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ORIGINAL RESEARCH

Using Masculine Capital to Understand the Role of a Sport Program in the Lives of Men From a Western Canadian Inner City

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The purpose of this study was to examine the role of a sport program in the lives of homeless men with severe mental illnesses and addictions. Interviews were conducted with eight men who attended a floor hockey program, and data examined using categorical-content narrative methodology. Five themes captured the role of the floor hockey program in the men's lives: (a) relationships with program leader, (b) therapy, (c) community, (d) action, and (e) achievement. These themes were interpreted using theories of masculinity (Connell, 1995; Gough, 2014). Relationships with the program leader and other men, and ways in which they were allowed to play with physicality, provided opportunities to accumulate masculine capital (i.e., ways in which competence in traditionally masculine behaviors provides masculine credit). Practically, the findings suggest that sport program delivery for men such as those in this study can be enhanced by providing opportunities for accruing masculine capital.

Keywords: sport psychology, sport, physical activity, health behavior, health, gender

Various types of physical activity programs may enhance quality of life for individuals with mental illnesses and addictions by improving physical health and/or reducing symptoms (Richardson et al., 2005). Although evidence for the benefits of physical activity for individuals with mental illnesses and addictions has grown in recent years (Rosenbaum, Tiedemann, Sherrington, Curtis, & Ward, 2014), questions remain about the types of physical activities that are most appropriate for various populations and how they should be delivered. Further research is needed to inform comprehensive evidence-based practice (Ellis, Crone, Davey, & Grogan, 2007). More specifically, researchers have observed the need for research examining "real-world" programs to learn more about the routine delivery of quality physical activity interventions for people with mental illnesses and addictions (Rosenbaum, Tiedemann, Ward, Curtis, & Sherrington, 2014). Further understanding of the perspectives of people who participate in such physical activity programs will enrich the evidence base and make contributions to the delivery of mental health services (Crone & Guy, 2008).

Mental health is the capacity for people to feel, think, and act in ways that enhance their ability to enjoy life and deal with the challenges they face. It is a positive sense of emotional and spiritual well-being (Public Health Agency of Canada [PHAC], 2006). On the other hand, mental illnesses (or disorders) are characterized by alterations in thinking, mood, or behavior and are associated with significant distress and impaired functioning (PHAC, 2006). Some of the most beneficial effects of physical activity are found among individuals with mild-to-moderate symptoms of mental illnesses, particularly for those with depression (Rosenbaum, Tiedemann, Sherrington, et al., 2014). However, relatively little is known about the role of various types of physical activity programs for individuals with severe mental illnesses and addictions (Carless & Sparkes, 2008).

Men are four times more likely than women to have impulsive disorders and substance-use addictions (Seedat et al., 2009). Findings from previous studies have revealed that involvement in sport and physical activity programs can provide men with severe mental illnesses opportunities to have social interactions that improve self-esteem and sense of identity (Carless & Douglas 2004). For example, Carless and Douglas (2008) used participant observation and interviews with 11 men (aged 24–43 years) who attended a vocational rehabilitation center in England to examine their experiences in a weekly sport program. Results were framed around three narratives. An action narrative reflected the importance of sport in providing the men with opportunities to engage in physical activities and having things to do. An achievement narrative described how

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the program provided participants with opportunities to accomplish things, nourishing a sense of success and confidence in their lives and with their bodies. Finally, a relationship narrative referred to the new social bonds participants established with other participants and the program providers.

Faulkner and Sparkes (1999) used an ethnographic approach to examine physical activity opportunities provided at an inner-city hostel for young people with a history of homelessness in London, England. Interviews were conducted with three men diagnosed with schizophrenia and their assigned caseworkers. Findings revealed that as a consequence of being in the program participants had reduced thought disorder, better sleeping patterns, and improved behavior on the days when they exercised. Faulkner and Sparkes concluded that these benefits stemmed from the distraction from everyday activities and opportunities for new social interactions the program offered. Other qualitative studies have revealed similar findings (e.g., Crone & Guy, 2008; Cullen & McCann, 2015; Hodgson, McCulloch, & Fox, 2011).

Although the evidence base is growing, there remains a need for research that further elucidates the benefits, or lack thereof, of various types of physical activity programs for people with mental illnesses and addictions and how such programs should be delivered (Crone & Guy, 2008; Ellis et al., 2007; Rosenbaum, Tiedemann, Ward, et al., 2014). During the process of conducting the 3-year study described herein, we realized that theories of masculinity (see Connell, 1995; Gough, 2014) could be useful in interpreting our results to create further understanding of how and why some men may gain benefits from their involvement in a floor hockey (a modified version of ice hockey, played in a gymnasium) program. In using theories of masculinity to interpret the findings of this study—theories that owe an intellectual debt to a number of feminist thinkers such as Simone de Beauvoir, Shulamith Firestone, and Kate Millett among many others—we were mindful of the fact that gender is not reducible to biological sex precisely because the ways men learn how to act are culturally and historically defined and influenced by different social contexts (Butler, 1999). Gender is, of course, a relational concept and although we acknowledge that we focused on masculinity with what we believe to be a sample of heterosexual men, it is important to emphasize we did not subscribe to heteronormative assumptions reflecting a cultural connection between physical anatomy and a socially reinforced gender binary (i.e., masculine/feminine).

Masculinity generally refers to a system of symbolic differences in which masculine and feminine places are contrasted. Masculinity is therefore effectively defined as nonfeminine (Connell, 1995). As Connell further noted, masculinity is simultaneously a place in gender relations; practices through which women and men engage that place in gender; and the effects of these practices on bodily experience, personality, and culture. On this note, it is by now common to recognize the existence of multiple masculinities and that gendered identities are influenced by wider cultural norms and interactions with other social structures, including race and class (Connell & Messerschmidt, 2005).

Hegemonic masculinity is a type of masculinity that occupies a dominant position in a given pattern of gender relations, a position that is always contestable (Connell, 1995). Traditional conceptualizations of hegemonic masculinity emphasize ways in which men consensually engage in physical practices (such as sport) that promote and reinforce their culturally defined dominant social position, while marginalizing women and men who subscribe to other definitions of masculinity (Connell, 1995). Further, hegemonic masculinity is not a preexisting trait but rather negotiated through social and cultural practices. Hegemonic masculinity, thus, is fluid and plural, based on culturally defined notions of power and control, and can be used to understand locally and temporally dominant ideologies that define men and male social practices (Connell, 1995).

For instance, masculine social practices in sport often involve aggressive and violent actions as men make public claims to hegemonic masculinity (Messner, 2007). Research has shown that overt or complicit subscription to hegemonic masculinities has a negative impact on health and health-related behavior (Smith, 2013). In fact, researchers have claimed there is a "crisis" in men's health (Robertson, Galdas, McCreary, Oliffe, & Tremblay, 2009) largely due to men's reticence to access traditional health services, the result of the embodiment of dominant versions of masculinity and a gender order that restricts their engagement in help-seeking behaviors (Robinson & Robertson, 2010). Men may, for example, avoid seeking help for health-related concerns because it threatens their sense of control and masculine identity (Smith, 2013).

However, by considering masculinity as plural, it is possible that when men take up some health behaviors they do not necessarily demonstrate weakness or position themselves as "subordinate" or "marginalized" (Connell, 1995). Thus, the traditional masculinity-health relationship, in which masculinity has a negative impact on health behavior, is not as straightforward as often proposed. Researchers have recommend that if men's health promotion activities are to have real impact, more theoretically nuanced empirical research on men's health is needed (e.g., Smith, 2013).

The notion of "masculine capital" may be useful for examining the complex, fluid, and at times contradictory relationships between hegemonic masculinity, health, and men's behaviors. *Masculine capital* refers to ways in which competence in traditionally masculine behaviors provides masculine "insurance" or "credit" to compensate for nonmasculine behaviors (de Visser & McDonnell, 2013; de Visser, Smith, & McDonnell, 2009). Recent work suggests that masculine capital relative to health behaviors and lifestyle choices is dynamic and fluid (and culturally defined) and that men can incorporate both healthy and unhealthy behaviors within a complex and, at times, contradictory masculine identity (Gough, 2014). For example, some men may frame health concerns in relation to dominant understandings of hegemonic

masculinity that places emphasis on idealized narratives of individual heroic struggle, achievement orientation, and personal control (Gough, 2013). They may also conceal vulnerability and deny pain to avoid appearing weak and, in so doing, circumvent seeking help for health-related issues. On the other hand, it may be possible for men to accrue sufficient masculine capital in one social setting to legitimize what are understood as traditionally nonmasculine behaviors (such as help seeking) in other contexts (de Visser & McDonnell, 2013).

Sport remains strongly aligned with dominant notions of masculinity (Connell, 1995) and may provide an important context for mental health workers to engage men with mental illnesses and addictions (Holt, Scherer, & Koch, 2013). Some men might subscribe to hegemonic masculinity while also engaging in healthy behaviors (Robertson, Sheikh, & Moore, 2010). For instance, skilled sporting performance may offer athletes more masculine capital than the unhealthy masculine behavior of excessive alcohol consumption (de Visser & McDonnell, 2013). Certain types of sport programs closely associated with masculine social practices may, thus, be relevant and appealing to vulnerable men. However, these sport settings may also serve to exclude other men who do not subscribe to dominant versions of masculinity or who do not have sport backgrounds. It is important to generate more precise understandings of what benefits men can gain from their involvement in such programs and how program delivery contributes to the accrual of such benefits. Concepts of masculine capital can be used to help understand why certain practices are eschewed or adopted by different people at different times, but more work examining the role of masculinities in men's health-related accounts and practices is required (Gough, 2013).

We used contemporary views of masculine capital and health to interpret results of this study of a sport program provided to homeless men with histories of mental illnesses and addictions. This research also responded to the observation of Carless and Douglas (2008) that although previous research suggests some ways in which sport can help people with serious mental illnesses, the question of *how* these changes occur is far from resolved. The overall purpose of this study was to examine the role of a sport program in the lives of homeless men with severe mental illnesses and addictions. The specific research questions were (a) what personal and social benefits did the men associate with their involvement in the program, and (b) how did features of the program facilitate the accrual of these benefits?

Method

We used a narrative methodology because, as Clandinin and Connelly (2000) suggested, narrative is a way of understanding experience. It involves collaboration between researchers and participants over time and settings. Narrative methodology involves telling and retelling stories of the experiences that make up individuals' personal and social lives. Given our interest in understanding the role of a sport program in the lives of men, narrative methodology provided us with a way to understand the stories they told about their lives, the stories they told about the sport program, and how these stories (and therefore the program) had meaning in their lives.

Researchers' Orientation

Lieblich, Tuval-Mashiach, and Zilber (1998) explained that reflexivity and self-awareness are crucial practices to monitor in the acts of reading, interpreting, and drawing conclusions of narrative material. Therefore, in using narrative methodology it is fundamentally important to illuminate the researchers' assumptions and preconceptions to enhance transparency. This research was conducted using a three-person team approach. One researcher had a background in psychology, whereas the fieldworker and other researcher had backgrounds in sociology. We sought to balance these disciplinary perspectives while conducting this study.

This study was underpinned by an interpretive paradigm (see Sparkes, 1992). From an epistemological perspective (i.e., assumptions concerning the nature of knowledge), we shared a subjectivist-idiographic and constructionist view and assumed that we played an active role in interpreting how the participants made sense of their personal and social worlds. From an ontological perspective (i.e., assumptions concerning the nature of reality), we subscribed to an internal-idealist view that individuals hold their own unique perceptions of social reality based on personal cognitions. We further assumed that there are shared aspects of participants' perceptions and experiences that can be identified. That is, whereas individuals construct their own perceptions of reality through their experiences and social interactions, there are usually some commonalties between people (Thorne, 2008). We sought to identify these commonalities as they related to the stories the men told about their participation in the sport program.

The combined experiences of the researchers may have influenced this study in various ways. It is therefore relevant to note that the researchers were white, heterosexual, middle-class men with long histories of involvement in various contact sports (including ice hockey and rugby). We had first-hand experience of the embodiment of masculinity in sport. As people for whom sport "worked"—as evidenced by our long-term and continued engagement—we likely focused on identifying some of the positive features of the participants' involvement in the program in ways that other researchers with more negative experiences of sport would eschew. Indeed, our research questions mainly focused on the benefits of the program, and how these benefits were accrued, rather than its limitations, weaknesses, and shortcomings. As white middle-class individuals, we were outsiders to the world of homeless men. One researcher had a history of mental illness and addiction. He had somewhat of an "insider" view into some of the issues the men in this study faced, but he had not experienced the spiral

that led the men in this study to life on the street. Given these varied experiences, we carefully monitored our assumptions (through maintaining journals and regular conversations) and approached this study by seeking to understand the men's stories rather than impose our own experiences onto their stories.

Participants

Participants were eight men aged 25 to 45 years who attended a weekly floor hockey program for at least 4 years. We purposefully sampled individuals who had regularly been involved in the program for several years because they would have a wealth of information to share, helping to provide the "best" and "most" information to help address the research purpose (Mayan, 2009). Seven participants self-identified as white and one as Aboriginal. Five men had been diagnosed with schizophrenia or bipolar disorder and three did not disclose their specific diagnosis of mental illness. All were, or had been, addicted to alcohol or illicit drugs. The men stayed at various times in subsidized housing, shelters, mental care facilities, group homes, or on the street (circumstances varied over the course of the study). Institutional Research Ethics Board approval was obtained and all participants provided oral informed consent.

Fieldwork

This study was drawn from a larger ethnographic study, the details of which have been reported elsewhere (Holt et al., 2013). Following Wolcott's (1995) approach, ethnographic fieldwork was completed over a 3-year period. The research was conducted in Edmonton, Alberta (Canada), a city with a population of approximately 900,000 people. Most recent statistics show that 2,174 individuals in the city were homeless, 75% of whom were men. Fifty-seven percent of this homeless population is 31 to 54 years of age (Homeward Trust, 2012). One member of the research team (the fieldworker) became a participant observer in a range of sport and recreation programs provided primarily to men in the inner-city area. As the fieldwork progressed, close relationships were formed with a mental health worker who ran a weekly floor hockey program supported by inner-city mental health and social services agencies. The mental health worker picked up individuals from the inner city in a van every Friday afternoon and drove them to a mental health hospital on the outskirts of the city. Games were played in the hospital gymnasium. The fieldworker participated in all aspects of floor hockey, including the van rides and playing in the games.

Interviews

This study used data obtained via interviews with the men. These interviews, which took 60–80 min, were conducted at a variety of restaurants and coffee shops around the central area of the city beyond the immediate confines of the inner city. These locations were selected by the participants as places where they felt safe and comfortable. Following our approved research ethics protocol, the interviewer paid for all meals as a token of appreciation for the participants' involvement in the interview portion of the study. No alcohol was allowed.

The establishment of trust and rapport was critical for these interviews. We learned that many participants in the floor hockey program had a distrust of social institutions, authority figures, and even having their conversations audio recorded. We did not want to risk asking people to be interviewed for them to decline and then feel uncomfortable attending floor hockey (and therefore seeing the fieldworker) in the future. To address this issue we approached men with whom the fieldworker had developed strong relationships and had regularly attended the program for several years. We also followed normal procedures of establishing ground rules for the interviewers (e.g., explaining confidentiality and beginning each interview with general conversation) to help the men feel at ease. Finally, it was made clear that the men did not have to answer any questions that made them feel uncomfortable.

We prepared a detailed guide to provide a focus for the interviews with questions in five distinct sections; opening/warm up, life history, sport, the floor hockey program, and an ending. Within these sections we had more specific probing questions designed to further interrogate stories the men told (see Appendix). We took a conversational approach (Rubin & Rubin, 2012). As such, in many cases the interviews were rambling and wide ranging, not following the sequence of the main sections of the interview guide. Nonetheless, by the end of each interview the interviewer ensured that all the main sections of the interview guide were covered.

Data Analysis

Interviews were transcribed verbatim by a professional transcribing agency and checked with the original audio recordings for accuracy. Participants were assigned pseudonyms and names of other individuals they referred to during the interviews were also changed. We adopted the standpoint of story analysts, treating stories as data and using analysis to arrive at themes that held across the men's stories. We focused on what was said rather than how stories were told. Using Lieblich et al.'s (1998) classification of four types of narrative (categorical-content, categorical-form, holistic-content, and holistic-form), our approach reflected the categorical-content type. The categorical element involved defining categories or themes from the stories across participants. The categorical aspect is useful when researchers are primarily interested in a problem or a phenomenon shared by a group of people. Content refers to the explicit content of an account, the meaning of stories, and analysis of what happened, or why, and who participated in the event, from the standpoint of the teller (Lieblich et al., 1998). Hence, in using the categorical-content approach to narrative, categories were defined (inductively) and text extracted, classified, and gathered into these categories. However, as

Lieblich et al. (1998) noted, the fine distinctions between different types of narrative are not always clear-cut. While developing the categories we wanted to contextualize these experiences within the broader stories of the men's lives. Thus, in conducting the analysis we also considered the more holistic aspects of the men's stories.

The following analytic steps were applied throughout our analysis. First, the fieldworker wrote individual profiles (or stories) for each of the men in the study. The stories had a basic structure depicting their biographies, life histories, and how they came to their current life circumstances. Having established this context, we focused on the stories they told about the floor hockey program. A basic thematic analysis was conducted (Maykut & Morehouse, 1994). One researcher led the thematic analysis and it was discussed during research team meetings. Relevant sections of the text were identified and assembled into themes that were relevant to the purpose of the study. Each transcript was coded individually and through this process a "long list" of themes created. Consistent with our philosophical approach, we sought to identify the common and shared themes underlying men's stories to understand more about the meanings associated with their involvement in the program. The thematic analysis was evaluated by all researchers and feedback relating to the coding of specific quotes and structure of themes was discussed and reconciled through a consensus approach.

Next, having inductively identified certain themes, we sensitively used concepts from the literature as analytic techniques to explore the themes and inform the interpretive aspects of the analysis. For instance, we realized that some inductively derived themes were similar to the Carless and Douglas (2008) findings, and we used their labels ("achievement" and "action") to create consistency with the existing literature. We were careful to avoid deductively imposing existing themes onto the analysis. For example, Carless and Douglas reported a theme of "relationships." We identified a similar theme but labeled it "community" because of some of the unique elements of the stories the men told. We also identified other narrative themes ("life histories," "program leader," and "therapy") that were unique to our analysis. Each researcher reviewed these themes and labels and provided feedback on initial written versions of the results until we were collectively satisfied with the final product.

We then used concepts of masculine capital to interpret meanings (and later discussed them) within and across the identified themes. In doing so, we were mindful of Gough's (2013) warning that if analysts adopt a masculinities framework, whether implicitly or explicitly, they run the risk of imposing their own categories on to the data rather than reporting participants' stories. Here it was useful having researchers from different disciplinary backgrounds to provide a balanced approach. We remained open to the complexities in the men's stories while using theories of masculine capital to help interpret the findings. As we sought patterns in the data that depicted men's stories about being involved in the sport program, we viewed masculinity as dynamic, fluid, and potentially contradictory (de Visser & McDonnell, 2013).

Results

Stories About Life Histories: "Everyday life can be a struggle."

The men faced extremely challenging circumstances in their lives as they struggled with homelessness, mental illnesses, and addictions. Many also had life histories that included family turmoil, criminal behavior, convictions, and imprisonment. Yet they recounted stories about their lives that reflected hope and optimism for the future. For instance, referring to his diagnosis of mental illness, Steve said:

> I'm borderline schizophrenic. I was diagnosed in 2002. My psychiatrist says it's gonna end . . . as you hit 30, it's gonna basically wear off right. Well, I'm 30 now and I feel like 'here I am,' you know, like 'I wanna work again.'

Providing another view, Mark noted, "I was also diagnosed schizophrenic, schizoaffective, depressive, even manic depressive, all of them. . . ." He continued to explain, "I don't care what anybody diagnoses . . . what label they give me, I just call myself a human being and Mark. You know, like everybody else." In both cases, Steve and Mark appeared to be admitting vulnerability by acknowledging their diagnosis, yet diminishing the symptoms and consequences of mental illness by giving the impression that they had gained control over their struggle.

The men faced significant structural barriers that placed powerful limits on their lives. As Mark poignantly noted, "everyday life can be a struggle." A particularly salient feature was the lack of regular stable housing and the way the men bounced around from shelter to shelter. Nathan, for example, explained the circumstances when he first became homeless. He said, "My mom dropped me off there [at a homeless shelter] one time 'cause she couldn't handle me no more. I stayed there for about a month then I found a place. It was pretty bad though, it was like a crack infested building." Nathan was now living in another shelter, but told us "I wanna get out of the place I'm living now 'cause there's too much drinking and drugs." Similarly, Carl said of another shelter, "it was hell man. . . . It was hell. I don't wanna talk about it no more." Ken, meanwhile, shared a story about a period just after he had been on suicide watch. As he reflected, there was simply not enough room at the hospital and no shelters with adequate facilities were available:

> Originally they were gonna send me back to the penitentiary where they have room, but you're treated like a criminal basically. . . . Going to the penitentiary was just hell. I mean, people think this [mental health care facility] is bad, they have no clue. Like, this is the best place that I've ever been . . . and the penitentiary was the worst place I'd ever been.

While the men vividly described incredibly challenging circumstances ("hell"), their descriptions were couched

in ways that demonstrated that they were, individually, strong enough to get through them. Importantly, all of the men were actually seeking help for their problems, as evidenced by the fact that they regularly attended the floor hockey program in the first place. Ken captured these sentiments succinctly when he said, "It's not like I don't wanna get better you know. I actually do wanna get better."

Relationships With Program Leader: "He loves me with all his heart."

The men attributed a great deal of credit to the mental health worker who established the floor hockey program over 25 years ago. He was respected as a strong leader and also recognized as a friend, trusted confidant, and mental health professional. The men understood that the way he structured floor hockey was important and each of them consented to the rules that were established for the weekly games. For example, the program leader did not allow fighting but tolerated a certain level of physical contact, which enabled the men to play with force and made the execution of skilled performance meaningful. The men also understood that the leader used floor hockey to build meaningful and enduring relationships. Jeff told us the following.

> What makes him successful is the fact that he just seems to have the ability to know how to talk to different people. I mean realistically, and that's not an easy thing when you have people with so many different types of personalities and skill sets. And he has a unique ability to motivate people without being harsh on them. I mean he can motivate a person pretty easily just by the way he talks to people.

Mark explained how building healthy, empathetic relationships with the long-term mental health worker in the context of floor hockey encouraged the men to seek his help in other settings:

> Anybody in the mental health business industry will tell you that it's tough to break down that wall, and that can be done individually or as a team. . . . And they always know they can pull you aside and you can talk, you can go in his office, anybody you know can talk alone or as a group. . . . Hockey gives that outlet.

Steve continues to face a particularly turbulent life of drugs and crime and was incarcerated during the course of the study. He talked about his relationship with the mental health worker with great affection. He said:

> He will basically give you the shirt off his back if he needed to. . . . Things would have been worse for me if [name of worker] wasn't there. And the fact that he became my friend over the years. He loves me with all his heart. And he doesn't want to see me do bad or anything. He wants to see me succeed at something that I want to do.

Therapy: "It's a type of counseling."

Stemming from the relationships they built with the mental health worker, the men described various ways in which playing floor hockey was therapeutic for them. Dave said, "it's emphasizing on the fact that it gives the individuals that drive to believe and have confidence in themselves again." For Ken, playing hockey "puts importance back in your life, it really does." Indeed, Steve was quite candid when he told us, "Ah yeah if it wasn't for the fact that [floor hockey] was there, I'd probably be, I wouldn't be here today." Jeff described hockey as follows.

> A type of counseling. . . . Well counseling not as in the idea of, you know, one person talking to another person. I mean counseling as in the area of if it builds, like counseling is supposed to be a format to build and make a person healthier. . . . This has actually worked a lot for confidence for me.

Individuals could only attend the program if they were sober. In fact, individuals were only turned away if they were drunk, high, or were perceived as exhibiting threating behavior to another member of the program. These accepted rules were important for the therapeutic value of the floor hockey program. As Mark remarked:

> It's honorable, you know . . . a lot of people in the inner city need that clean honorable reason to enjoy life . . . the therapeutic values of it. I've seen them just evolve into better people, you know? Not only mentally, physically, spiritually, whatever, their whole life. It evolved them as well because [it is a] team sport and how important the physical aspect [is], especially for somebody suffering from mental illness.

Dave acknowledged that although the program would not transform the broader structural conditions that the men faced it was of tremendous therapeutic value for him:

> It's not gonna change the employment rate or take people off addictions, but I can tell you when you're depressed or certainly when I got the notice about cancer [diagnosis]. . . . A depressive moment where you just wanna give up. You know certainly the thought [suicide] was in [my] mind, but. . . . People can say 'look I'm going through a shitload and I just, yeah I'd love to go to hockey, when do I go?'

Community: "It gives you a sense of being with a group."

The men in this study had attended floor hockey for several years and their involvement in the group gave them a sense of belonging to a meaningful community of other men facing similar challenging circumstances. Dave said:

> I'm big on community. . . . What it's done for community, these community of individuals that have low self-esteem and challenges. I think by not having the

> hockey these individuals are wondering what's for them? Where? What can I be a part of?

Playing floor hockey, in this sense, was more than developing relationships. It was being part of a larger community that these men sorely lacked in their lives. As Nathan explained, "there's different variety of communities that come, like we have people that come from [different places]. . . . Yeah that's new and I like that because it shows that people that come from different walks of life can still have a good time." Expressing similar sentiments, Carl said, "I don't know how to put it, it was just somewhere to come where you could feel at home." For Jeff, the floor hockey community was a powerful source of collective solidarity:

> It gives you a sense of being with a group. And then you get the idea that you're working as a team. And it's important. . . . When you're in a life where most things are not team oriented, when you have a chance to work as a team, it's a good thing.

Importantly, this sense of belonging to a community meant being part of a community that was striving to be healthier. This was critical for Mark, who said, "we're all on this planet, we're not alone, it's not 'I don't care,' you know? Even if you think you're alone, you're not alone buddy. We need you, man they [need you] . . . everybody's there."

Action: "It's gotten me out of bed every Friday."

Floor hockey gave the men something to do, a brief weekly reprieve from the tension and tedium of inner-city life. This may seem mundane in a sense, but simply having something to do was important for these men. As Carl said, "Look upon how you [would] feel if you didn't have nothing to do all week. . . . Because they have nothing better to do. Well, not better to do . . . just no way of getting out of doing what they do." Here Carl was referring to the idea that if the men were not at floor hockey they would otherwise be involved in unhealthy—and sometimes illegal—behaviors.

Floor hockey also gave the men something to look forward to. Ken, who had been suffering from a bout of severe depression and had been hospitalized a few weeks before his interview, told us that:

> It's gotten me out of bed every Friday. So it actually gets me out of bed which is a miracle. . . . It fills a void that you can't fill in the community outside. . . . This just fills that void, and like I said, it gets me up on Fridays, which I normally wouldn't.

For Jeff, floor hockey "becomes a part of your life where you look forward to it when you're not, when you don't have other things preceding it that are, that are more important, but not as, as fun. [I have] actually tried to actually set my schedule around it."

Achievement: "Hockey is near and dear to Canadians' hearts."

Floor hockey provided the men opportunities to engage in public displays of skill, competence, and power, which sharply contrasted with their everyday lives. The game itself was fun and exciting. Steve told us: "Well, I honestly tell you . . . to keep a small little black object out of a net. . . . I guess the idea of keeping that little black puck out kind of arouses me." Jeff reflected on his performances as the goalie (an achievement in itself because he was blind in one eye):

> Having those games where you [are] just clear where you just have 60 or 70 shots in less than 45 minutes and, and maybe 2 or 3 goals against. When you have 70 shots and you're only having that few goals against, you're killing it.

Floor hockey reminded the men of the happier times. Ken said:

> I think why I like it the most is it reminds me of when I was a kid and we started our own road hockey league in our neighborhood and we went all the little villages around our neighborhood played each other at road hockey. Didn't have any parents involved, there were no referees. . . . There's nobody yelling at you if you miss blocking a shot you know?

It seemed important that the sport was an adaptation of "real" ice hockey, which dominates Canadian media and national masculine consciousness. As Ken further explained:

> Hockey is near and dear to Canadians' hearts. They play hockey in the road, you know on busy streets. They play hockey like inner city kids in New York play basketball. You know, if they can find a spot to play hockey they play hockey.

As such, floor hockey provided a social setting in which men could engage in skilled performance in ways that emulated the professional sport, the national community, and the activities of other "ordinary" Canadian men.

Discussion

The overall purpose of this study was to examine the role of a sport program in the lives of homeless men with severe mental illnesses and addictions. The specific research questions were (a) what personal and social benefits did the men associate with their involvement in the program, and (b) how did features of the program facilitate the accrual of these benefits? Inductively derived themes highlighted the importance of creating and sustaining empathetic relationships with the mental health worker and the other men within a community that was striving to be healthy. Floor hockey also provided opportunities for therapy, action, and achievement. In this section, we interpret the findings to shed light on

how these men gained benefits from their involvement in a weekly floor hockey game. We suggest that the ways in which these men were encouraged to play provided opportunities to accumulate masculine capital within the social context of floor hockey.

The most positive results arising from physical activity interventions for individuals with severe mental illnesses involve inpatients (e.g., Faulkner & Sparkes, 1999) or vocational programs (e.g., Carless & Douglas, 2008) when physical activity is part of an overall therapy program (Ellis et al., 2007). Some of our findings (e.g., in terms of relationships, achievement, and action) were consistent with previous studies but unique precisely because we studied a drop-in program for people who were not in a particular therapy program. Our findings demonstrated that even in the absence of a more comprehensive therapy program involvement in a regular and consistent sport program could provide therapeutic value and other benefits. The program may have offered an alternative venue for negotiating and demonstrating embodied masculinity in ways that differed to the men's regular interactions in the inner city (Harding, 2010). Rather than using the floor hockey program to link the disparate cultures of the inner city with those of the mainstream population (McLaughlin, Irby, & Langman, 1994), it became a social context for engaging in healthier behaviors *within* the cultural milieu of inner-city life.

The men tended to frame their life stories in ways that reflected individual heroic struggle and a need for personal control, both traditional masculine practices that have been associated with unhealthy behaviors (Gough, 2013). For instance, some men (Steve and Mark) described their mental illnesses in ways that either suggested the effects had worn off or they had rejected their diagnoses. We ascertained from our long-term engagement in the fieldwork that no men had consistently engaged in traditional mental health and social services to overcome these challenges. In fact, in coping with mental illnesses, addictions, and terrible accommodation, the men had consistently avoided seeking help throughout their lives, which is consistent with reasons cited for the crises in men's health (Robertson et al., 2009). Yet, as Ken explained, all of the men were seeking help by being involved in the floor hockey program. We suggest this apparent contradiction between avoiding traditional forms of help and seeking help by attending floor hockey can be explained and understood using concepts of masculine capital.

The capacity for men to acquire and use masculine capital is limited because masculine or nonmasculine behaviors have a different value that can vary across social and cultural contexts (de Visser & McDonnell, 2013). In accordance with Gough's (2013) argument, the men in this study eschewed traditional forms of seeking help and sought assistance through playing floor hockey because it gave them a resource for gaining masculine capital in ways that would not be provided by, for example, only visiting a counselor in a medical or social services office. But, in fact, by developing relationships with the mental health worker, the men did occasionally visit him in his office. In this way, the opportunities for gaining masculine capital within the social context of the floor hockey program could compensate for more common culturally defined nonmasculine behavior of seeking help (de Visser et al., 2009). These opportunities were important because men from inner-city areas often embody a range of "hidden injuries" of social class (Sennett & Cobb, 1972) and physical ones stemming from a culture of violence that plays a powerful role in shaping social relationships and their gendered identities (Harding, 2010).

It is important to underscore that the leader who ran the program was not viewed as a traditional type of mental health worker. He was viewed with great affection ("he loves me with all his heart"), which may not be an expression typically used to describe a client–counselor relationship. By understanding masculinity as fluid and plural, whereby masculine identities can be developed by accruing masculine capital (de Visser & McDonnell, 2013), the men's stories about their leader demonstrate that they could engage in nontraditional masculine practices within a traditionally masculine sporting context and broader social milieu of life in an inner city. In doing so, they developed strong and enduring relationships with the mental health worker so that seeking his help was not an admission of weakness.

The men described floor hockey as a type of therapy. This may reflect some of the physical and mental health benefits of engaging in physical activity (Rosenbaum, Tiedemann, Sherrington, et al., 2014), but it seemed more closely tied to the relationships the men had with the mental health worker. The client–counselor relationship is a fundamental feature of counseling and the main mechanism associated with the attainment of positive therapeutic results (Okun & Kantrowitz, 2014). Such relationships may be particularly important to develop with men from inner-city areas who may be distrustful of institutions and people in positions of power (Holt et al., 2013). Playing floor hockey therefore allowed men to reframe help seeking in this social context and through negotiations with the mental health worker that were congruent with masculine social practices. Perhaps seeking help from the mental health worker through the social context of floor hockey was actually a way of establishing masculine capital for members of this group, whereby having a strong relationship with the leader reflected a position of dominance within the floor hockey group.

Relationship building and enhanced social opportunities have emerged as important benefits of sport programs for men with mental illnesses and addictions (Carless & Douglas, 2008; Cullen & McCann, 2015; Faulkner & Sparkes, 1999; Hodgson et al., 2011; Holt et al., 2013). In the current study relationships were important. But the men's stories revealed floor hockey was more than developing relationships—which reflects a person-to-person connection—and more about developing connections to a wider community of other men in similar circumstances. The floor hockey program therefore served as a venue for traditional masculine bonding but within a community that was striving to be healthier.

The action narrative described ways in which floor hockey gave the men something important to do. This theme is consistent with findings from several other

studies that have examined the benefits of physical activity programs for people with mental illnesses (e.g., Carless & Douglas, 2008; Crone & Guy, 2008; Faulkner & Sparkes, 1999). Having something to do may be particularly important for men who are experiencing homelessness and are not in an institutional or vocational therapy program. In fact, the stories showed that having something to do was more than overcoming boredom for these men (Holt et al., 2013). For several men coming to floor hockey was actually an alternative to substance use or illegal activities. If nothing else, the program kept the men out of trouble and sober for a day.

The achievement narrative reflected feelings of accomplishment the men obtained through playing floor hockey. Similar findings have been reported in other studies (Carless & Douglas, 2008; Crone & Guy; 2008; Hodgson et al., 2011). A novel aspect of the current study was that the men were permitted to engage in floor hockey in ways that a certain amount of physical contact was allowed, although fighting was strictly forbidden. These rules allowed for the physical deployment of skill and power, which may be particularly salient for men from less affluent class backgrounds as they stake their public claims to masculinity (Connell, 1995). In fact, being able to play with physicality while not fighting seemed to offer more masculine capital than fighting because it bolstered practices that emphasize individual responsibility and self-control. In this sense, self-control was a healthy masculine behavior. Conversely, in other contexts, self-control may be unhealthy (e.g., if men avoid seeking help for health issues because it threatens their sense of control.

Allowing physicality but forbidding fighting was a way to encourage men to gain masculine capital in healthy ways (i.e., through skilled performance) in addition to engaging men in healthier and help-seeking behaviors (cf. de Visser & McDonnell, 2013; Smith, 2013). This may have implications for health promotion in other masculine settings. The potential to accrue masculine capital may be a hook to engage vulnerable men in settings where they can be exposed to health services. In this respect it was important the game was a version of ice hockey, a sport which dominates the media and national consciousness in Canada in ways that, for instance, football (soccer) and rugby union do in the UK and New Zealand.

Strengths of this study were the strategies embedded within the research design to help establish methodological rigor rather than relying on post hoc checks (Morse et al., 2002). These included methodological coherence, prolonged engagements in the field, and a reflexive team approach. Limitations of this study must be acknowledged. The sample size was small, which is not uncommon in studies of physical activity among men with mental illnesses (e.g., Carless & Douglas, 2008; Faulkner & Sparkes, 1999). Prolonged engagement in the field was important, but nonetheless we would have been able to gain more detailed information about the changes in the men's stories through repeated interviewing over time. This is challenging given some of the circumstances associated with conducting research with individuals with mental illnesses or who are homeless (Carless & Douglas, 2008). Furthermore, while we were careful to use existing research sensitively in our analysis, there may be some tension in taking a subjectivist-idiographic epistemology and internal-idealist ontology and producing a realist account of the commonalities between the men's stories. Pragmatically, this tension may be less important than the benefits of producing broader understandings of the shared elements of the men's stories about the benefits of the floor hockey program in their lives (de Visser & McConnell, 2013). Finally, by sampling a group of heterosexual men and using theories of masculinity to interpret the findings of this study we did not consider how the floor hockey program may limit the participation of individuals who do not subscribe to hegemonic masculinity.

The findings reveal more about the benefits of sport programs, building on the existing evidence base by confirming some concepts (e.g., action and achievement), expanding on others (e.g., community), and providing new insights (leader and therapy). Conceptually, we provided insights into the role of masculinities in the context of a sport program (Gough, 2013). Practically, the findings suggest providing opportunities to accrue masculine capital may enhance sport program delivery for men such as those in this study. Issues like the role of a mental health worker, the way the sport is delivered, and the choice of the sport were crucial features of program delivery that facilitated the accrual of these benefits.

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Appendix

Opening Questions ("Rapport Building")

[Goal—to gain further trust and to get a sense of what the inner city is like. Make it clear we are viewing them as the "experts" rather than interrogating them].

1. What is it like to live in the inner city?
2. How would you describe living in the inner city to a stranger?
3. Demographics. Ask: Where are you from? Clarify race. Ask for age. Ask how did you end up here?

Life History

4. Take me through how you ended up using services like the ones provided by [XXX]?
5. What are some of your earliest memories of those issues (i.e., whatever reasons mentioned above that led them to [XXX])?
6. Who has helped you/held you back along the way?
7. What help has been missing that could make life easier for you?

Questions About Sport in General

8. How has sport been a part of your life (if at all)? [Probes: What sports did you play when you were growing up? How did you get involved? Who encouraged you to play? Parents? Coaches? Friends?]
9. What did/do you like about playing sports and other recreational activities? Can you tell me about any distinct memories that stand out? [Probe, if needed, issues like pleasure in competition, winning, dominating opponents/confrontations with other bodies, skill development].
10. If you did not play sport, why not? What barriers prevented you from participating?

Questions About Floor Hockey

11. When did you start playing floor hockey?
12. How did you come to learn about floor hockey and other similar services in [XXX]?
13. Can you tell me why you play floor hockey now and what it means to you?
14. What do you like about playing floor hockey?
15. What do you think are the benefits/things you might get from playing floor hockey? [Probe to really tease out details].
16. Give me your thoughts on the van ride to where we play floor hockey. What do you like/dislike about "getting to" the location at which we play? [Probe for insight into the atmosphere "surrounding" a sporting event—i.e., is there something beyond the "act" of playing that informs their experience?]
17. What is it like playing in the basement of the mental health building (i.e., what is it like as a space?). [Probe to tease out the importance of this space for them, and what it means to them].
18. Take me through what it feels like to move your body when you play floor hockey?
19. What, if anything, don't you like about it?

Ending

- Summarize some of the key issues
- Ask if they have anything to add
- Ask if there are other questions you think you should ask other people
- Ask who else they think might do an interview