repetitively that it would be difficult to determine whether it should be considered single or multiple codes. Second, when it came to quantifying the presence of codes in the whole data set, such repetition could skew results, inflating the presence of a single theme. I decided to be conservative with how many repeated codes I would tally, choosing only to allow repetitive codes in a single interview if there had been significant deviation in topic between the occurrences.

I developed the coding system during the first two sweeps of the data. I utilized the software MAXQDA to manage, tally, and analyze the codes, but all coding was done manually –

no codes were produced using automatic functions in the program. The final coding system consisted of 62 original base codes in 14 categories. After the coding system was complete, I conducted additional passes of the data until I achieved saturation. I continued to pick out subtle expressions of masculinity throughout the third sweep of the data – especially for those base codes that I had developed in the second sweep. My fourth sweep of the data produced very few codes, and I concluded that I had reached saturation. On occasion, I recorded passages of text as multiple codes; a single statement from the respondent could be, for instance, coded for "objectification of women" as well as "expression of sexual prowess." These four complete coding passes resulted in the production of 939 individual codes from 735 passages. A complete breakdown of the coding system and the tally of original codes are located in appendix A.

4 FINDINGS

My findings break down into three major sections. First, by examining the base codes I reveal general trends in masculine performance in the interviews. Second, I identify six emergent themes in the data, and operationalize each through combinations of base codes and code groups. Third, I extrapolate the masculinities that these men enact, both at the time of the interview and in their past. In doing so I demonstrate how their previous masculinities were challenged and reshaped by the acquisition, diagnosis, and treatment of SMI.

4.1 Basic Results

As the most fundamental level of my analysis, I reveal trends regarding how masculinity is enacted and understood by the respondents through the presence and prevalence of base codes

and code groupings. Table 4.1 shows the number of coded segments by group along with the number of respondents whose interviews contained these codes. The prevalence of code groups that relate to relationships and sex is not surprising, since these were the original topics of inquiry. For these groups a more nuanced analysis of individual codes is required. More telling are the groups that were not expressly addressed in the original line of questioning, but had common spontaneous occurrence, such as the groupings of Misogyny, Provider Role, and Fatherhood. The particularities of these code groups and individual codes manifest in the emergent themes section to follow.

During this basic level of analysis I identified an emphasis on those forms of masculinity associated with working and poor classes. Participants had a mean monthly estimated income of $612. Since the respondents are low income the types of issues that they spoke of reflected this, as did the masculine norms they did not discuss. For instance, participants frequently discussed material possessions, especially in regard to relationships. I coded discussion of the impact of money and possessions on the chance to develop romantic relationships in 34 (57.6%) of interviews. Often participants were responding to interviewers asking about why respondents didn't have romantic partners, such as one who said he needed a car to date: "Well, nice car, nice date. With the money I would get more involved in church and would find me a church girl"[3] (3010, white) [4]. Many expressed the perception that women had rejected them for their financial insecurity: "She really wasn't interested in me anyway, she was really interested in somebody with money" (3005, white). The prevalence of these codes juxtaposes the absence of masculine expressions associated with higher classes, such as leadership and autonomy, which were scarcely present in the sample.

[3] All punctuation has been left as is from original transcriptions.
[4] Denotes case ID and race.

Table 4.1 Frequency of Code Groups

Code Group	Coded Segments	# of Respondents	% of Respondents
Sexual Virility and Activity	317	58	98.3
Romantic Relationships	215	50	84.8
Misogyny - Other	99	40	67.8
Provider Role	52	29	49.2
Fatherhood	35	23	39
Treatment Process	43	21	35.6
Religious Devotion	35	17	28.8
Stoicism	26	16	27.1
Assertiveness	23	14	23.7
Autonomy	20	12	20.3
Competition w/ Other Men	17	12	20.3
Violence	22	12	20.3
Anti-Gay	26	11	18.6
Anti-Hegemonic Statements	9	6	10.2

I evaluated the proportion of base codes tagged as overt expressions of hegemonic masculinity to statements that are merely complicit to hegemonic norms. In total, 309 codes were recorded that embodied hegemonic masculinity in that they expressed domination of women or other men. Such codes were present in 55 (93.2%) of the interviews. Codes reflecting complicity to hegemonic masculinity totaled 561, and were present in every interview. It is clear from the general prevalence of masculine expression that the men in the sample seek to embody hegemonic masculinity, or at least reap the rewards of this system through complicity.

At this base level I also analyzed codes that directly address role loss. While I found that themes of role loss were common throughout many of the interviews, direct statements reflecting on the experience were relatively few since role loss was not addressed directly by the interview

questions. In total, 35 codes addressed role loss, and were present in 20 interviews. Hegemonic masculinity is constructed relationally (Connell and Messerschmidt 2005), so these codes often emerged when there was a change in role that influenced the respondent's interactions with women, either socially, sexually or financially. One respondent expressed general discomfort with dating: "I don't, it's been so long I don't know what I, I dated a lot but it's been a long time. Sometimes I feel like I don't know how to act" (3018, white). Inability to fill the role of sexual partner was also a major barrier to ideal masculinity: "it [absence of sex] makes me, it doesn't make me feel like a man, it makes me feel like a neuter" (3157, white). Finally, the provider role appeared as a major site for the production of hegemonic masculinity, and losing this role caused major barriers for some men: "we have financial problems 'cuz, uh, I'm not making any money. I was making the money and we've been going through some changes" (3013, black). In the more complex sections of my analysis to follow, role loss impacts the masculinities that the respondents adopt or seek, and acts as a catalyst for those that are abandoned or reconstructed.

4.2 **Emergent Themes**

Six themes emerged from my examination of the narratives in the interviews. These themes encompass either trends of behavior related to masculinity or interactions between masculinity and the treatment process. As I identified the emergent themes from the interviews, I determined which basic codes captured the elements of the theme. I describe each emergent theme below, along with an operationalization of it using basic codes, and a quantification of its prevalence in the sample.

4.2.1 SMI Relationship Interference

The first and most frequent emergent theme was "interference with romantic relationships" as a result of SMI. Throughout the interviews, participants expressed frustration about romance as a result of their illness and treatment. Sometimes these frustrations were directly caused by SMI, such as potential partners rejecting participants due to stigma. At other times the effects were more indirect, such as a lack of potential partners due to the limited social network that accompanies SMI. This obstacle is of great importance for the participants since performance of masculinity is relational to women.

This theme emerged sometimes historically, as respondents lamented interference of SMI with previous relationships. Several respondents reported relationships that ended due to the stresses of mental illness and treatment. One participant told of a very positive relationship that lasted three months but then ended: "I was just too rough. I still had too many personality dysfunctions for her to continue the relationship and she ended it" (3157, white). According to many respondents, interference from SMI also explained the lack of current relationships. One participant discussed the alienation that comes with SMI: "sometimes I feel, sometimes I just I have ways that they don't like, and they don't understand that because of my mental illness" (3087, black). Men often attributed the hindrance to lack of exposure to desirable partners: "I can still have sex if I wanted it, put it that way but I've just not found nobody that I wanted to have sex with is why I haven't had sex" (4905, white). Often participants lamented having only other patients to choose from for romance: "there's nobody that I'm attracted to that I would want to date or anything that would lead possibly to marriage and then sex, you know. I'm not interested in anybody here in other words" (4931, white). When respondent did turn to other patients for partnering, the results were sometimes reported as damaging: "it didn't work out

because we were both unstable … That was too emotionally draining with her illness and it was creating illness in me just trying to do everything" (3007, white). The men make it clear that relationships are important to them, but their SMI complicates finding and keeping a healthy relationship.

Stigma was also a major source of relationship issues. In 16 interviews participants cited stigma as a reason they couldn't solidify relationships. Usually these statements were very direct, as one man said when asked if he thought his mental illness was preventing relations, "It's just not attractive, you know, personality wise" (4931, white). Sometimes participants said that stigma would make them undesirable partners: "most of the people that are normal … won't touch a mental health patient for a mile unless they're an alcoholic" (4908, white). Stigma, in its most extreme manifestations, was linked to aggressive and misogynistic attitudes toward women. One man explained his experiences with stigma:

> "If I was a normal person I could probably get women left and right, but for some strange reason a lot of women look at me with hatred and disgust because I got a problem and they don't and uh, that kinda makes me feel bad. Nobody wants a person that's on medicine ... That's just my feeling about it but I could be wrong, too." (1052, white).

In his interview I identified seven separate codes for misogyny and makes the comment "If I was normal, who knows, I coulda been rapen' some girl, or whatever." While a causal relationship between stigma and aggression toward women is beyond the scope of this analysis, there is a clear and disturbing correlation.

I operationalized SMI relationship interference by combining the following basic codes: romantic relationships being hindered by SMI, partnering is blocked by SMI, stigma prevents partnering, lack of potential partners, and treatment hindering sexual relations. There are certainly many more examples within the coding system expressing how SMI could interfere

with relationships, such as sexual dysfunction, diminished sex drive, issues with assertiveness or autonomy, or the aforementioned lack of money and material possessions. However, when operationalizing this theme I only included those codes where the respondent expressly discussed how SMI interferes with relationships. Even with this conservative operationalization the codes used to signify this theme appear in 81.4% of the interviews. It is crucial to conceptualize hegemonic masculinity as relational to women (Connell and Messerschmidt 2005), and the ability to form romantic relationships is central to normative gender relations. Therefore, I interpret the abundant presence of this theme as definitive evidence that hegemonic masculinity is limited for men with SMI.

4.2.2 Masculine Materialism

As discussed, over half of the respondents lamented the lack of money and physical possessions perceived as necessary for relationships. This is one part of an emergent theme in the data which I refer to as masculine materialism – an overall relationship between masculinity and the ability to produce material gain for the self and others. I operationalized masculine materialism by combining the basic codes of "money and possessions in relationships", "employment", "overt discussion of a provider role", and "giving money to partners." This combination of codes shows the expression of masculine materialism in 40 (67.8%) of the interviews. This theme ads complexity and nuance to the aforementioned monetary limitations on partnering. Masculine materialism encompasses fears about the legitimacy of the man that manifest through his viability as a long term partner – a very real barrier to the hegemonic ideal.

Sometimes respondents addressed the connection of work to masculinity very directly, as one man stated when asked how mental illness had affected his sex life: "Not being able to work

all the time. Feeling less than a man than what I am because of the work situation and money" (3040, white). For some men, getting regular employment was part of the recovery narrative. One participant explained how he left his partner altruistically: "I was in the process of moving and I told her that I had to go away. To get myself straightened out, get myself a job and everything, and I told her I might come back for her." When asked to elaborate he said he was not "living up to the standards of what her mom thought [he] should be and she thought she could do better" (1052, white). Participants expressed the perception that manhood hinges on the ability to work, and that their partners and extended networks hold this standard of masculinity as well.

Purchasing things for partners or otherwise supporting them financially was a large element of this theme. In discussing his most important relationship, one respondent discussed the time before his illness: "I bought her things all the time. I was working in the steel mills. You make good money in the steel mills … So I had money. We'd go out and I'd spend money on her, you know" (4931, white). Some participants seemed eager to offer direct financial support, even with casual partners. One respondent described a longtime friend with whom he started a sexual relationship, denied that it was a direct exchange when the interviewer asked: "I knew she needed some money. She didn't ask me for money, I just gave it to her … That is just how we got into the sex thing ... I was just helping her out" (1006, black). It is as if his masculinity was legitimated by offering financial support, but this effect might be undone were the act interpreted as prostitution on her part. For some participants the provider role also extended to the potential for having children: "if I didn't have a mental illness, I'd probably have kids, but I really don't want to have kids, for one reason … I'm not able financially to take care

of them" (3005, white). Participants tied money and employment to masculinity, both as a barrier and as a rare opportunity to prove their worth.

4.2.3 Sexual Dysfunction

I identified sexual dysfunction as a common theme in the interviews, an important pattern because sexual prowess is often one of the few paths to masculinity available to lower class men. Throughout the interviews the participants discussed the persistent issues around sexual ability and desire, often citing it as their reason to not seek partnership. I operationalized this theme by combining the basic codes for erectile or ejaculatory dysfunction, absent or diminished desire for sex, and poor sexual performance. The combined code for sexual dysfunction was present in 42 (71.9%) interviews. One participant highlighted the importance of sexual performance to masculinity when he discussed pleasing one partner, and then the consequence of failing to please another partner:

> "Wonderful, vindicated as a man because an important part of being a man is to have successful sexual intercourse that both gets him off and gets his woman off. I had this one happen to me when I just felt so let down one time when I successfully had sexual intercourse and she didn't give me any response, didn't feel a thing. Or, "are you finished yet." (3157, white)

Most men attributed physical sexual dysfunction to medications. Lack of desire for sex had more varied explanation. Sometimes it too was attributed to medications: "Ever since I've been on Prozac my libido has been considerably down … My sexual urges are feel, um just kind of fleeting fantasies. I don't feel a strong enough urge" (3157, white). Other men tied it to choice and the recovery narrative, as with one participant who explained why he was not upset about his lack of desire for sex: "Because there's other things I need to do and focus on. Cause I

don't wanna get anyone pregnant, or catch a disease, uh I got myself to think about and I just wanna keep my life as simple as possible" (1052, white).

Some respondents attached competition with other men to sexual dysfunction, revealing a tie to hegemonic masculinity. One participant explained how a relationship failed due to sexual dysfunction: "she wasn't having sex with me because I wasn't satisfying her … so she was going with somebody else" (3066, white). Another man explained that avoiding competition made it easier to accept his impotence: "I'm afraid … that if I had an interest in a woman that worked here, or had my own girlfriends, that would bring on hate feelings from the men, that they would become jealous … they would try to beat me and try to kill me and try to get rid of me" (3052, white). The link between sex and masculinity is nuanced and multifaceted, but clearly important for these men, impacting how they attempt to construct a functional masculinity.

4.2.4 Sexual Conquest

Sexual bragging rights are quintessential to hegemonic masculinity, and the men in my sample are no exception to this standard. Some participants seized opportunities to discuss their ability to seduce and satisfy women. Further demonstrating the reliance of masculinity on sex, 20 (33.9%) of the participants' interviews included descriptions of sexual conquest[5]. Interestingly, sexual conquest and sexual dysfunction were not mutually exclusive, usually due to of one of these themes being historic – stories of old achievements, or past dysfunctions now overcome. Whether through ongoing exploits or stories of a vigorous past, some participants employed sexual conquest as a key path to masculinity. I operationalized this theme by

[5] Due to the nature of secondary analysis, I had concerns that the original line of questioning had inflated the presence of this theme. To alleviate the concern I constructed an alternate, more conservative version of the theme using only codes that were flagged as overtly hegemonic. The resulting difference was minimal, with the theme emerging in only one fewer interview.

combining the basic codes of being desired by women, expressions of sexual prowess, and convincing women to have sex.

Participants discusses being desired by women with some regularity (27 codes in 15 interviews). One participant described how women pursued him, telling a story from a party when he was younger: "Just from watching her body language and how she was trying to sneak and look at me and sneak closer. I was like, 'you probably could leave with her tonight and have sex with her'" (3152, black). When men brought up being desired by women it was purposeful and sometimes repetitive. In one such case a participant brought up a sexual encounter throughout his interview: "[she] was very turned on by me … she filleted me and I did cunnilingus on her and sucked her nipples. The next morning she told me quote, 'you did everything right' unquote … She was just really, really turned on by me and made that quite clear" (3157, white). For men who were currently struggling with sex and romance, stories about previous conquests were a way to claim masculinity.

For men with ongoing sexual conquests, sometimes their exploits took the form of multiple partners: "I get it about once a week … [with] different people" (3141, black). Another respondent, when asked if SMI had affected his sex life, bragged that it hadn't hindered his virility: "I don't think it has, it ain't bother me ... I still got women" (30778, black). Although promiscuity was usually presented as positive, one married man was disturbed by his behavior, saying "It's been hell ... I've been doing too many women … Four, three or four times a day. Different women" (3117, black). He discussed this compulsive cheating throughout his interview, and was clearly disturbed by these acts.

Some men expressed their masculinity with straightforward discussion of sexual prowess, often with misogynistic vulgarity: "I went back to the bedroom, I tore that pussy up … I fucked

the shit out of that. She looking good too." This respondent then became aggressive with his interviewer: "This mother fucking dick do get all hard. When this mother fucker gets big, it gets about this long. Look" (4005, black). Other respondents similarly bragged about the impressiveness of their manhood: "She touched my [penis] … She looked at me and smiled like she was impressed" (3051, black). Also noteworthy were expressions of sexual stamina, such as one respondent who said he and his girlfriend would "fuck all day long" (1028, white), and another who claimed to have had sex with his partner every day for a year (1121, black). These boasts sometimes were tagged for disorganization, such as one interviewee who said his goal was to stay erect for a year (1034, white). Over all, the theme of sexual conquest permeated the interviews where it was present, showing that it was central to the masculinity of those for whom it mattered.

4.2.5 Sexual Reductionism

Another tie between masculinity and sex was an unexpected theme of what I call sexual reductionism – a tendency to reduce people, relationships, and situations to their sexual elements alone. Many of the respondents, when asked about a relationship – even their "most important" relationship –would discuss a purely sexual relationship. In addition, when asked why they were drawn to a particular person, frequently they would give physical characteristics. Many of these codes occurred when the interviewer asked participants how time was spent with their partners, to which they answered with sexual activities. As stated in the data overview section, the original goal of the interviews was to focus on relationships with a sexual component, which may have contributed to the emergence of sexual reductionism. However, the presence of this theme is still meaningful, evidenced by the prevalence and tone of these sentiments.

Operationalized as the codes for objectification, reduction of relationships to sex, and focus on sex as physical only, the theme is present in 32 (54.2%) of the interviews[6].

Regularly, participants would describe their most important relationship in purely sexual terms, telling stories that would normally be considered rather casual, shallow, and short-term. When met with such a narrative, interviewers would ask if there were any other features that had drawn them to the partner, such as the following passage:

I: Okay. What attracted you to Leslie?
R: The way she looked.
I: The way she looked?
R: Looked.
I: Okay. Looked. And what was it about the way she looked?
R: She looked sexy.
I: Okay. Was there anything specific or just?
R: Her body.
I: Uh, is there anything else that attracted you to her? Besides her body?
R: She wanted to get fucked. (4005, black)

The respondent continued to describe the relationship in mostly physical terms, explaining that they had sex regularly and in various locations, and broke up after two months. Attitudes like this, where participants expressed no reason for a relationship other than sex, where common in the interviews.

When men talked about finding a good partner, they often reduced this idea to physical characteristics. One respondent, when asked to describe the "right one" he was looking for, responded with "Well, I don't know. Blond, brunette, about my age, very good looking" (3146, white). When asked if there were any other characteristics that mattered, he said there were not.

[6] As with sexual conquest I constructed a more conservative version of this theme using only overtly hegemonic expressions. Similar to sexual conquest the reduction in prevalence was minimal, with the theme still emerging in 29 interviews compared to 32.

Like sexual conquest, sexual reductionism is likely so pervasive because many other pathways to hegemonic masculinity are barred for these men. Inaccessibility to financial success, fulfilling a provider role, or a position of dominance or leadership of other men leaves only a carnal option for masculine performance.

4.2.6 Aggressive Relational Masculinity

Hegemonic masculinity is fundamentally marked by dominating others. Throughout the interviews, participants regularly exhibited aggression in a variety of ways, from misogynistic statements to highly aggressive statements about the treatment staff, to discussions of violence. I call this emergent theme "aggressive relational masculinity" – a collection of masculine behaviors and expressions meant to intimidate, demean, and subjugate others. Operationalization of this theme collects many basic codes from several different code groups (see table 4.2). Many of these basic codes were infrequent when quantified alone, but when combined show a pattern of behavior that attempts to elevate the position of the participant by belittling others. Aggressive relational masculinity was present in 35 (59.3%) interviews.

Table 4.2 Aggressive Relational Masculinity Code Makeup

Basic Code	Frequency
Anti-Gay; In others	23
Assertiveness; Defensive Masculine Statements	2
Competition with Other Men	17
Misogyny; Double Standards	4
Misogyny; Specific Woman/Women	23
Misogyny; Woman's Role	3
Relationships; Fear/Assumption/Suspicion of Infidelity	8
Treatment Process; Aggressive Statements	5
Violence; Abuse of Partner	3
Violence; Stories of	11
Violence; Urges	7
Total	106

As a signifier of hegemonic masculinity, aggressive relational masculinity is frequently directed toward women, via various misogynistic attitudes and assertions, such as proclamations of a proper woman's role ("she's a good housewife. Cooks good, keeps the clothes clean. Do things that a woman should do for a man" 3013, black), and expressions of the sexual double standard. Misogynistic statements ranged from demeaning and paternalistic to delusional and aggressive expressions of rape culture: "this one woman at the halfway house that's pretty delusional and doesn't know her ass from a hole in the ground … Said I raped her and beat her and they were going to put me away in jail and chop off my dick. And they were talking crazy like that gal did" (3052, white). One participant even told of the physical abuse he inflicted on his partner: "I remember one time I was on that [cocaine] real bad and I was fighting her and beating her up and she calls this place up and took her and put her somewhere and wouldn't tell me where she was at" (3117, black). These men use aggressive masculinity to reify patriarchy and position themselves over women. Through this relation to women they remain complicit to hegemonic masculinity, despite their mental illness.

Participants also demonstrated relational aggression aimed at other men, recreating the hierarchy of masculinities central to hegemonic masculinity. For instance, participants often expressed anti-gay sentiment. Sometimes these statements were expressions of a general moral position: "there is a lot of homosexuality in America today, and I personally don't associate with homosexuals" (1015 black); "I grew up in the church and we were taught that homosexuality was wrong" (3040, white). Often these homophobic sentiments were rambling and externalized, as with one respondent who justified his assertions by claiming the CIA "do not hire homosexuals. They are unstable. It's abnormal. Homosexuality is an abnormal condition in their [the CIA's] way of thinking. There is a choice there. They say, they say they are born that

way but they're not. There is a choice" (4931, white). Often anti-gay aggression was linked to treatment and HIV education efforts, such as one man who said that educating gay men about HIV was a form of approval, saying "What you should tell a homosexual is, he needs to stop being homosexual" (1015, black). Another participant expressed disdain for having a gay provider: "I was seeing a faggot by the name of [therapist Name] at the time, he's a therapist and he's gay" (1052, white). By openly demonstrating homophobia, these men lay claim to a position above the subordinated gay masculinity, even if their own position is marginalized (Connell 2005).

While much of aggressive relational masculinity involves demeaning or dominating others, it also involves fighting back against those who are perceived as limiting the masculinity of the subject. For instance, one participant took severe issue with his case manager, who he perceived as interfering with his recovery and sex life: "She's tied into the system, it's her bread and butter. And she licks its anus, that's my case manager she licks its anus … They are non-responsive [about sex]. Especially my present case manager" (3157, white). Another respondent recited a lengthy hyper-masculine fantasy where he "wasted 17 football players" who were abusing a pair of "Indian children," all while impervious to harm: "I ran down the hill and wiped out the opposition with a chain and a spark plug socket. I took one, when those guys shot at me with a .357 Magnum handgun, nothing happened to me. And then I thought, well, they're trying to kill me, and I'm not going to die" (3052, white). More subtle were spontaneous statements in defense of masculinity, such as one respondent who was quick to clarify that his girlfriend was not allowed to see other men, and another who said, after discussing his lack of sexual activity, that he was "not a wimp dick" (3024, white). Whether real or illusionary, assertive or

reactionary, clearly some men with SMI seek masculinity by fighting against those they see as oppressing them.

4.3 **Masculinities**

As I worked with the data, during the development of the coding system, the coding saturation process, and the development and operationalization of the emergent themes, I became intimately familiar with the narratives of the men in the sample. I learned, by intricately documenting their statements and stories, just what kind of men they had constructed themselves as; to put it in Goffman's terms, I had been witness to their apologia (Goffman 1962). Patterns emerged in how they envisioned their manhood, sets of behaviors and attitudes became clear that coalesced with culturally normative masculinities. Three distinct masculinities were enacted in the sample: breadwinner, sexualized, and religious. The three masculinities were by no means mutually exclusive, with significant overlap both as a blend of features as well as change from one to another (or all three) over time. Like the emergent themes I was able to combine sets of basic codes that could be used to mark the presence of each masculinity in the data.

4.3.1 Sexualized Masculinity

The most common masculinity I identified in the sample was based on sexuality. Sexual superiority is not reliant on class or race, nor is it necessarily negated by mental illness, making it a viable path to hegemonic complicity for men with SMI. The men who embodied this masculinity showed sexual dominance over women, and by extension superiority to other men. This masculinity was easily operationalized by combining the emergent themes of sexual conquest and sexual reductionism. Doing so showed that this masculinity was present in 41

(69.5%) of the interviews. This overwhelming presence is not surprising considering the emphasis on sex for the original study. It is also worth noting that not all these men were currently reliant on sexualized masculinity for hegemonic complicity – sexual histories were often the source of these codes. Regardless of factors that may have inflated the expression of this masculinity, the narratives in the sample clearly indicate the centrality of sex to participants' masculinity.

The glorious claim to masculinity that is sexual boasting often emerged as stories past – tales of sexual exploits from younger years, often before diagnosis occurred. Frequently this was paired with justifications as to why said exploits remain in the past. Some men recognized and admitted that diagnosis and treatment had obstructed their sex lives, while others relied on a normative life course explanation such as aging out of promiscuity or a change in morals. Often, however, these social gymnastics were rather transparent; several participants explained their lack of sex as a choice or result of aging right after lengthy discussions of sexual dysfunction. In fact, of the 41 men demonstrating a sexualized masculinity, 30 had experienced sexual dysfunction.

This overlap of a reliance on sex for complicity and the presence of sexual dysfunction may explain the high levels of aggressive relational masculinity in men embodying sexualized masculinity. Of the 41 men showing sexualized masculinity 28 also exhibited aggressive relational masculinity. Often this would manifest as toxic levels of misogyny, such as one respondent's absolute certainty that any women would want him for his money:

> "if a woman accepts her relationship with me, she's doing it only for money … there are women who would date me, I know lots of 'em, they're always giving me messages at work. And I get messages from other women I see, an uh, eating places, you know. Uh, but I don't take them up on their offers because I think they only want money." (1015, black)

His interview was dense with aggressive relational masculinity, including comparing his former wife to a prostitute. In a similar interview, the participant blamed his lack of interest in relationships on the women of his past: "a woman doesn't mean nothing to me, because I been fucked over by them … Running around on me. They do everything on me. One female gave me diseases" (1028, white). Later this participant demonstrated misogynistic attitudes, describing his girlfriend only in physical terms, and then explaining that "She was a virgin. That's why I liked her. I was the only guy that ever fucked her." For these men whose masculinity rests on a foundation of sexual conquest and objectification, the interference of SMI on realizing this masculinity can lead to heightened aggression. I assert that this bleak portrait – sexuality steeped in misogyny and aggression – represents a fundamental reason to directly address masculinity in the treatment of men with SMI.

4.3.2 Traditional Breadwinner Masculinity

Hegemonic masculinity is largely dependent on being at the top of the hierarchy – the strongest, most ambitious, most dominant, most attractive, and most successful. For a vast majority of men this is simply impossible, especially for working class men. Therefore, a primary strategy for working class men to reap the benefits of patriarchy has been to adopt a traditional breadwinner masculinity. By holding down a good job, supporting a wife and family, and being a dutiful father, men of lesser means remain complicit to hegemonic ideals without accomplishing them outright. In my sample of men with schizophrenia, the traditional masculine breadwinner role was usually presented as a long term goal for the future, usually tied in with a narrative of recovery. On occasion, however, it served as a shameful stain of failure, a cherished position now denied by their illness. To capture the features of this masculinity I combined the

basic codes for general talk of fatherhood, potential for fatherhood, spending time with kids, employment, overt statements of provider role, giving money to one's partner, and assertions of a traditional role for women. This operationalization resulted in the traditional breadwinner masculinity being present in 35 (59.3%) of interviews.

A good number of the men discussed their long term goals for recovery, and often these included capturing the traditional breadwinner masculinity. This man stated plainly his need to be able to provide before seeking a relationship: "I feel I need something to bring to the table before I can expect a woman … to you know to give her part … yeah I'd have to bring something to the table myself, I don't feel like I have anything to offer right now … Economic, financial [or] emotional" (3061, white). Another asserted that rather than uncommitted sex, "What you're supposed to be doing is be with your husband or wife … And providing. If you're a man, provide for your wife." Later, in regard to his lack of relationship he said "I ain't got time for it, I'm a strictly like a businessman you might want to say… I'm getting my act together" (1029, black). This interplay of relationships and the recovery narrative allowed these men to express that the traditional breadwinner masculinity was honorable and just, and that they claimed it as their own by proxy of taking the steps required to achieve it.

Reaching a traditional breadwinner masculinity was not always a beacon of hope – often it represented shortcomings. One participant told of a seven-year relationship that embodied this masculinity, but that he ultimately had to leave his partner in order to focus on recovery:

> "I'd invite her over to dinner, her and her kids. We'd go out to eat, went to some movies, uh, went to parks … Just being there with her and her kids. And being there for them … I was in the process of moving and I told her that I had to go away. To get myself straightened out, get myself a job and everything, and I told her I might come back for her." (1052, white)

Even though the loss of this father-like role caused him pain, the ability to provide was important enough to make him leave. Another respondent regretted not being able to provide better, saying "I wish I would have had my son at a later date … I wish I was financially more stable so that I could present him with more opportunities" (3152, black). Sometimes the pressure of this failure was ongoing, as one man expressed: "[I'm] feeling less than a man than what I am because of the work situation and money … I'm not always the provider. I'm not always the one with the money to take care of the bills. It makes me feel like I'm not taking care of her the way that she wants" (3040, white). Although having a family offers a vital support network and sense of purpose, falling short of the ideals of providing and proper parenting can be a source of stress.

4.3.3 Religious Masculinity

Where the first two masculinities emerged over time through the interworking of the masculine expressions that were coded throughout my work, religious masculinity was more abrupt in its appearance. While it was not my intention to initially code for religious expressions, a significant portion (35.6%) of the sample wrapped their masculinity up in religious ideology. I found similarities to the traditional breadwinner masculinity in that religious masculinity usually involved vague, long term plans tied to a recovery narrative. However, unlike the other two masculinities, no particular set of masculine expressions were linked to religious masculinity. Instead, employment of this masculinity was highly strategic, framing masculinity within a context of religious culture and ideology. For instance, participants often used religious devotion to frame lack of sex as celibacy, and lack of relationships as waiting for a "church girl".

I coded for expressions of religious devotion, such as attending services, making claims based on religious ideals, or attributing things to divine will. Generally speaking, recovery and treatment is often interwoven with faith, especially for those getting treatment from the state. Where resources are limited, support is drawn from the community, and religious organizations serve as a source of volunteers, social support for patients, and a physical site for extra therapy such as group meetings. However, adopting this masculinity served a very strategic purpose for the men in my sample, allowing them to alleviate the pressures of hegemonic ideals like sexual conquest and instead claim an honorable moral high ground. Since religious masculinity was not reliant on specific masculine expressions, I operationalized it very simply, combining the basic codes of religion as reason not to have sex and religious commitment/involvement. This resulted in religious masculinity being present in 21 (35.6%) interviews.

While religious masculinity was not tied to particular expressions of masculinity, participants often used religious ideology to justify relational assertions complicit with hegemonic masculinity. For example, men reified homosexual men as a subordinated masculinity: "Homosexuality is a very bad sin, according to the bible … being a good Christian is not hanging out with very bad people" (1015, black). Also, participants used religion as a way to classify women, especially when it came to determining if they could be trusted as relationship worthy. One respondent, when expressing a desire for a deeper relationship than just sex, said, "maybe I should go look in my church. Maybe I should get someone from the church … they'll stay with their men, you know, because they've been brought up this way" (4931, white). Even for men who lack hegemonic traits, religion is a path for reaping the benefit of hegemonic masculinity by claiming a moral high ground.

Sexual dysfunction and relationship SMI interference - the two emergent themes that most definitively embody SMI's interference with relational masculinity - were abundant in men with religious masculinity. Of the 21 men exhibiting religious masculinity, 16 had the presence of sexual dysfunction and 18 had relationship SMI interference. Here the strategic use of religious masculinity becomes very clear. For example, one participant opened his interview with statements about how his medication had all but removed his desire for sex, even to masturbate. He then said that he enjoys being asexual because the "Bible it says you can't," and that he doesn't "search out easy sex and easy women … that will do it for money or just because she is horny … Because I am a Christian." Toward the end of the interview he claimed he is waiting for marriage, "Cause if you have sex with anybody that isn't your wife, its adultery" (3061, white). Another respondent discussed using women for sex in the past, but said he now had various types of sexual dysfunction and hadn't had sex in a year. When discussing why not, he said it was due to his increased religiosity, and even put the possibility of a new sexual relationship up to divine will: "I just uh, you know trying to get closer to God, do what's right. Hopefully if try to do what's right with God maybe one of these days he will find me a half-way decent wife or girlfriend" (3005, white). Religious ideology becomes a convenient tactic for masking inaccessibility to the hegemonic ideal of sexual prowess.

When sexual dysfunction was combined with SMI relationship interference, the strategy was even clearer. One such respondent spoke of the troubles with meeting people, and the turmoil SMI can cause once in a relationship. Also, he discussed his ongoing struggle with loss of libido and erectile dysfunction, going into detail about his medications being the cause, and said he was actively seeking treatments to rectify the dysfunction. Despite these issues, he was dating several women who he had chosen not to sleep with for religious reasons, saying "What

changed for me recently was just a more religious attitude towards intimate relations. I've been reading in the Bible and learning, in the Bible's viewpoint that fornication is a sin no matter how it's committed." In addition, later in the interview he boasted over 50 partners in his lifetime, and expressed misogynistic attitudes toward women who get abortions, despite having two previous partners who had abortions (3007, white). Becoming religious allows for a complex strategy of shifting the blame for sexual dysfunction to a moral stance, laying claim to hegemonic masculinity through past sexual conquest while taking a religious superiority, and showing dominance over women while systematically berating and dehumanizing them.

Only two of the 21 men employing religious masculinity had neither sexual dysfunction nor relationship SMI interference, but those interviews were similar in several ways. Both were both quite short and had signs of disorganization, both men were in relationships where they expressed dissatisfaction with the morality and religiosity of their partner, and both were highly focused on discussion of god and religion – to the point that many topics sought by the interviewer were not discussed fully. Many of the men expressed a history with religion, and likely were newly exposed to religious organizations through the treatment process. This data shows a clear pattern of men utilizing this renewed exposure as a way to alleviate the pressures of the hegemonic ideal.

4.4 Masculinity Prevalence & Interactions

As stated previously the presence of the three masculinities was not mutually exclusive. Significant overlap occurred, sometimes in the form of a synthesis of multiple masculinities, for other men as a replacement of one masculinity with another. Table 4.3 shows a configuration of the masculinities and figure 4.1 offers a visual representation of their overlap. How common

each masculinity was and the intricacies of their interaction lie at the heart of my analysis. In many interviews where multiple masculinities were present, the interactions between them were normative and relatively unconnected to the respondent's mental illness; an interviewee may express sexual prowess in one part of the interview, and then his goals for getting married and having children later. Those interviews that had a singular masculinity, regardless of which, showed similar trends of being rather short, having cases that are highly disorganized, and having significant SMI relationship interference and sexual dysfunction. Here I focus on trends where the interactions of multiple masculinities have relevancy to the participant's illness and treatment career.

Table 4.3 Configuration of Masculinities

Religious	Traditional Breadwinner	Sexualized	Frequency	Percent
	■	■	15	25.42
		■	14	23.73
■	■	■	9	15.25
■	■		6	10.17
	■		5	8.47
			4	6.78
■			3	5.08
■		■	3	5.08

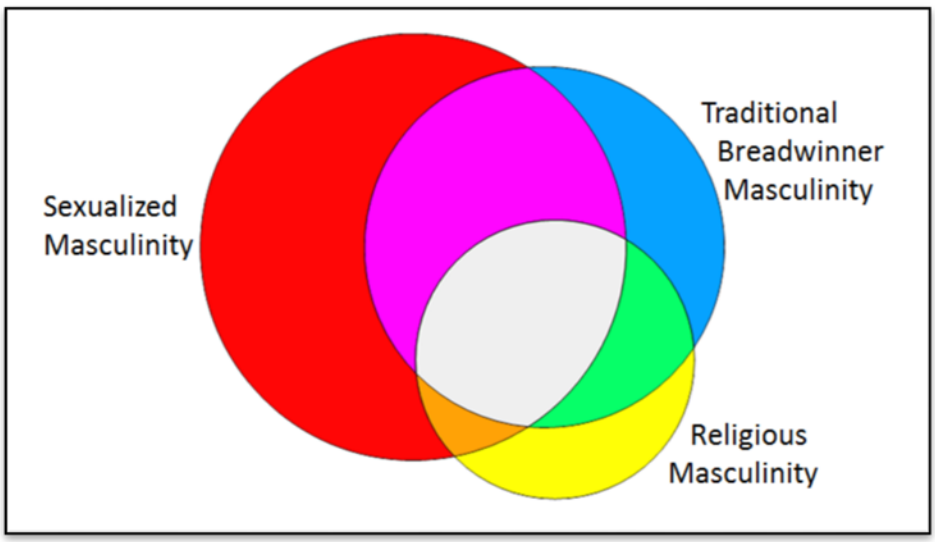

Figure 4:1 Venn Diagram of Masculinities

Sexualized masculinity was not only the largest group, but also had the most number of cases where no other masculinity was present. Although this is likely in part due to the line of questioning for the interviews, I interpret this trend as evidence that men with SMI are a subordinated masculinity, barred from many masculine norms of the hegemonic ideal. Men with limited access to hegemonic masculinity often default to carnal expressions of manhood (Connell 2005; McKeown et al. 2008). In the 14 interviews that had only sexualized masculinity present the respondents gave very brief answers, indicating reluctance to discuss certain topics. Of these 14, five were highly disorganized, with respondents seemingly unable to answer more complex questions. The remaining nine respondents used a significant amount of vulgarity, heavily objectified women, and presented their relationships as entirely sexual in nature, shallow and short-lived. They were also divided into those who were currently satisfied with their sex life and those who were not. As would be expected, those who were satisfied had little instance of sexual dysfunction or relationship SMI interference, while those who expressed dissatisfaction had very high rates of these themes.

Traditional breadwinner masculinity had the second most common presence at 35 cases, but was far less likely than sexualized masculinity to be present alone. This was largely due to the fact that sex was discussed directly in the interviews as where elements of this masculinity were not, and also that the idea of being a provider and family man was often ideologically intertwined with religion. As a whole, men who exhibited this masculinity fell into roughly three categories: those who exhibited this masculinity in regard to past relationships, those in an ongoing breadwinner role, and those who placed it as a long term goal of recovery. When participants spoke of past roles, there was often a sense of regret and loss in their tone, but when

relationships were ongoing, men often seemed to gain a lot of satisfaction and worth from assuming a provider role, even in the face of turmoil:

> "She used to smoke crack. I had to help her out a lot because sometimes she would get out of control. … I would get angry because of the money situation. She would waste money on drugs and I would have to look out for her. I felt depressed and hurt by her. She started to realize that I have been helping her and she was starting to appreciate it more." (3127, black)

Most frequently, however, having a wife and family were positioned as vague, long term goals. In the presence of sexualized masculinity, such goals were sometimes framed as a way to secure a sexual relationship.

Men who demonstrated religious masculinity with a traditional breadwinner role without sexualized masculinity had a common narrative. These men had high levels of sexual dysfunction, expressed opinions that sex and sexuality were immoral, and focused on morality when discussing potential partners that was at times misogynistic. They strategically employed the morality of religious belief to alleviate themselves of the pressures of sexualized masculinity, and excused their lack of relationships on the grounds that available women were unfit. One of these men tied his ability to provide to the moral inadequacy of a love interest who worked as a go-go dancer, which he "didn't care for," saying he would only pursue her if he could "do well enough to get them both out of here" (3061, white). Thus emerges a relational compliance with hegemonic masculinity that relies on circular thinking: in the absence of worthy partners his claim to traditional masculinity is protected by religious ideology, so long as he does the right thing and stays celibate, and thus superior to the women within reach.

The traditional breadwinner masculinity was often entwined with a narrative of recovery. Many men discussed having a family as a primary goal for "straightening themselves out." The mediating variable in this narrative was financial security, first in basic material possessions seen

as necessary for partnering, then as a key factor in supporting a family. Discussion of money and possessions in regard to relationships was present in 23 (65.7%) of the breadwinner interviews. Overall, fatherhood was a complicated and uncertain topic for many respondents: "I have been pretty successful. I have no kids. As I get older I just wonder what I was thinking when I was young. I wouldn't mind having a kid or two. But, uh maybe that's not a good idea" (3107, white). There was evidence that narratives surrounding fatherhood were actively constructed by treatment professionals. Several patients reported recommendations by staff to not have children until they were more stable – or not at all. One participant and his partner were trying anyway despite recommendations:

> R: They felt like I couldn't afford it. They felt like I couldn't afford a kid, that I would lose self motivation and maybe I am just not smart enough right now or got the stuff it takes to have a kid.
> I: How do you feel when they tell you that?
> R: That I'm schizophrenic and they know partially that's why, they don't really know the whole story, but they do speak some truth. (3040, white)

Another man explained that he had taken the staff's advice in this decision, which included a recommendation for abstinence over birth control:

> R: Dr. Smith has she said that she definitely thinks that we should not have a child.
> I: Why is that?
> R: Well her exact words, "you can't even take care of yourselves let alone a child."
> I: What do you think she meant by that?
> R: I think she meant that it is hard enough for us to manage our own lives, let alone the life of the child who would be very hard to take care.
> I: Yeah, so, does she recommend any birth control methods or anything like that?
> R: She said to just abstain is the best one. Uh, because, she says birth control pills alter the woman's metabolism and if she is on medication they don't if it is really working and all this.
> I: How do you feel about her recommendation about not having a child?

R: I trust her.

I: You trust her?

R: Yeah, she makes sense you know.

I: Why do you think those recommendations were made?

R: Because of our inability to cope with everyday living skills. I mean that if you are in the hospital and your wife is in the hospital at the same time, and we have had similar circumstances, so… (3016, white)

While these recommendations from staff likely have the best intentions, they can erect multiple barriers to the performance of healthy, positive masculinity. For this patient, not only is achieving masculinity through fatherhood unavailable, but sexual empowerment with a trusted partner is proscribed as an expression of masculinity. These barriers could in turn result in patients resorting to toxic forms of masculinity such as aggression or risky sexual behaviors.

Religious masculinity was the smallest category, with only three cases where another masculinity was not present. These men exhibited high levels of SMI relationship interference, and while not all three had codes tagged for disorganization, they all showed severe anxiety surrounding sex and relationships. This passage demonstrates this anxiety, as the respondent frames avoiding sex as an important accomplishment:

"My sex life has been great to me because I have been very good about not having sex. I haven't had sex in over a year and a half, and I think I'm doing good. I shouldn't have sex until I'm married. I don't think I should have sex until I'm married again, till I get married. And um I won't have sex until I'm married." (3087, black)

Religious masculinity was also the only masculinity having the largest proportion (9 cases) where the other two masculinities were present as well, demonstrating how it was largely not

dependent on particular expressions of masculinity, but rather how it assimilates other masculine expressions ideologically.

When all three masculinities were present the interactions between them were complex and multidimensional. Occasionally a religious, traditional masculine role served as a path to sex: “The Lord wants me to find somebody that’ll be truth to me, I’ll be truth to her and we would be as one and get married ... I wanna have children. See I wanna keep on having sex and then not have children” (1114, black). Sometimes the presence of all three masculinities would leave men stuck without an available course to claim any one completely. One such respondent expressed a strong libido, but an inability to act on sexual desire, claiming he gets sick from religious guilt after intercourse. Finding a wife to start a family with was the answer to this dilemma, but SMI relationship interference kept him from finding a suitable partner. Ultimately, frozen by these contradictions the respondent minimizes his agency: “my belief is that you don’t need to have sex until you’re married because there are ways that God provides us with ways of coping with needing sex until you’re married” (4931, white). Divine will was employed frequently as a social escape route for the complications of religion, sex, and SMI. Another man, who had all three masculinities present throughout his interview, expressed how a previous relationship ended because his religious ideology demanded marriage, but he felt incapable of fulfilling the breadwinner role (3022, black). Although religious organizations offer a place of welcome, comfort, and affordable treatment for low income consumers, the ideologies that sometimes come packaged with these advantages appear to conflict with other masculine norms, leaving men in a state of frustration.

4.5 Masculinity & Treatment Pathway

While a good deal can be learned from the prevalence and interactions of these three masculinities, ending the analysis here would overlook a pattern in the data that brings crucial insight to the interworking of SMI, treatment, and hegemonic masculinity. While some men performed a blend of two or three of these masculinities, in many of the interviews multiple masculinities were not embodied simultaneously. Instead, a clear pattern emerged where one masculinity was supplanted by another in strategic response to barriers caused by SMI. I have developed a model that captures the nuances of this pattern called the *Masculinity and Treatment Pathway*. This model can be utilized as a tool and framework for future research on role loss and strategic masculinity performance that occurs during the diagnosis and treatment process.

The basic pathway, as shown in figure 4.2 below, has five stages. The first stage is the onset of symptoms from SMI and diagnosis. At this point the individual has a masculinity they are enacting, constructed through their experiences and context of their life. As I have demonstrated through the analysis of this data, this onset of SMI causes stage two - barriers to the expression of this existing masculinity. This leads to stage three, role loss associated with barriers to masculinity. At stage four the individual engages in treatment for their SMI[7], where symptoms are managed and barriers to masculinity are potentially addressed. Also at stage four the consumer is socialized into a recovery narrative, where alternate masculinities may be presented. At stage five the pathway splits. Through the treatment process, if the barriers to the original concept of masculinity are removed, the subject will likely return to their original masculinity. However if barriers to masculinity persist, the subject will likely adopt a new masculinity that strategically outmaneuvers those barriers. The drive to achieve hegemonic

[7] While a similar series of events may take place for men who do not seek treatment, this analysis is limited to those who do.

masculinity, or at least remain complicit to it, supplies the motivation to rework one's gender performance. How quickly the pathway advances and how long the subject lingers in a stage can vary greatly, and patients could go through the pathway more than once, especially if they experience trauma, relapse of mental illness, or significant life changes.

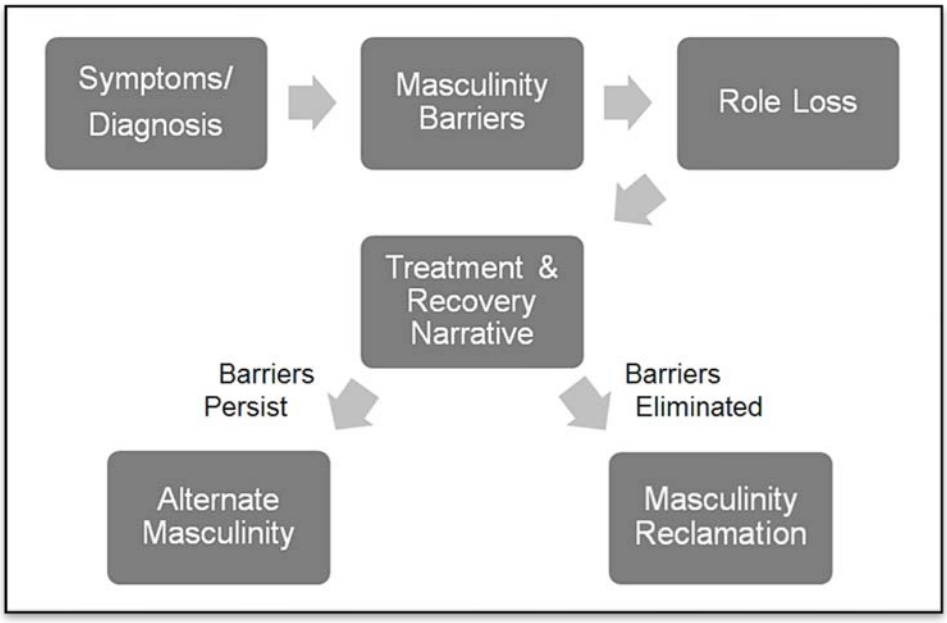

Figure 4:2 Masculinity & Treatment Pathway

When a subject does deviate to a new masculinity, the source of that masculinity can vary. A man might revert to a masculinity they enacted when they were younger, or may be offered a path through friends or family. Regardless of the source, the treatment process is certain to help mold this alternate masculinity – a phenomenon present in this data set. Respondents occasionally discussed recommendations made by staff in regard to activities and choices related to masculinity, such as whether to date, have sex, or parent children. The structures of treatment facilities also encourage or discourage certain masculinities, such as prohibitive policies surrounding sex (Deegan 1999). If consumers are referred to faith based organizations for additional treatment, religious individuals volunteer at the CMHC, or local

churches offer support for the mentally ill, then the treatment career is likely to steer them toward a religious masculinity. While this causal chain was not abundantly clear in the data, several respondents who demonstrated religious masculinity commented that their contact with religious people and organizations had increased recently. Treatment is an intense environment emphasizing resocialization that is certain to have gendered elements.

Many of the respondents in my data showed evidence of this pathway. Some had completed a cycle, sometimes possibly two. Several men, often younger and earlier in the treatment career showed evidence that they were at middle points in the pathway, negotiating and weighing the conflicted messages and barriers of different masculinities. Such was the case with one respondent who despite a strong presence of sexualized masculinity hadn't had sex in over a year:

> "So I have to keep continue on these paths to see if I'm right or wrong, and uh, that's what I've been doing so I told myself that it's not, just being in the, in church, you know what I'm sayin, they stated that premarital sex is wrong, period. You know what I mean? But sometimes I feel like uh, I don't know if this is right, and I'll never know until it's that time but since I feel like okay, if you're, you and this person uh, have come to a point where uh, where you uh, know each other and you feel like you love each other…" (3152, black)

He discussed throughout the interview the messages of sexualized masculinity from his social network competed with his religious ideology, and expressed continual uncertainty about which path to take. Within the framework of the pathway he is lingering at stage four, negotiating and weighing the benefits of the two conflicting masculinities before him.

It was fairly evident, even with the limitations of secondary data analysis, to see examples of men who had completed the pathway. Of these, some men had alleviated the barriers to masculinity enough to maintain or return to their original masculinity. These men

often shared certain trends. First, and perhaps most important, the barriers to their masculinity were minimal or short-lived, such as sexual dysfunction that was alleviated quickly. Second, they generally had more stability and a better support network, often being in a committed relationship or married. In these cases, a man may have to renegotiate the manner by which he enacts his masculinity, but is able to maintain his masculinity. One respondent, who was married, demonstrated these trends. He had a fairly prominent sexualized masculinity with elements of objectification and sexual prowess, but explained his diminished desire for sex as due to age rather than medications. In addition, he explained that his wife's libido was also diminishing, insulating him from the failure to exhibit sexual prowess. Later he defended his loss of the provider role by attributing it to age as well:

> I: What do you like least about the relationship right now?
> R: I like least about it, we have financial problems 'cuz, uh, I'm not making any money. I was making the money [to work] and we've been going through some changes in [?].
> I: So you've had some lifestyle changes?
> R: Yeah, lifestyle changes. Yeah, I'm retired, and she's still ain't working [?], but when I was working, she wasn't working so… it it's kind of hard starting back to work, you know, you haven't, when you haven't been used to it. (3013, black)

Although he admits the shift bothers him, he strategically keeps his masculinity is intact. First he frames these changes within the normative life event of retirement, and then asserts that his overall financial contribution has been greater than his wife. His claim to the traditional breadwinner masculinity remains intact, demonstrated by the following statement that emphasized traditional gender roles: "She's a good housewife. Cooks good, keeps the clothes clean. Do things that a woman should do for a man." Even though his role as provider has been removed, his strategic employment of masculinity allows him to keep reaping the benefit of her continued role of housewife.

When men are unable to reclaim their masculinity they supplant it with an alternate one. This process was evident in several men who currently embodied a sexualized masculinity. When barriers to long term committed partnering, such as the stigma of SMI, were combined with limitations on achieving a traditional breadwinner role, men often defaulted to laying their claim to the hegemonic ideal through sex. One participant, a black male in his early 50's, demonstrates this course through the pathway. His current expressions of masculinity were highly sexualized, boasting sex several times a week with different people, asserting that his partners are always satisfied, a confession of "kind of" forcing a woman to have sex, and demonstrating misogynistic sexual reductionism toward his last girlfriend:

I: What did you like least about your relationship?
R: Uh, that she didn't want to leave when I got through with having sex with her.
I: Why did you want her to leave?
R: I was through with her.

When discussing his most important partner ever, the mother of his daughter, expressions of sexual masculinity were present as well but the focus is on a traditional family man masculinity that is connected to religious ideology:

I: how did your relationship get started with Jill?
R: We met in church.
I: Who talked to who first?
R: She talked to me.
I: Um what attracted you to Jill?
R: Oh, I knew she'd be a good mother.
I: Ok. How did you and Jill spend your time together?
R: Shows, parties, we did everything, shopping, uh, we lived together for a little while. We had an apartment together.
[…]
I: Ok. Any other things you liked the most about your relationship with Jill?

R: I wanted to have a baby, I wanted to bring somebody in this world, and uh, Jill was the right partner.

This original synthesis of all three masculinities was made impossible to maintain, however, as SMI set in and the traditional breadwinner role became impossible to fulfill.

I: How did your relationship with Sharon end?
R: I went to the military.
I: So why did that stop it?
R: I just cut everything off.
I: Why did you do that?
R: I was probably getting sick.
I: Can you explain that a little more?
R: Uh, I had a nervous breakdown when I came out of the military, in the military. I had a nervous breakdown. I was wondering what was wrong with me, by that time. […]She wanted to get a house together and everything. You know, she had this big dream. And uh, I wasn't living up to it. To her dream … I wanted the same thing … I had the nervous breakdown and everything.

After explaining that he could no longer fulfill the masculinity that he and his partner envisioned, prompted by the interviewer he reflects on how his outlook on relationships has been affected:

I: Do you think that your relationship with her, or you guys separating has affected your relationships since then? Or not having a relationship since then, if there was a period that you didn't for some reason?
R: Yeah.
I: What – can you talk about that?
R: My feelings, pretty emotional feeling. Emotional feelings that I can't find somewhere else. Just not there for me. I just can't find nobody that I can connect with … I don't want to put forth the energy, all the energy and go through all that again. (3022, black)

This series of interview excerpts detail a very unfortunate pathway for the respondent. He was unable to overcome the barriers of SMI to his ideal masculinity and is unwilling to risk the

failure of another attempt. As a result he has relegated himself to a toxic masculinity rife with sexual conquest, misogyny, and shallow sex.

Several participants showed completion of the pathway, having abandoned a sexualized masculinity for a religious one in the face of unrelenting sexual dysfunction. One man, white in his mid-fifties, exemplifies this strategic path. His interview is rife with sexualized masculine notions such as discussing how many women desire him and a youth filled with sexual conquest: "I have counted in my life that I have had over fifty partners…I was frivolous and promiscuous." He discusses, however, that he suffers from severe and ongoing erectile dysfunction and his doctor is incapable of adjusting his medicines to alleviate it. In the more recent past, he discusses a partner with whom he attempted a rather paternalistic traditional provider role, but barriers to employment caused him to abandon the relationship: "I can't afford a wife and…I didn't think I could live with her for the rest of my life and take care of her and all her problems. I guess I wasn't' the man for the job." His current masculinity revolves around one day having a wife, and adopting a religious view of sex: "What changed for me recently was just a more religious attitude towards intimate relations. I've been reading in the bible and learning, in the bible's viewpoint that fornication is a sin" (3007, white). It appears as though the respondent has gone through the pathway twice, first switching from a pure sexualized masculinity to one focused on providing, but then persistent barriers led to another to a mostly religious masculinity. Ultimately, religious masculinity serves as a safe haven for this respondent whose interview tone shows he would prefer sexual conquest and the patriarchal dividend of a subservient wife, but is incapable of achieving these masculinities due to barriers from SMI.

Although the occurrence of supplanting one's masculinity as described by the masculinity and treatment pathway may seem natural or even unavoidable, it is problematic. The

men who had deviated to a new masculinity showed high levels of dissatisfaction, stress, sadness, and aggression. Simply because a man finds a new way to lay claim to some aspects of hegemonic masculinity does not mean he is happy. After all, masculinities compete with one another for dominance, often through discourse that devalues the other masculinities. A man who has placed his masculine expression in being an honorable family man and provider, for instance, may hold a very negative opinion toward a sexualized masculinity that objectifies women and constructs sex as recreational rather than tied to marriage.

This path is clear in my final example – a black respondent in his fifties who is clearly dissatisfied with his new sexualized masculinity, even hating himself for his actions. When asked about his sex life at the beginning of the interview, he responds "it's been hell…I've been doing too many women… Four, three or four times a day. Different women… I'm a married man." His constant compulsive cheating is not only troublesome and dangerous (he rarely used condoms with prostitutes), but a source of confusion: "I just want to know why I keep going buying stuff like this (prostitutes). I got a wife at home." The respondent divulges that he was exposed to the promiscuity of sexualized masculinity while in treatment:

R: When I got locked up at Central State they put me with a whole lot of different kind of people. Sex-fiend, sex-maniac, stuff like that. And they talk to you all the time [?].
I: Did something happen to you in there?
R: No…
I: Other than just talk?
R: Got in a fight that's about it.
I: So how did talking to those people change your…
R: I ain't never [?]
I: So you've never been around those kind of people, did it change your attitude about women?
R: [R shakes head yes]

Ultimately he expresses that it was the inability to achieve the role of father and breadwinner that led him down this path: “If I had kids I probably wouldn’t be going through all this … I wouldn’t be having sex with these women … I’d be home working, going to the store … taking care of my kids … If I didn’t have the nervous breakdown I’d probably have some kids right now” (3117, black). The compulsive divergence to sexualized masculinity is clearly in response to the persistent barriers to a traditional breadwinner masculinity. This tragic example of the masculinity and treatment pathway shows how barriers to masculinity that are caused by SMI can lead to extremely dangerous behaviors. These behaviors can have serious consequences for the patient and for those around them, such as this man’s wife who is potentially exposed to extreme sexual health risks.

While the masculinity and treatment pathway is not a definitive model, and requires more testing and application, I think it offers a flexible yet informative framework with which to examine the interactions between gender performance and SMI. When negotiating the demands of hegemonic masculinity in the face of SMI, men are presented with ample opportunity to slip into toxic manifestations of masculinity such as misogyny, aggression, violence, and risky sex. As their patients struggle with role loss and manhood, mental health professionals may be able to utilize this framework as a treatment tool. Such a tool might allow for reflection on the intricacies of masculinity that men must negotiate in treatment, and thus assist in helping patients construct new paths to masculinity that are healthy, positive, and productive.

5 DISCUSSION

My primary goal in conducting this research was to explore how men with SMI express masculinity and how these expressions are impacted by their illness and treatment. In doing so, I

hoped to supply evidence that men with SMI could be firmly identified as embodying a marginalized masculinity, and to begin a conversation about the role of gender in mental health care that would inform policy change. Through exploring the narratives of these men, I have provided substantial evidence that hegemonic masculinity holds importance within the context of mental health treatment. Within the fertile line of questioning of the original interviews, a wealth of masculine expressions emerged spontaneously, showing that men with SMI strive to enact the idyllic embodiments of hegemonic masculinity, and when barriers impair claim to this ideal complicity is strategically maintained.

The men in the sample largely sought to claim masculinity in very normative ways – very few gave any indication that they rejected hegemonic ideals of masculinity. The specific nuances of how masculinity is impacted by SMI took form in the six emergent themes. The story told by these themes is not surprising, and begins with the systematic barriers to masculinity. Limits on employment and other financial strains led to a preoccupation with *masculine materialism,* leaving men feeling frustrated and damaging their self-worth. These material limitations, in combination with stigma, social isolation, and the scars of past losses led to an almost universal expression that SMI causes significant *relationship interference*. Finally, nearly three quarters of the men had their masculinity challenged by *sexual dysfunction.* Their responses to these barriers are largely unhealthy and dangerous, as men grasp at whatever masculine expression is available. When possible, men claimed masculinity through *sexual conquest*, by discussing emotionally shallow and often dangerous sexual habits. In addition, participants objectified women and belittled relationships through a pattern of *sexual reductionism*. Finally, a majority of respondents (54.2%) demonstrated *aggressive relational*

masculinity, revealing severe hatred of homosexuals, competitive attitudes toward other men, various forms of extreme misogyny, abuse of partners, and violent urges.

How the emergent themes played out serves as evidence that men with SMI are a marginalized masculinity, for whom full enactment of hegemonic masculinity is a near impossibility. For men with marginalized masculinities, one or more facets of hegemonic masculinity become impossible, leaving limited options for remaining complicit. In the case of men with SMI many limitations emerge from the inability to perform certain roles in society where masculinity is produced. Some limitations change from man to man, such as the ability to hold a job or sexual dysfunction. Others, such as the stigma attached to SMI, remain more constant. The more limitations a particular man faces, the more narrow his options for complicity. In the most extreme cases, men with SMI are limited to the most basic aspects of hegemonic masculinity that rely on aggression, risk taking, and even violence. Here the clinical and policy implications of this thesis become clear: addressing gender norms directly in treatment through gender-focused treatment policies and improved training of mental health professionals may prevent the manifestation of these toxic expressions of masculinity.

As the conversation about gender in mental health care continues and expands, I believe my identification of the masculinities employed by these men can serve as the beginning taxonomy of masculinities to be expanded on. Certainly the strategic enactment of sexualized, breadwinner, and religious masculinities will not be unique to this sample, and additional masculinities are sure to be identified in other populations. In addition, I assert that the masculinity and treatment pathway offers a valuable, if rudimentary, theoretical framework for the future academic examination of how masculinities are challenged, modified, and supplanted over the treatment career. It is my hope that this framework, through further use, can be refined

to capture more nuance of the cycle, expanded to more diverse populations with different demographics and types of mental illness, and modified to by employed with femininity. Furthermore, I believe the masculinity and treatment pathway has the potential, with some refinement, for direct clinical application as a guide to identifying and understanding the personal masculinity path of individual patients.

5.1 Limitations

As research continues on the role of gender in mental health treatment, the limitations of this research can serve as a guide to the next steps. For research that seeks to emulate this thesis closely in core questions and method, more varied samples are needed as the current research participants were similar on many key variables. Foremost, this study should be replicated with men who are diagnosed with SMIs other than schizophrenia, as different barriers and masculinities are likely to present. Second, the men in this sample were almost exclusively impoverished. The findings will likely differ in middle and upper class samples, as masculinities are often tied to class (Connell 2005). Related to economic condition, the men in this sample all received care through CMHCs – consumers of private mental health care may have drastically different experiences with negotiating gender norms. Lastly, this sample comes from the limited geography of an urban Midwestern context, which begs the question of regional difference in gender norms.

The nature of working with secondary data limited my analysis to a degree. As I stated in previous sections, some expressions of masculinity may have been more prominent due to the original subject of the interviews, while others may have been diminished or absent for the same reason. For example, my research can make no claims regarding how men with SMI

conceptualize their masculinity in relation to the hegemonic norms of leadership, level of education, or athleticism. These topics offer promising directions, however, for further inquiry. In spite of the limitation of secondary analysis, expressions of masculinity saturated the data, leading me to the conclusion that additional secondary analysis should not be ruled out. Furthermore, if secondary data can offer this rich of an analysis, well-crafted primary data collection would undoubtedly produce dramatic results. The implications of this promising outcome are twofold. First, institutions in a position to approve such research should, while ensuring ethical protection of consumers, allow and encourage research on gender in mental health care. Second, for those interested in continuing this line of inquiry, the negotiations required to gain access to mental health consumers will be worth the effort.

One unfortunate limitation of this work was that I was unable to identify clear patterns associated to race. Many of the connections between race and mental illness – differential treatment by staff, increased medicalization, and racially biased diagnoses – were beyond the scope of this data. Basic codes, emergent themes, and masculinities showed no significant correlation to race. By no means, however, do I assert that the lack of clear connection within this data set should be interpreted as evidence that no connection exists. Rather, I assert that it was the limitation of secondary analysis of interviews where race was not directly discussed that led to this inconclusive outcome. Race, class, and masculinity are simply too entwined to not impact one another within this context – this data was simply too limited to tease out these nuanced relationships.

Finally, research on gender in the context of mental health must undoubtedly be expanded to women and femininity. While many of the theoretical basics of this thesis may hold true in such an examination – the impact of role loss, the formation of the apologia, and the

strategic employment of new or different gender performances – such a study would require a nearly complete redesign and preparation. Regardless, such a study is, for reasons too numerous to list here, absolutely crucial.

6 CONCLUSION

I have shown in this thesis that the men in this sample experienced substantial barriers to performing their masculinities, leading to significant role loss and subsequent frustration. Within the framework of hegemonic masculinity, I have demonstrated that many of these men are relegated to a marginalized masculinity, restricted to less socially complex expressions of masculinity that rely on aggressive relational masculinity. Finally, by exploring the complexities of these men's narratives, I constructed the theoretical framework of the masculinity and treatment pathway in hopes that it will guide future studies of gender in mental health treatment, and perhaps be modified for use as a tool in treatment, allowing counselors to guide patients in reflecting on their gender performance.

Gender is a pervasive organizational factor in society, and the pressure for men to perform masculinity is intense. This robust data set provided a unique opportunity to explore the complex interaction of masculinity performance and the treatment career of men with SMI. Just as mental health care providers refused to recognize the importance of sexuality in their patient's lives for decades, so too has gender gone unexamined and underestimated as a crucial consideration when guiding the care of someone afflicted with SMI. It is my hope that this research endeavor will be the catalyst for awareness, further research, and practical change that will improve the quality of treatment for those afflicted with mental illness

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APPENDIX: CODE SYSTEM

Code Groups	**Original Codes**	**Codes Tags**	904
Anti-Gay			26
	Anti-Gay / In others		
		000	11
		100	7
		110	5
	Anti-Gay / In Self		
		000	1
		100	2
Anti-Hegemonic Statements			9
	Anti-Hegemonic Statements / general		
		000	5
	Anti-Hegemonic Statements / sex		
		000	4
Assertiveness			23
	Assertiveness / Defenive Masculine Statements		
		100	1
		110	1
	Assertiveness / Lack of/Inability		
		000	14
		001	1
		010	6
Autonamy			20
	Autonomy / As benefit to lack of relationship		
		000	5
		010	1
	Autonomy / General change in Autonamy from SMI		
		101	1
	Autonomy / R expresses being controlled		
		000	2
		001	1
		010	1
	Autonomy / Self Improvement, general		
		000	7
		001	1
		002	1

Key to code tags: First digit – 0 = complicit, 1 = overt hegemonic
Second digit – 0 = not disorganized, 1 = disorganized
Third digit – 0 = no role loss, 1 = role loss, 2 = role reacquisition

Competition w/ Other Men			17
	Competition w/ Other Men	000	5
	Competition w/ Other Men	100	7
	Competition w/ Other Men	110	5
Fatherhood			35
	Fatherhood / Deciding to not have children cause SMI		
		000	9
		010	1
	Fatherhood / Expressed difficulty of parenthood		
		000	1
	Fatherhood / General Discussion of Fatherhood		
		000	3
		010	3
		100	2
	Fatherhood / Potential ForFathering Children		
		000	4
		010	6
	Fatherhood /Spending time with children (own or other person's)		
		000	6
Misogyny - Other			98
	Misogyny / Double Standards		
		100	4
	Misogyny / Objectification		
		100	26
		110	13
	Misogyny / Specific Woman/Women		
		000	3
		010	1
		100	17
		110	2
	Misogyny / Woman's Role		
		100	3
	Misogyny / Women Generally		
		000	4
		010	1
		100	19
		110	5
Provider Role			54
	Provider / Employment		
		000	11
		001	1

		010	6
		100	5
	Provider / Financial Distrust of Partners		
		000	2
		100	5
	Provider / General/Overt Statements of Provider		
		000	5
		001	1
		100	13
	Provider / Giving Money to Partner		
		000	4
		100	1
Romantic Relationships			213
	Rel. / Fear/Assumption/Suspicion of Infidelity		
		000	6
		010	2
		100	3
	Rel. / General Masculinity		
		000	2
		100	10
		101	1
		110	6
	Rel. / Hindered by SMI		
		000	12
		010	4
	Rel. / Lack of Potential Partners- Sex or Relationship		
		000	19
		010	4
		101	1
	Rel. / Money/Posessions		
		000	30
		001	7
		002	1
		010	5
		100	8
		110	7
	Rel. / Partnering Blocked by SMI		
		000	20
		010	12
	Rel. / Reduction of Rel. to Sexual Activity/Physicallity		
		000	10

		010	2
		100	3
		110	3
	Rel. / Self improvement as path to relationship		
		000	12
		002	3
		012	2
		100	1
	Rel. / Stigma Prevents Partnering		
		000	15
		001	2
Sexual Virility and Activity			317
	Sex / Being Desired by Women		
		100	17
		110	10
	Sex / Convincing Woman to have Sex		
		000	1
		100	3
		110	2
	Sex / Erectile/Ejaculatory Dysfunction		
		000	22
		001	1
		010	6
		100	4
	Sex / Expressions of Sexual Prowess		
		000	2
		100	8
		110	6
		111	1
	Sex / Focus on Sex/Relationships as Physical Only		
		000	2
		100	2
	Sex / Lack of Sex		
		000	43
		001	2
		010	7
		100	7
		101	3
		110	5
	Sex / Money for Sex		
		000	4

		010	2
		100	3
		110	3
	Sex / No or Diminished Desire for Sex		
		000	25
		001	4
		002	1
		010	9
		111	1
	Sex / Poor Sexual Performance / Sex not Good		
		000	10
		001	1
		100	4
	Sex / R cheats on partner		
		100	5
	Sex / R Expresses feeling unattractive		
		000	6
		001	1
		100	1
		110	1
	Sex / Religion as reason to not have Sex		
		000	29
			2
	Sex / SMI interferance - General		
		000	28
		001	3
		010	15
		100	4
		111	1
Stoicism			26
	Stoicism / Avoidance of Emotional Topic		
		000	4
		001	3
		100	2
		110	1
	Stoicism / Direct statement/reflection on		
		000	6
		010	2
		100	1
	Stoicism / Reluctance to seek help		
		000	1

		010	1
		100	5
Treatment Process			43
	Treatment / Aggressive Statements		
		100	5
	Treatment / Issue with Gender of Staff		
		000	2
		100	3
	Treatment / Staff Recommendations to Not Have Children		
		000	3
	Treatment / Staff Recommendations to Not have Sex		
		000	6
	Treatment / Treatment Helps With Sexual Relations		
		000	1
		001	1
	Treatment / Treatment Hinders Sexual Relations		
		000	5
		010	3
	Treatment /Complaint of Staff Unrespomsive to sex/gender issues		
		000	11
		010	3
Violence			23
	Violence / Abuse of Partner		
		100	3
	Violence / Anger		
		100	2
	Violence / Stories of		
		000	6
		100	3
		110	2
	Violence / Urges		1
		000	3
		100	2
		110	1