Moral Matters: Schizophrenia and Masculinity in Mexico

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We met Israel, a neatly-dressed, well-groomed man in his forties, during a recent summer of fieldwork at the outpatient clinic of a large, public psychiatric hospital in Central Mexico. That summer, the interviews we were conducting, alongside a team of researchers in clinical psychology, were focused on the elusive psychological concept of "duration of untreated psychosis," or DUP, and what seemed to be causing relatively long periods of DUP in Mexico.[1] Research from our field site in Mexico has shown how stigma and lack of mental health literacy are barriers to psychiatric care, especially for those living in rural communities (De Snyder, de Jesus Diaz-Perez, and Ojeda 2000). However, what we found interesting across many interviews was the key importance that gender norms, roles, and expectations seemed to hold for shaping the response to, and course of, a diagnosis of schizophrenia. In particular, gender influenced how schizophrenia was viewed and received by individuals and families, how family caregiving arrangements changed in response to symptoms, how gender influenced pathways into formal psychiatric treatment, and how people's explanatory models (Kleinman 1978, 1988) of schizophrenia were filtered by their gendered identities and role expectations. That is to say, we came to think of the lived experience of schizophrenia as fundamentally gendered, having particular significance for women and men given the shifting social meanings of gender in contemporary Mexico.

In this article, we focus on the ways that social-role expectations for men, changing political and economic contexts in Mexico, and globalizing cultural norms influence men's understandings of schizophrenia and the impact of this illness on their lives. Psychiatric and epidemiological studies have reported earlier onset of schizophrenia for men, which may point to differences in neurodevelopmental processes (e.g., Huang et al. 2017), a more aggressive illness subtype, or increased social risk factors (Abel et al. 2010; Donoghue et al. 2014). Survey-based research shows differences between men and women with schizophrenia in such domains as age of onset, symptomology, cognitive function, and prognosis (Morgan, Castle, and Jablensky 2008). Meta analyses from North America and Europe show men have a more severe illness course, experience a more critical family environment than women (Leung and Chue 2000), and are less likely to seek psychological services (Barajas et al. 2015). Still, these findings vary across settings and have been difficult to replicate (Cascio et al. 2012; Thorup et al. 2014).

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Further, the extant literature has paid limited attention to gender as a sociocultural construct; instead, psychological research has offered neurochemical explanations for observed sex differences in schizophrenia.[2] Possible sociocultural explanations for gender differences include that men with schizophrenia may suffer greater withdrawal from familial engagement and increased hostility, perhaps due to their inability to uphold cultural expectations of economic productivity (Falkenburg and Tracy 2014). In a study of patients diagnosed with schizophrenia at US outpatient clinics, Jenkins and Carpenter-Song (2009) showed how men experienced difficulties fulfilling the economic provider role, which was associated with increased social stigma and internalized shame. Building on these findings, here we suppose that the impact of schizophrenia spectrum disorders on men reflects social and cultural expectations of masculinity, particularly the economic constraints facing men in contemporary Mexico. Certainly, gendered social-role expectations intersect with social-class positions to shape illness experiences, as some people are more able than others to flexibly adapt and respond to a diagnosis of major mental illness (Seale and Charteris-Black 2008).

Gendered role expectations shape how the men in our study and their family caregivers understand the onset, course, and consequences of schizophrenia. This was clear in Israel's case, as his first experience of psychosis was provoked by the loss of his upper-level managerial job at a large chemical manufacturing plant. Israel had developed a convincing explanatory model of schizophrenia since his diagnosis 14 years prior. Israel didn't contest the biomedical diagnosis, accepting that his was a chronic illness, which he attributed to ongoing unemployment. He situated his illness course squarely within *la crisis*, the economic crisis and recession that has plagued Mexico since the early 2000s and had deepened by 2013, when we met and interviewed him. *What do you mean*, we asked Israel, *that* la crisis *caused your illness*? Israel proceeded to explain: Mexico signed onto the North American Free Trade Agreement (NAFTA) in 1994, opening the market for foreign investment and transnational companies to set up manufacturing plants. The job Israel held in a chemical plant from 1995, when he graduated from a reputable, regional public university with a degree in engineering, was essentially made possible by NAFTA. And yet, manufacturing jobs began to leave by the late 1990s, drawn to Asia or other emergent global economies where wage and labor protections were even weaker than Mexico.[3] By 1998, the plant where Israel had moved his way up the ranks to regional manager, enjoying the respect of his employees, peers, and family members, abruptly closed. This event and his subsequent unemployment were, for Israel, not just the social forces shaping his life circumstances, but, in his view, the direct causes of his persistent and troubling symptoms of psychosis.

Through Israel's story and the stories of other men we interviewed, the significance of schizophrenia is deeply associated with structural transformations in Mexico's political economy and the impacts on men's ability to meet gendered social-role expectations. In some ways, then, our argument aligns with Warner's classic political-economic critique, in which he argues that recovery from schizophrenia is determined by labor market dynamics, such that prospects are worse in periods of economic contraction (when there is lower demand for labor). (See Warner [1985] and Hopper's [1987] insightful review of Warner's argument.)

While ours is not as bold an argument, our analysis of men's narratives of schizophrenia does illuminate how the varying political and economic developments (such as NAFTA) that are associated with projects of contemporary globalism and modernity in Mexico are also acting upon ideas of moral personhood, which in turn impact mental health, illness, and care seeking. Whitney Duncan (2017) has recently argued that neoliberal globalization, as it is taking place in Mexico, is reshaping subjectivities such that individualism and autonomy are emerging alongside a deepening sense of personal responsibility for mental health, at the same time that family values and traditional medicine practices persist, resulting in a complex cosmopolitan "psy" landscape. With Duncan, our discussion reveals how modernity in Mexico, as an incomplete project—tacking between reconstructed pasts, insecure presents, and uncertain futures—impacts gendered experiences of mental illness and attempts at recovery. Gender—which we understand as both a category of social experience with associated roles and responsibilities and as the lived experience of being a gendered self and relating to intimate others—is a fundamental aspect of cultural identity and moral personhood, shaping how people understand, accept, and/or contest their diagnosis of schizophrenia and its consequences for their lives. One of the central questions we explore in this article, and in the broader project from which it is drawn, is: how are the impacts of schizophrenia on individuals and families shaped by social-structural shifts and the ideological-interactional work of gender as a fundamental dimension of the cultural experience of schizophrenia spectrum disorders?

Culture, Morality, and Psychotic Disorders

In responding to this question, we are motivated by the recent edited collection on schizophrenia by Tanya Luhrmann and Jocelyn Marrow, *Our Most Troubling Madness*. In the Introduction, Luhrmann eloquently reviews the past several decades of anthropological engagement with schizophrenia, as well as the broader history of psychological and social science research on this "most troubling madness." As anthropologists, Luhrmann writes, one of our central aims is to reveal the processes through which "something about the social world gets under the skin"; she goes on, "the puzzle is to figure out what it is" (Luhrmann 2016, 3). In this article, our aim is not to challenge schizophrenia as a cross-cultural diagnosis.[4] Rather than contesting or accepting the universality of schizophrenia, and partly because we interview patients already diagnosed with schizophrenia, our intention is to understand the impact of this diagnosis on the subjective experiences of patients and their caregivers (Jenkins and Barrett 2004). In particular, we are interested in the ways subjective experiences of schizophrenia are shaped through cultural expectations of gender and gendered social roles. As Myers points out in a recent review, cultural analyses of schizophrenia point towards "the value-laden commitments that people must learn to meet in order to thrive in sometimes highly-specified local moral worlds" (2011, 309). Here, we are particularly interested in revealing how gendered expectations and relationships are a central part of the local cultural and moral worlds encountered by men living with schizophrenia. The experience of often-debilitating symptoms and no ready cure that accompany schizophrenia usually entail long-term medication management, which has its own side effects on bodies and minds and which also profoundly influences people's sense of themselves as moral persons.

In what follows, we show how men's experiences of schizophrenia and of moral personhood are intimately shaped by gendered social-role expectations in contemporary Mexico, given the structural shifts associated with incomplete projects of modernity, industrialization, and urbanization and the impacts of these on men's possibilities of achieving culturally valued lives.

The present discussion engages with current anthropologies of morality, particularly insofar as we highlight the ways psychotic disorders impact moral personhood through gendered cultural expectations. Cheryl Mattingly has poignantly presented current debates within the anthropology of morality as tensions over the relative emphasis given to "large moral projects of modernity" in structuring and "flattening out" moral expectations, compared to highlighting "people's creative activity or engagements with moral dilemmas" (2014, 34–38). Mattingly points to a "first person virtue ethics" (37) as an alternative to a Foucauldian discursive approach. Whereas the latter emphasizes power and subjectification, her first-person phenomenological approach attends to the ways people strive to craft moral lives in the face of challenges such as chronic illness from the bottom-up, or from the stuff of everyday life. In this essay, we attend to the power of masculinity as a moral project, tied to modernist-individualist values in Mexico that hold men economically responsible for wives and children in heterosexual nuclear families. In this way, by focusing on gender and power as they shape men's experiences of schizophrenia, we both draw on, and depart slightly from, Mattingly's insistence on a first-person approach. We also, however, are keen to analyze those moments when men demonstrate resistance to the dominant cultural narratives of masculinity, even when this resistance is uncertain or incomplete. In part, our analytic approach reflects the long-standing tradition in humanistic medical anthropology of reading illness narratives as accounts of the gaps between cultural expectations and people's messy, real-world engagements crafting moral selves in the face of danger and uncertainty (Kleinman 2007). More recently, Myers and Ziv (2016) have argued that, for people living with schizophrenia, illness narratives give voice to people's struggles for subjectivity and also represent a form of resistance to social defeat (Luhrmann 2007). Analyzing first-person narratives of schizophrenia can thus reveal "the concrete situatedness of moral action and the intimate social relatedness of moral concerns" (Mattingly 2014, 38)—one of our central aims in this article.

Still, this important anthropological theorizing about culture and morality, along with work on narrative and schizophrenia, has not specifically theorized gender as a fundamental dimension of moral personhood and of cultural experiences of mental illness. In fact, one critique Mattingly (2010, 38–41) makes in her engagement with an anthropology of ethics is precisely that structural categories, such as gender, are only understood through first-person phenomenological accounts. Yet, in this article, we posit that gender as a social category, containing powerful discourses for how men and women ought to live, remains highly relevant to the way we as anthropologists theorize morality and moral dilemmas. Specifically, we show how persons living with schizophrenia assert themselves as moral beings and how gender identities and role expectations are central to people's conceptions of moral personhood. We also show that gendered role expectations and men's abilities

to respond to illness diagnoses are influenced by their social-class position and access to resources. While we are critical of universalist assumptions of morality and masculinity, we also acknowledge the power of dominant discourses of masculinity in shaping men's experiences of what it means to live with schizophrenia.

Our argument, in other words, is that morality is not gender neutral but instead fundamentally shaped both by the structuring power of cultural expectations for gendered personhood and also by individuals' engagements with dominant gendered norms. Thus, we view men diagnosed with schizophrenia as striving for moral lives within the structural realities of contemporary Mexico, which make normative gender-role achievement difficult for all men, but particularly for men living with chronic mental illness. In their strivings, we hear not just of men's hoped-for-lives, but of the weight of the project of Mexican modernity as it falls upon them while failing to provide them opportunities or resources needed to achieve the masculinized ideals it sets forth. Moral personhood in these cases is a project of striving for lives that lie somewhere in between cultural expectations of masculinity and social realities of limited economic opportunities and frayed family relations. In the case studies below, we hone our analysis on how men's moral concerns reflect gendered cultural norms and social-role expectations, which are made both explicit and complicated by the lived illness experience of schizophrenia.

Schizophrenia and Gender in Mexico

Schizophrenia ranks tenth in psychiatric conditions causing premature death in Mexico (Sandoval De Escurdia & Muñoz, 2005). The last epidemiological study of schizophrenia carried out in Mexico estimated that the disorder affected 1.05% of the population, with slightly higher rates in men than women (1.2 vs. .09, respectively) (Lozano et al. 1995). Mexicans diagnosed with schizophrenia (and other mental disorders) can receive free psychiatric care and psychotropic medications through the national health program, *Seguro Popular* (Popular Insurance). Challenges remain, however, in relation to limited access to care, especially for those outside major metropolitan areas like Mexico City that lack psychiatric treatment resources and mental health personnel. For instance, Mexico has a dearth of outpatient mental health facilities with just .03 outpatient facilities for every 100,000 people, compared to the US rate of 1.95 facilities per 100,000 (WHO 2011). Additionally, there are insufficient psychiatric practitioners to meet population needs in Mexico. With 0.67 psychiatrists per 100,000 inhabitants, Mexico ranks below the WHO Americas regional average of 1.60, and below the mark of 1 psychiatrist per 100,000, which is often used by the WHO as an indicator of insufficient psychiatric coverage. Mexico's lack of outpatient mental health facilities—in conjunction with the limited public resources available for psychosocial treatment—contributes to the burden of schizophrenia on individuals, families, and society. While public mental health researchers have demonstrated the utility and cost-effectiveness of combining psychotherapy with antipsychotic medication, (Lara-Muñoz et al. 2010), few patients receiving treatment under Seguro Popular or in public mental health facilities have access to such care (see also Ramírez Stege and Yarris 2017).

Anthropological studies of gender push us to understand how meanings of masculinity and femininity are constantly shifting alongside social structural transformations. Possibly the most impactful work in this regard for scholars of gender in Latin America is that of Matthew Gutmann (1996), who, based on long-term ethnographic research in a working-class barrio in Mexico City in the early 1990s, shows how men renegotiate traditional gender roles in response to women's increasing participation in the formal, waged economy. Gutmann critically engages with the gender construct of machismo, showing how this gloss stereotypes men as one-dimensional subjects, overgeneralizing the multidimensional nature of male identities and the complicated ways men engage in intimate relations with their female partners, express emotions, and participate in the lives of their children. Building on Gutmann's critiques of machismo, Emily Wentzell examines the construction of what she describes as "composite masculinities" as men respond to the relatively new, and possibly quintessentially "modern," diagnosis of erectile dysfunction (ED) (Wentzell 2013, 32).[5] In the current analysis, we are informed by Gutmann's critical deconstruction of masculinities and by the ways masculinity is coproduced through men's interactions with clinical providers and family members in response to chronic mental illness.

Recognizing the importance of contemporary anthropological views of gender as performed or composite identities, impermanent, and in flux, we also observe the ways that "traditional" notions of gender continue to weigh on the illness experiences of Mexican men living with schizophrenia.[6] Thus, while acknowledging that the meanings of Mexican masculinities are shifting in response to changing social conditions, here we examine how lingering cultural expectations of men—to be independent economic actors, financially independent agents who materially support wives and children—persist in shaping men's sense of themselves as moral persons coping with the effects of schizophrenia on their lives. Indeed, we have found that men's abilities to achieve gendered role expectations are interrupted by schizophrenia but also exacerbated by structural transformations that render men and their families without the economic resources needed to achieve cultural ideals of masculinity. Through the following discussion, we therefore contribute to the work of other psychological anthropologists who acknowledge the central importance of gender—here, specifically, by focusing on men and masculinities—as a constitutive frame through which persons living with chronic mental disorders construe their sense of themselves as moral actors striving to achieve cultural expectations in the face of social-structural transformations.[7]

Research Methods and Participants

This article emerges out of an ongoing, interdisciplinary research project with a psychiatric teaching hospital in central Mexico in which the first author has participated since 2012. The hospital has a large catchment area—as the only public psychiatric hospital in the region, patients come to receive treatment (both inpatient and outpatient) from many neighboring states. All patients receiving care at the hospital are enrolled in Seguro Popular, Mexico's public, universal medical insurance program, which covers the cost of their routine appointments and psychiatric medications.[8] The ongoing research collaboration is conducted in partnership with the attending psychiatrists and residents in psychiatry at the

hospital. Like the anthropologists in Luhrmann and Marrow's (2016) volume, our research method can be considered "clinical ethnography," in that it occurs in partnership with mental health providers and seeks to understand cultural influences on—and cultural meanings of—schizophrenia in order to contribute to treatment, recovery, and the easing of patients' distress (Luhrmann 2016, 4).

Over the course of four years of summer fieldwork sessions at the hospital, Yarris has interviewed dozens of patients and their family caregivers who attend outpatient visits at the public psychiatric hospital. The findings presented here come from fieldwork conducted by the authors in 2013, when our inclusion criteria for the research study included only patients who had received a diagnosis of schizophrenia or schizoaffective disorder by their attending clinician (psychiatrists and residents in psychiatry). Clinicians used the diagnostic criteria of DSM-IV (APA 2000), and *citas*, or appointments, were largely focused on medication management. Thus, clinicians used their limited time with patients to discuss symptoms and adjust dosages and occasionally to address the social barriers patients faced to taking their prescribed medication. All patients had been receiving psychiatric care for at least six months at the time of the study. It is customary in Mexican public hospitals for patients to be accompanied to their *citas* by at least one family member, who may include parents, siblings, aunts and uncles, and adult children. We interviewed patients and their family members separately, in Spanish, in private consultation rooms in the hospital's outpatient wing; interviews lasted from 20 to 60 minutes.

If patients agreed and consented to participate, they were interviewed that same day in a private area of the outpatient clinic by one or two members of the research team. If a patient was accompanied by a family member to the clinic, the relative was asked to wait for the interview with the patient to conclude; at the end of the patient interview, family members were invited to participate in an interview about their experiences caring for the patient. Once the interviews were completed, the patients were given 200 pesos (roughly US$15) as compensation for their time. The research protocol was approved by the Institutional Review Board of the University of Southern California (IRB UP-12-00309) and the hospital's ethics review board.

We developed an in-depth, semistructured interview, which included questions about basic demographic information, living arrangements, participants' psychotic symptomatology, and histories of care seeking. Some questions drew upon Kleinman's (1978, 1988) explanatory model approach in order to assess how patients and family caregivers understood their diagnosis and its impacts on their social roles and family relationships. For instance, we asked: "When you first noticed changes in yourself, what did you think was happening? How has your illness affected your social roles (including current or past employment or academic pursuits) and family relationships (as a father, son, spouse, mother, daughter)? Do you think something about your illness has been particularly difficult because you are a man/woman? Do you think that being a man/woman has helped you cope with any particular part of your illness?" Family caregivers were asked about their experiences caring for the patient and their perspective of the impact of mental illness on the patients' social

roles and relationships. Interviews were audio-recorded (with participants' permission) and analyzed using Dedoose Version 4.5 (2013), applying a thematic approach, through which we inductively identified meaningful themes from the data and deductively considered these themes in relation to our research questions and aims. While there were specific interview questions focused on gender, we considered the entire interview and all question responses when coding for gender-related themes.

A total of 20 patients participated in the study: eight women, and 12 men. For the purposes of this article, we will focus on the experiences of the 12 men interviewed. The average age of the participants was 39 (the age range was 27 to 56). We asked participants if they were married, single, divorced, or had been involved in prior romantic relationships. Only one participant was married, and the other 11 were single, though two participants had been married prior and had since divorced. Four of the men were unemployed, and the remaining seven men reported that they worked in agriculture, carpentry, and at mechanic shops (all jobs notable for emphasizing manual labor). Four men lived in rural settings, and the remaining seven lived in an urban area, namely, the large metropolitan area of approximately 1.5 million inhabitants on the outskirts of which is located the psychiatric hospital. Though participants ranged in socioeconomic status, they all used public insurance and received their medications without a copay. Most participants arrived at their psychiatric appointments accompanied by caregivers: five men came with their mothers, one with his father, one with his sister, and one with his wife. The remaining four men came to their appointment unaccompanied. As we describe below, location of residence (rural or urban), marital status, employment, and age all intersect with masculinity to shape patients' experiences of mental illness. (See Table 1 for descriptive information on all 12 male participants.) In what follows, we draw on patient and family-member interviews for three cases to illustrate how gendered expectations, roles, and responsibilities shaped these Mexican men's experiences of and responses to schizophrenia. The three cases of Israel, Victor Manuel, and Carlos demonstrate how social-role expectations for men related to economic provision, heterosexual marriage, and biological reproduction persist, even as these expectations play out differently depending on men's ages, socioeconomic status, education levels, age of onset, family relations, and life experiences.

Israel: NAFTA, Unemployment, and Psychosis

Economic restructuring in Mexico since NAFTA's passage has shifted global manufacturing processes, leaving many Mexicans who previously found work in industry, like Israel, chronically unemployed. It was the loss of his managerial job and subsequent inability to retain his previous middle-class status as an economic breadwinner for his parents that Israel perceived as catalyzing his first psychotic episode. Israel lives with his mother and maternal aunt in the large, metropolitan area where the clinic is located, meaning he can commute to his monthly *citas* at the hospital without much hardship. He resides in a cosmopolitan cityscape that reflects the influence of the late-capitalist consumer economy, ripe with advertising, large "big box" retail stores, the presence of a global financial industry, and many new suburban housing developments, all existing alongside persistent poverty and underdevelopment.

Table 1. Demographic Information for the 12 Male Participants with Schizophrenia Spectrum Disorders

ID	Name	Age	Education	Marital Status	Current Home	Family Caregiver	Employment
01	Fernando	50	High School	Single	Urban	Without Caregiver	Street Seller
02	Gerardo	50	Unknown	Divorced	Urban	Without Caregiver	Delivery Assistant
03	Victor Manuel	27	Elementary	Single	Rural	Father	Farmer
04	Israel	42	Bachelor's	Single	Urban	Mother	Unemployed
05	Carlos	29	Some University	Single	Urban	Mother	Student
06	Cristian	45	Some University	Divorced	Urban	Without Caregiver	Mechanic's Assistant
07	Luis	49	Some University	Single	Rural	Without Caregiver	Carpenter
08	Mariano	28	Elementary	Single	Rural	Without Caregiver	Farmer
09	Pablo	37	High School	Single	Rural	Mother	Unemployed
10	Ricardo	30	Elementary	Single	Urban	Mother	Unemployed
11	Saul	56	Bachelor's	Married	Urban	Wife	Unemployed
12	Teodoro	35	Elementary	Single	Rural	Sister	Farmer

Israel is an only child and has never married; he does not have children. For years after earning his Bachelor's degree in engineering at a reputable public university, Israel worked for multinational firms, such as Audi, Volkswagen, and Dow Corning, firms that expanded into this region of Mexico with new tax breaks and subsidies enabled by NAFTA. Israel remains proud of his profession and glowed as he described how he rose through the managerial ranks, earning the respect of his employees who referred to him with the deferential title, *Licenciado*, and who he often treated to a round of *chelas* (beers) during their regular Friday happy hours. His job allowed Israel to enjoy both his professional status and its associated responsibility, but also the economic independence and well-being that his employment afforded. Furthermore, during his years of work at the plant, Israel economically supported his mother, paying her rent and buying her gifts such as designer clothes and perfumes. Israel drove his own car, took women out on dates, and seemed to have achieved the desired ideal singleton lifestyle of a modern, independent, middle-class man. While at the time Israel was enjoying his bachelorhood, he knew his class status would eventually enable him to marry and support a family of his own.

Israel's middle-class fantasy came to a crashing halt when the chemical plant he worked for abruptly closed. For Israel, being laid off and confronting the uncertainty of unemployment occasioned his initial psychotic break. He recalled not wanting to go out, not even getting out of bed, withdrawing from his social relationships, and losing both body weight and *ganas de vivir* (will to live). Israel also remembered feeling as though his body was *descomponiendose* (decomposing), and that things were literally falling apart all around him. The year of his

lay-off and first psychotic episode, 1998, was four years after the passage of NAFTA, when many multinational factories like the one Israel worked for began to relocate operations abroad, to Asian countries and elsewhere, seeking to lower even further their costs of production. Israel was very clear that this macroeconomic restructuring, which had left him and "half of all Mexicans" (*la mitad de los Mexicanos*, in his words) unemployed, was the ultimate (distal) cause of his schizophrenia. Phenomenologically, Israel felt getting laid off in his body/mind as *una presión enorme* (an enormous pressure), and he found himself in the position of having "a college degree and professional experience but no way to find work" (his words), falling from the middle-class status that he erroneously thought he had achieved for life. The way Israel describes the onset of psychosis illustrates what Scheper-Hughes and Lock (1987) theorize as three levels at which we might think of illness as embodied experience: at the level of the individual physiological mind-body, the symbolic social body, and the body politic, where power and structural transformations are inscribed onto individual bodies. At the level of the body/mind, Israel's subjective sense is that his illness is causing his body to fall apart (*descomponer*), which can be interpreted as a metaphor for the ways in which the broader body politic in Mexico is "falling apart" under economic restructuring, which in turn leads to a break down in gendered social-role expectations for men. Israel generates his own meanings from the suffering in his body/mind, construing new modes of social interpretation through his first-person experience of mental illness.

At age 42, and 15 years after his first psychotic episode, Israel has not been able to recover either his employment or his class status, rendering him unable to economically support his mother and also unable to achieve that other most significant marker of Mexican middle-class masculinity: heterosexual marriage, children of one's own, and economically supporting a family and household. This gendered reality Israel experiences as compounding his economic/class status loss, and he became visibly troubled when we asked him whether he thought he would marry in the future. Israel admitted, *todavia tengo ganas de casarme* ("I still want to get married"), but he acknowledges that his status as unemployed makes marriage almost an impossibility. In his words, *¿Cómo me voy a casar*, *si no tengo trabajo?* ("How will I marry, if I don't have a job?"). He explains, "No Mexican woman would want to support a husband who doesn't have a job." In Israel's view, then, the major impediment to achieving the middle-class, masculine role status he desires to reclaim is not the psychotic disorder per se, but the consequences of illness for his employment prospects, prospects further curtailed by the state of the Mexican economy. Thus, when we ask Israel to name the biggest obstacle he faces to living the life he desires, he doesn't name his disorder (even though he—unlike other patients—adopts the diagnostic language of schizophrenia), he calls out the *crisis económica mundial*—the global economic crisis—as the cause of his inability to find work, marry, and become the man and recover the social status he one day enjoyed. In other words, while he has lived with schizophrenia for 15 years, if Israel were able to recover his status as an employed and economically productive man, in his view, his illness might be cured.

Victor Manuel: Between the *Milpa* (Cornfield) and Global Culture

The case of Victor Manuel illustrates how mental illness experience exacerbates the tensions between masculinity and an incomplete Mexican modernity. Victor Manuel is a 28-year-old young man who arrives at his clinic visit the day we interviewed him dressed in sagging jeans, belted low around his hips, with a white graphic-designed t-shirt and an LA Dodgers baseball cap on his head, tilted sideways. To begin the interview, we had to ask Victor to take his head phones out of his ears; he was listening to US rap music, of which he is a fan. Victor is single, never having married, and without children. He lives with his father, José Antonio, in a small, rural town about a two-hour bus ride from the city where the clinic is located, making his commute to the clinic rather burdensome (in time and bus fare). Victor finished high school, but he had never found steady employment and was unemployed when we met him. While Victor's favorite pastime is hanging out in the local cyber café, watching hip hop videos and reading up on his favorite rap artists from New York or LA, his father has other plans for his future. Jose Antonio keeps trying to get his son to work alongside him in the *milpa* (cornfield), but Victor has actively resisted his father's attempts to make him into an agricultural laborer.

For generations, the men in Victor's family have been corn farmers, planting and harvesting this crop so essential to the Mexican diet on land that has been passed down from Victor's great-grandfather and treated with great care for the livelihoods it has supported across the generations. Corn farming has become precarious work since the passage of NAFTA flooded the Mexican market with heavily subsidized, US-grown corn, radically reducing the price that Mexican farmers could earn for their crop and pushing hundreds of thousands of *campesinos* like Jose Antonio to emigrate from rural areas to Mexican cities and abroad, to the United States. Jose Antonio has survived this difficult post-free-trade period, his role as a man and economic agent largely intact—despite declining exports and limited local sales, he continues to farm, has not left his hometown, and is able to earn enough money to (barely) support himself, his coresident sister, and Victor Manuel. Victor, however, has vigorously and vehemently resisted his father's entreaties that he join him in the fields to maintain the family tradition of farming. In fact, Victor attributes his first psychotic episode, which occurred when he was 21 years old, to the pressure placed on him by his father and his paternal aunt to work in the fields, to assume his role as a *campesino*. Victor recalled that his father and aunt harassed him for not earning an income and for spending their money on fashionable hip hop style (*gringo*) clothes. In his illness narrative, schizophrenia (like Israel, Victor doesn't contest the diagnostic label, but he does push back against the anticipated, chronic course of illness) is a direct result of this social pressure, which included his father's and aunt's threats to put him out of the house if Victor didn't start working and "being a man" (their words).

In response to this pressure, Victor fled, running away from his dad, aunt, and the life they wanted him to lead. Victor described this episode such: "I left running, running through town, naked, aggressive, and uncontrollable." This first psychotic episode ended with Victor Manuel put into jail, since local police didn't otherwise know how to respond to his unruly

behavior. From jail, a local physician referred Victor Manuel to a psychiatrist, and he had been in psychiatric care at the hospital for about seven years. While psychotropic medications, which Victor can list off in quick succession ("perphenazine, haloperidol, biperiden, olanzapine") help manage his symptoms, Victor still suffers from auditory hallucinations. He describes hearing voices as (in his words) "A recording in my brain . . . of Lucifer and Satan, who tell me *groserias*, repeating over and over that I am worthless and a nobody," hallucinations that have provoked him to act out aggressively towards his father and aunt. Victor describes the impact of schizophrenia as "making you feel as if you want to die, you get depressed, you want to cry, you aren't happy, you lose the illusion to live, the will to live." Victor has tried self-medicating with marijuana and alcohol, to varying degrees of symptomatic relief; however, his use of marijuana only further aggravates his father and their relationship, and Victor believes his last alcohol binge caused him to relapse.

During our conversation, Victor's disposition was sullen and withdrawn; he talked about not feeling well, feeling physically sick and having not wanted to come to the clinic that day for his *cita*. He nonetheless brightened up when we asked him what he liked to do in his spare time, leading him to talk about going to the cyber café, going online and watching rap videos. Victor said he loved music and dreamed of being a rapper, living in a city where he could see live music on a regular basis, and connect with other young people around a shared love of hip hop culture. He also liked fashion and pleaded with his father to buy him clothes in modern urban styles every time they shopped at their local *tiangüis* (flea market). His father refused, however, telling Victor he had to work in the fields to earn money and buy his own clothes, depriving him of what would be considered traditional moral self-making by denying him choice or the ability to explore an alternative way of life. Jose Antonio attempted to assert his paternal authority as a means of helping Victor achieve an ideal of masculine independence through agricultural work, the only masculine identity Jose Antonio himself had ever known. In his view, independence and economic activity are fundamental pillars of masculinity, as men must "work so that they can live on their own and not depend on others." Further, Jose Antonio said "Marriage isn't just about love, it's about supporting women, who want clothes and nice things, and there has to be money to buy those things." Nonetheless, Jose Antonio viewed this masculine ideal as out of reach for his son, due to Victor Manuel's illness and his unwillingness to assume the role of agriculturalist and become the man his father hoped he would be.

Taking Victor Manuel's illness experience and explanatory model seriously means situating his psychosis as a response to the stress of finding himself situated between a subject position he longed for, but couldn't quite achieve (global, hip hop culture), and one that was attainable, but which Victor rejected (corn farmer, or *campesino*). The masculine role for social and economic productivity that had been filled by men across generations in Victor's family was one he himself refused to occupy, and yet the alternative cultural model of masculinity he sought, embodied in hip hop music and dress, was not associated with a clear path to economic productivity. Furthermore, the *campesino* role was one of deep-rooted cultural value, while hip hop was associated, for Jose Antonio at least, with moral degeneration. Understanding the onset of Victor's psychosis through his explanatory model brings about

an ironic twist—the pressures he felt to conform to his fathers' (and by extension, to rural Mexico's) culturally elaborated model of (moral) masculinity were stressors large enough to trigger delusional symptoms. Victor was stuck, metaphorically and psychologically, between the *milpa* and an elusive, global modern masculine identity that remained far off, unattainable, and morally risky.

Carlos: A University Career, Interrupted by Psychosis

Carlos is a 29-year-old young man when we meet him at the hospital for our interview. He is well-dressed and groomed and appears self-conscious, interspersing our interview with questions, such as, "did I answer well enough?" Carlos was accompanied to his clinical visit by his mother, whom we also interviewed. At the time of our interview in 2013, Carlos was living in the city where the hospital is located, with his mother and 27-year-old sister. However, his family is originally from a small, rural community outside the major metropolitan area, having moved to the city before Carlos began his university studies in anthropology at a major public university. For Carlos, coming to the city from his former hometown was a cultural shock; he remembers the move this way, "*Fue como un 'boom', toda mi vida cambió*" (It was like a "boom"; my whole life changed"). Carlos began to experience his initial psychotic symptoms early on in his university studies as an anthropology student, and he recalled beginning to feel heightened anxiety around his peers and in social situations. He also heard voices and found himself frequently distracted. Carlos described feeling a gap between himself and his university peers who seemed more comfortable with the youth culture of the city, particularly going out to bars, drinking and socializing in groups on the evenings and weekends. As Carlos faced his peers' repeated invitations and constant exhortations to go out drinking, he struggled to find ways to decline without being further ostracized by his peers. He says his social awkwardness, alongside his emerging psychotic symptoms (talking with himself), led his classmates to "label me as crazy." Under the strain of psychotic symptoms and social pressures, his academic work suffered, and eventually Carlos was expelled from the university, as students and administrators became suspicious of his behavior and uncomfortable with his presence at the well-known institution.

While Carlos had sought help through his university's health center, after his expulsion from school, his mother took him to the public psychiatric hospital for treatment. At the time of our interview, Carlos had been in psychiatric care for a total of eight years. He visited the outpatient clinic for monthly visits, and his symptoms were managed with medications. Despite a rather sophisticated biomedical understanding of his illness ("I have a slight brain disease," in his words), all was not resolved in his understandings of his illness and its impact on his life. Carlos referred hopefully to his new course of study to become a professional chef, thinking this would land him a well-paying career, a path to economic independence, and the promise of fulfilling the male breadwinner role. But as he talked about his dreams for the future, there was an underlying uncertainty, as if the future he so longed for remained elusive.

Like other patients, Carlos has internalized the biomedical explanatory model of schizophrenia as a chronic illness with no cure. He repeats a phrase often used by psychiatrists to encourage patients to accept their illness and adhere to medication regimes, "*no hay cura, pero hay que controlarlo*" ("there's no cure, but you have to control it"). "Control" means take medication, consistently, for years. Carlos' mother, Marta, tells us he struggles with medication management, uncomfortable with both the physical side effects as well as his sense that submitting to a medication regime means admitting he can't control his symptoms on his own. Marta tells us that for a time she even had to hide Carlos' medications because he was taking higher doses than what was prescribed, thinking that would result in a more rapid recovery. Carlos tells us he understands his diagnosis, but he insists that his illness is "*una esquizofrenia leve*" ("a light schizophrenia"), this phrase capturing his hopes to overcome the illness and recapture some of the life he longs to achieve.

We also interviewed Carlos' mother, who brought up her divorce from Carlos' father as a precipitating factor of her son's first psychotic episode. While the timing of the divorce and Carlos' illness onset corresponded, Carlos himself had not brought up his parents' divorce as a possible explanation, focusing instead on fraying social relationships and stress at school. For Marta, the frayed relationship between herself and her former husband is a source of stress that complicates his course of illness and care. She told us that she disagrees with Carlos' father about his treatment; whereas she encourages Carlos to take his medication, his father does the opposite, exhorting that the condition that afflicts Carlos is "all in his head" and that he should "just get over it." Through Marta's discussion, insights into the gendered dimensions of Carlos' illness become apparent, for his father's view sounds a good deal like the expression "just man up"—tolerate your troubles, be stoic about expressing them, and overcome any setbacks or symptoms by using your own toughness.

Carlos seems to have internalized his father's critiques of the medical model of illness through his own ambivalence towards treatment. Marta has encouraged Carlos to seek psychotherapy in addition to medications—a rare treatment plan in Mexico as most patients lack private insurance or money to pay for psychotherapy visits (Lara-Muñoz et al. 2010). However, his mother says that Carlos is reluctant to see a therapist, in part because he perceives doing so as an admission of his moral weakness; or, in his father's view, of his failure as a man to manage his problems without outside help. In this way, Carlos remains stuck in a liminal space between illness and health, dependence and independence, his father and mother, and expectations of manhood he finds himself unable as of yet to uphold. This case thus illustrates Robert Barrett's argument, which is that we can "juxtapose schizophrenia and modernism" (1988, 466) in so far as the former is a condition transcending the bounds of modern social norms and cultural categories.

Not yet 30 years old, Carlos remains hopeful that he will be able to complete his current course of study, establish himself in a career as a chef, and resume expected gendered social roles. While he lives with, and is currently dependent on, his mother for daily care and support, in some ways Carlos' longed-for future follows his father's model of manhood. For Carlos, and for his mother and father, the chain of culturally expected events for a young

man like him is: secure a well-paying job, attain financial stability, get married to a wife, have a (nuclear) family with biological children. This cultural model of manhood came across when, at one point in her interview, Marta said, "*quisiera que tuviera su esposa*, *sus hijos*, *su casa*... *necesitaría eso*" ("I wish that he would have his wife, his children, his house, (he) needs this"). It's hard to discern from Marta's phrase who "needs" this model of masculine provider/husband/father to be fulfilled more—Carlos or his mother.

Discussion

Across these three cases, we see how the meanings of schizophrenia and the impacts of this illness on men's lives are profoundly shaped by contestations over contemporary versions of masculinity in Mexico. Often, family caregivers articulate the expected model of masculinity even more succinctly than patients; as Jose Antonio or Marta said, the life they want(ed) for their adult sons involved them being economically independent and able to support wives and children–having families of their own, rather than being dependent on their parents into adult life. This expectation also comes across clearly in Israel's case, as his mother had witnessed and enjoyed the benefits of her son's success as an upper-middle-class professional with a stable and solid income, but then psychosis sweeps away the possibility of this lifestyle. In this and other cases, then, patients and their family caregivers shift blame outwards, towards the social-structural transformations associated with the incomplete projects of modernity and economic development in Mexico. According to Israel, NAFTA is to blame for the closing of the plant where he worked and his subsequent inability to find employment; in Victor Manuel's narrative, globalization has put him in touch with the cosmopolitan youth culture and lifestyle of the hip hop generation, and yet, he can't attain this global identity—his rural residence, relative poverty, and, increasingly, symptoms of his mental illness acting as barriers to his ability to access the material accoutrements of this modern global lifestyle. And Carlos situates his "light schizophrenia" (his term) in a context of psychiatric stigma and social rejection, where his family ties weakened and where relations with peers were strained by expectations of alcohol consumption and securing a university degree. In other words, in these men's narratives, their attributions for illness were squarely situated in social-cultural transformations, and yet they experienced their illness as having profound consequences for themselves as men and as moral actors.

In sum, the men in our study seek to fashion moral selves in the face of the limitations and constraints of social-structural transformations associated with neoliberalism, globalization, and a fragmented Mexican modernity while contending with the debilitating symptoms and social stigma of schizophrenia. Mexican economic restructuring of the past several decades—economic processes associated with global modernism, such as open markets, international investment, industrialization and then deindustrialization—are often situated by our interlocutors as the underlying causes of their psychotic disorders. Even when not framed as etiology of illness, men's illness narratives point to these structural transformations as shifting the nature of economic and social life, and yet failing to provide them with the means of achieving the modern role statuses that are held out as contemporary ideals. For men, this means that symptoms of mental illness are intertwined with meanings related

to lack of economic productivity, inability to marry and have children, and a failure to fulfill expectations that men should be independent economic and social actors. Of course, men's ability to achieve social-role expectations and live morally valued lives are also shaped by social class and access to social and economic resources. Thus, Carlos has the benefit of middle-class standing and access to greater economic resources than Victor Manuel or Israel, allowing Carlos access to privately paid psychotherapy services, should he want to use them, and the ability to pay for training in a new career as a chef. Nonetheless, all three of these stories show how living with a psychotic disorder such as schizophrenia challenges men's ability to be independent neoliberal subjects, as they struggle to manage chronic psychiatric symptoms and rely on family members for economic and social support. In fact, our interlocutors experience dependence on family caregivers as a further sign of their failure *as men*; a dynamic of kin caregiving that we do not have space to examine here. What we want to emphasize, however, is that these dynamics of desired personhood for those living with schizophrenia are deeply gendered, such that independence and autonomy emerge as drivers determining the self-evaluations of men.

This discussion offers insights about the relevance of a gendered perspective for clinical practice. Several factors may impact men's ability to fulfill their gender-role expectations and contribute to poorer treatment outcomes and course of illness for those living with schizophrenia. Among these is limited self-efficacy, the belief that one has the capacity to succeed or reach a goal, which may be related to struggles with medication adherence. Men's sense of inability to meet gendered cultural expectations could also be related to socially adverse behavior, such as self-neglect, social withdrawal, or challenges in communication and relationships. We agree with psychologists who urge schizophrenia researchers to attend to sociocultural context and explicitly examine gendered dimensions of patients' illness experience (Nasser, Walders, and Jenkins 2002). Incorporating gender-relevant conceptualizations in therapeutic practice can also benefit therapists' attempts to assist patients with reintegrating in their communities and recuperating social roles and routines (Riecher-Rössler and Häffner 2000).

In a recent, compelling compilation of her research on schizophrenia and other forms of mental suffering across multiple ethnographic sites, Janis Jenkins (2015) shows how experiences of major mental illness push the boundaries of individual experience, situating contemporary selfhood squarely within broader social conditions of violence, vulnerability, and "extremity" that characterize contemporary (late) modernity. Israel, Victor Manuel, Carlos, and other men living with schizophrenia in contemporary Mexico share experiences of "extremity." The first-person phenomenology of lived illness experience is extreme—often painful, distressful, and debilitating. Moreover, these men find themselves occupying the extremes, or margins, of Mexican society, as they are caught between the promise of modern, independent, economically productive masculine ideals and the reality of unemployment, illness diagnosis, and subsequent dependence on family caregivers. Still, we see how men living with schizophrenia are reimagining themselves as men, moving between gendered role expectations and their actual lived illness experiences and seeking to recontour the moral dimensions of their lives. Given that gendered expectations and relational dynamics

are so central to the cultural experiences of schizophrenia in men's lives, there is a need for additional anthropological attention to gender as a central signifying processes through which culture "gets under the skin" to impact the lives and moral strivings of people living with schizophrenia diagnoses.

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Notes

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1. Clinical psychologists in Mexico are studying the impact of psychoeducational campaigns to increase knowledge and recognition of psychosis, with the goal of reducing stigma and therefore DUP (Calderon et al., 2015).

2. There are several hypotheses for the better prognosis in women. One that has garnered attention is the "estrogen hypothesis," which posits that estrogen may have a neuroprotective function (Grigoriadis and Seeman 2002).

3. For more on NAFTA's uneven impacts on the Mexican economy, see https://fas.org/sgp/crs/row/RL34733.pdf and https://www.cfr.org/backgrounder/naftas-economic-impact.

4. Diagnosis in the clinic where we work is uncertain and tenuous, sometimes taking the form of a medical problem like epilepsy, other times landing on anxiety or depression, and finally, settling on schizophrenia, schizo-affective, or schizo-typical disorder.

5. While obviously different from schizophrenia, ED is also a chronic condition without a clear etiological explanation and absent an apparent cure, thus leaving men and their intimate others to renegotiate the meanings of masculinity in gendered relationships.

6. Traditionally, men in Mexico are expected to be economic providers to their households, whereas women are traditionally valued based on childrearing and social reproductive labor (Ruse et al., 2011). While we are attuned to shifts and changes in these typical constructions of masculinity and femininity, we have also seen how traditional constructs continue to weigh on the lives of men and women and on their experiences of mental illness.

7. Psychological anthropologists (too many to mention here) have long examined women's gendered experiences of mental distress. Recently, Luhrmann and Marrow (2016) offer case studies of women around the world, illustrating how gendered expectations for women in family relations and sociocultural reproduction exacerbate the challenges of mental illness.

8. These medications have been approved for treating psychosis under Mexico's Seguro Popular (as of 2012): clonzepam, risperidone, haloperidol, olanzapine, biperiden, perphenazine, quetiapine, levomepromazine, clozapine, aripiprazole, and trifluoperazine.

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