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RESET STUDIOS

MEN AND IDENTITY RESEARCH RESPONSE

Men Are Not Okay

Why Gendered Recognition, Identity Disruption, and Internal Strain Must Be Seen Before Collapse

Accountability, context, and the case for identity-aware support before visible failure

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Research-informed analysis | October 7, 2026

This article examines whether men and women receive equal recognition of grief, biological change, identity disruption, and internal strain before society reduces a person to symptoms, danger, or a criminal act.



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The statement “Men are not okay” is not a diagnosis of men as a group. It is a warning about what can remain hidden when visible functioning, silence, institutional compliance, emotional containment, or physical strength is mistaken for internal stability.

It is also a warning about recognition. Society does not interpret the same signs in every person the same way. Gender can influence whose distress is contextualized, whose hormonal or biological change is discussed, whose history is considered, whose silence is treated as strength, and whose behavior is reduced immediately to danger or criminality. The scientific question is not whether men and women are internally identical. They are not. The question is whether comparable internal domains—grief, shame, identity disruption, hormonal change, suicidality, psychosis, moral conflict, fear, and loss of control—are investigated with equal seriousness before a person is reduced to one visible act.

This question requires unusual care. Context is not excuse. Recognition is not absolution. A mental-health condition does not erase harm, and a gender disparity does not determine the outcome of any individual case. Yet accountability does not make internal experience disappear. A responsible model must be able to hold the act, the harmed people, the person’s condition, and the unequal recognition environment at the same time.

A Difficult Comparison Must Be Made Carefully

The first trial of Lindsay Clancy ended in a mistrial on September 4, 2026, after jurors could not agree on whether she was criminally responsible for killing her three children. Her defense did not dispute that she carried out the killings; it argued that postpartum psychosis prevented criminal responsibility. Prosecutors argued that she knew what she was doing. After the mistrial, the judge rejected a defense request for a judgment of acquittal, finding that the prosecution had presented evidence from which a rational fact finder could find murder. Clancy remained charged, and prosecutors had not yet announced whether they would retry the first-degree murder charges, pursue lesser charges, or dismiss the case (Casey, 2026).

Those facts establish important boundaries. Clancy attempted suicide after the killings, but it is inaccurate to describe the event as suicidal rather than homicidal. The deaths of the children remain homicides; the disputed legal question was her criminal responsibility. It is also inaccurate to say that moral injury outweighed the criminal act. Moral injury was not the legal defense, and a mistrial did not establish that any psychological condition outweighed the offense. The trial concerned whether a mental disease or defect prevented criminal responsibility under Massachusetts law.

The case nevertheless exposes a legitimate gender question. Public discussion made extensive room for postpartum psychosis, maternal mental health, medication, hormonal transition, caregiving strain, and the possibility that a person who committed catastrophic harm was not fully criminally responsible. Men deserve equally serious investigation of biological, psychological, relational, social, and identity conditions when those conditions are relevant. That does not mean the law should produce the same result in unlike cases. It means that context should not become available only when the defendant fits a socially recognizable story of vulnerability.

The comparison must also account for jurisdiction. Clancy faced life imprisonment if convicted of murder, not the death penalty (Casey, 2026). Her Massachusetts case therefore cannot prove that a woman was spared a death sentence that a man would have received. Nationally, however, gender is relevant to capital prosecution. In an analysis of more than 14,000 Texas capital cases, male defendants were more likely than female defendants to have death sought and imposed, and outcomes also varied with the genders of the prosecutor and victim (Niven, 2026). The most death-sentence-oriented combination was a male prosecutor, male defendant, and female victim. The least death-sentence-oriented combination involved a female prosecutor, female defendant, and male victim.

That study supports concern about gendered decision-making. It does not prove that every man receives harsher treatment, that every woman receives leniency, or that Clancy’s outcome was caused by gender. It was observational, limited to Texas capital prosecutions, and could not eliminate every difference among cases. The responsible conclusion is narrower: gender can shape how punishment is sought and imposed, so any comparison must examine law, jurisdiction, offense characteristics, victim characteristics, prosecutorial decisions, clinical evidence, and defendant gender rather than relying on outrage alone.

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Grief Does Not Remove Responsibility

A 2026 study in *Death Studies* examined six men receiving treatment in a high-secure forensic hospital in the United Kingdom after killing a loved one while experiencing psychosis. Through interpretative phenomenological analysis, the researchers identified three central themes: reconstructing a divided identity, grieving under institutional restrictions, and living with the aftermath of the homicide. Moral conflict, stigma, continuing bonds, and disenfranchised grief shaped how the participants understood both their losses and themselves (Shaw et al., 2026).

This study cannot be generalized to men broadly. Six participants in an exceptionally severe forensic context cannot establish a universal male grief pathway, explain ordinary occupational or relational disruption, or show that psychosis ordinarily results in violence. It also cannot tell us how women in comparable forensic circumstances would be treated. Its value is more precise: it demonstrates that grief, responsibility, stigma, psychosis, moral conflict, and identity division can coexist within one person and remain analytically distinct.

The men were grieving people whose deaths were connected to their own actions. Recognizing that grief does not excuse the act. Acknowledging moral injury does not eliminate accountability. Understanding identity division does not erase responsibility. Yet responsibility does not make attachment, loss, remorse, shame, continuing bonds, or the collapse of a previously recognizable identity disappear.

The central question is not whether grief should replace responsibility. It is whether a responsible scientific and institutional model can hold both without contaminating one construct with the other.

A Divided Identity Is Not Simply a Lost Identity

Identity loss suggests that a valued identity has disappeared or become unavailable. Identity division is different. A divided identity may include the person who existed before an event, the person who committed an act, the person who loved the deceased, the person held accountable by an institution, the person viewed through public stigma, the moral self that cannot reconcile behavior with values, and the emerging self attempting to live with what cannot be reversed.

These positions do not necessarily replace one another. They may remain active at the same time. The problem may not be that the person has no identity. The problem may be that several identities remain present but cannot be organized into a coherent and morally livable understanding of self.

For the Identity Architecture Model™, this distinction matters. Identity disruption should not automatically be defined as the disappearance of identity or treated as another name for depression. It may involve contradiction, fragmentation, role collapse, moral conflict, social labeling, a broken life narrative, or an inability to integrate a former self with present reality. This is a Reset Studios proposition informed by the qualitative findings; the Shaw et al. (2026) study does not validate the IAM or establish that an identity-focused intervention will produce integration.

Men Have Hormonal Systems, but Hormones Are Not an Excuse

Public conversation often recognizes women's hormonal transitions while speaking about men as though their behavior emerges from willpower, character, or thought alone. Men also have dynamic endocrine systems. In a longitudinal study of 51 first-time expectant fathers and 57 nonfathers, researchers measured testosterone, oxytocin, vasopressin, and cortisol across pregnancy and four months after birth. Expectant fathers showed lower testosterone and vasopressin at several time points, oxytocin changed across the prenatal period, and some prenatal hormonal patterns predicted later paternal investment (Rilling et al., 2025).

The finding is useful because it rejects the idea that men are biologically static while women alone undergo hormonally relevant transitions. It does not establish a male equivalent of postpartum psychosis. It does not show that hormonal change causes depression, aggression, homicide, grief, or identity division. The sample was small, involved medically and psychiatrically screened first-time fathers, relied partly on self-reported paternal behavior, and examined caregiving—not violence or criminal responsibility.

The implication is therefore not that "hormones made him do it." The implication is that men's internal systems deserve assessment rather than assumption. Biological state, sleep, pain, medication, substance use, neurological history, endocrine change, trauma exposure, role transition, and identity disruption may all be relevant in a complete evaluation. None should be invoked casually, and none should be used to erase accountability.

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Two people can display the same outward silence while carrying very different internal states. Conversely, two people can carry comparable fear, grief, hormonal change, or identity strain while receiving very different social interpretations. Observable behavior alone cannot tell us which internal system is operating.

Moral Injury Is Not a Substitute for Criminal Responsibility

Moral injury describes the disruption that can follow perpetrating, witnessing, failing to prevent, or feeling betrayed by events that violate deeply held moral beliefs. It may involve guilt, shame, anger, betrayal, spiritual conflict, loss of meaning, or a changed relationship with humanity. It is not a legal verdict, a synonym for insanity, or a mechanism for outweighing a criminal act.

This distinction is especially important in cases involving severe harm. Moral injury may occur after a person recognizes what they have done. Criminal responsibility asks a different question: whether the law holds the person responsible at the time of the act. Grief asks what has been lost and how that loss is experienced. Guilt asks how the person evaluates an action. Shame concerns judgment of the self. Psychosis concerns a clinical condition involving impaired contact with reality. These domains may interact, but one cannot be used as proof of another.

If an assessment combines them into one distress score, it cannot show whether a person is grieving, ashamed, psychotic, morally injured, afraid of punishment, or struggling to reconcile incompatible identities. That is construct contamination, not precision.

Gender Changes the Recognition Environment

The most defensible comparison between the Clancy case and the men in the forensic grief study is not that the acts were identical or that the legal outcomes should match. It is that social recognition changes the conditions under which internal experience can be named.

Clancy's defense had a culturally recognizable narrative available: childbirth, postpartum mental illness, treatment history, medication, a suicide attempt, and expert testimony. The male participants in the UK study were located within a different recognition environment—high security, institutional restriction, stigma, responsibility for a loved one's death, and limited permission to grieve. Their grief existed, but the social legitimacy of that grief was constrained (Shaw et al., 2026).

Recognition does not mean sympathy without limits. It means that a relevant condition is allowed to enter assessment. A man should not have to become suicidal, psychotic, violent, incarcerated, or visibly collapsed before grief, role loss, hormonal change, identity strain, and the need for nurture become discussable. Early recognition is not leniency. It is prevention.

Why Men May Reject the Mental Health Doorway

Men's lower use of psychological services is sometimes explained as ignorance, denial, or resistance. That explanation is incomplete. A 2025 meta-analysis covering 35 samples found that stronger endorsement of traditional masculinity was associated with less favorable attitudes toward psychological help-seeking and greater self-stigma. Gender-role conflict showed similar associations (Üzümçeker, 2025).

The meta-analysis supports a link between masculine norms, self-stigma, and help-seeking attitudes. It does not prove that masculinity caused an individual man to avoid care, that all men share the same norms, or that changing language alone will increase service use. The included studies were largely correlational, used different measures, and represented cultural contexts unevenly. Attitudes are also not the same as actual behavior.

Still, the finding helps explain why a mental-health label may feel costly. Some men hear the label not as an invitation to understand their experience, but as a threat to competence, employment, authority, fatherhood, athletic identity, public credibility, or control. If disclosure appears likely to produce stigma or role loss, silence can function as self-protection.

This does not justify abandoning mental-health care. It justifies creating more than one ethical entrance to support.

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Identity Awareness Can Be an Earlier Entry Point

Two private conversations supplied for this article—one with an emotional transformation practitioner and one with a former professional football player—raised a consistent practical question: would some men engage earlier if the first conversation concerned identity, role, loss, capacity, and internal strain rather than immediately asking them to accept a mental-health label?

These conversations are not research evidence. They cannot establish prevalence, causation, or treatment effectiveness. They do, however, identify a testable engagement hypothesis. Men who maintain work, leadership, caregiving, or public performance may recognize "my role no longer fits," "I do not know who I am outside this position," "my internal capacity is changing," or "I cannot keep carrying this alone" before they identify with depression, trauma, anxiety, or another diagnostic term.

The phrase "identity awareness before mental health" therefore needs a careful revision. Identity awareness should not be positioned before mental health as a clinical rule, and it should never delay assessment when psychosis, suicidality, severe impairment, or immediate danger is present. The more defensible proposition is this: identity awareness can operate as an earlier, lower-stigma entry point alongside mental-health care. It can help a person notice disruption before visible collapse while preserving a clear pathway to qualified clinical evaluation when symptoms or risk require it.

That distinction protects both the person and the science. Identity disruption is not a substitute diagnosis. The Reset Studios ecosystem is not a replacement for psychiatry, psychotherapy, emergency care, or the criminal justice process. Its proposed contribution is to identify forms of disruption that may appear before, outside, or alongside a diagnosable condition.

When the Crowd Becomes the Voice

The conversation with the former professional football player also surfaced a pressure that deserves greater attention: athletes no longer leave public scrutiny at the stadium, in the locker room, or with the next morning's newspaper. Social media places commentary, ridicule, accusations, performance criticism, and personal attacks in a device that remains accessible throughout the day. The same platform that builds a player's visibility can carry strangers' judgments into his home, family life, recovery time, and private understanding of self.

This does not mean that online criticism automatically causes a mental illness or identity fracture. The conversation cannot establish that relationship. It does identify a credible pathway for research. A player may already be negotiating injury, contract uncertainty, retirement, public expectations, reduced playing time, family responsibility, pain, or the fear that his value will disappear when performance changes. Repeated online badgering may then reinforce the harshest interpretation of those experiences.

In my forthcoming book, *Am I the Drama or Am I the Disruption?*, I examine what I call **The Voice**. The Voice is the internal message that interprets what is happening and tells a person what the event means about who they are. It may sound like, "You failed," "You are no longer valuable," "You disappointed everyone," or "You cannot let anyone see that you are struggling." For a professional athlete, thousands of outside voices can begin repeating the same message until public criticism becomes private self judgment.

That is where identity strain can deepen. The athlete is no longer responding only to a poor performance or a hostile post. He may be defending the provider self, performer self, public self, teammate self, injured self, and private self at the same time. When those roles cannot be reconciled, criticism can land on an identity that is already carrying fractures the public cannot see.

The Reset Studios proposition is that institutions should assess this exposure before dismissing it as part of fame, competition, or the price of professional sports. Teams, leagues, agents, media departments, sponsors, and player associations should examine not only the volume of online abuse, but also the player's role transition, identity concentration, recovery capacity, disclosure safety, and access to support that does not begin with a diagnosis.

The book takes the question further: What happens when the voice outside the man becomes the voice inside him, and he can no longer tell which one belongs to him?

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The Missing Layer Beneath Performance

The first supplied framework image, *The Missing Layer Beneath Performance*, illustrates the hypothesis that visible performance and observed symptoms do not exhaust the person's condition. Hidden grief, shame, fear, role strain, moral conflict, and loss may sit beneath both. Identity architecture concerns how those experiences affect continuity, meaning, capacity, and coherence. Stabilization concerns the person's ability to respond without relying exclusively on suppression, fear, or unsustainable compensation.

The figure should be read as a conceptual model, not a validated causal sequence. Research has not established that every disruption moves from hidden strain to symptoms and collapse, or that the proposed Reset sequence prevents psychiatric illness or violence. The model's research value lies in the questions it makes measurable: What changed? Which roles are carrying the change? What remains functional? What is that functioning costing? Which internal and environmental supports are absent?

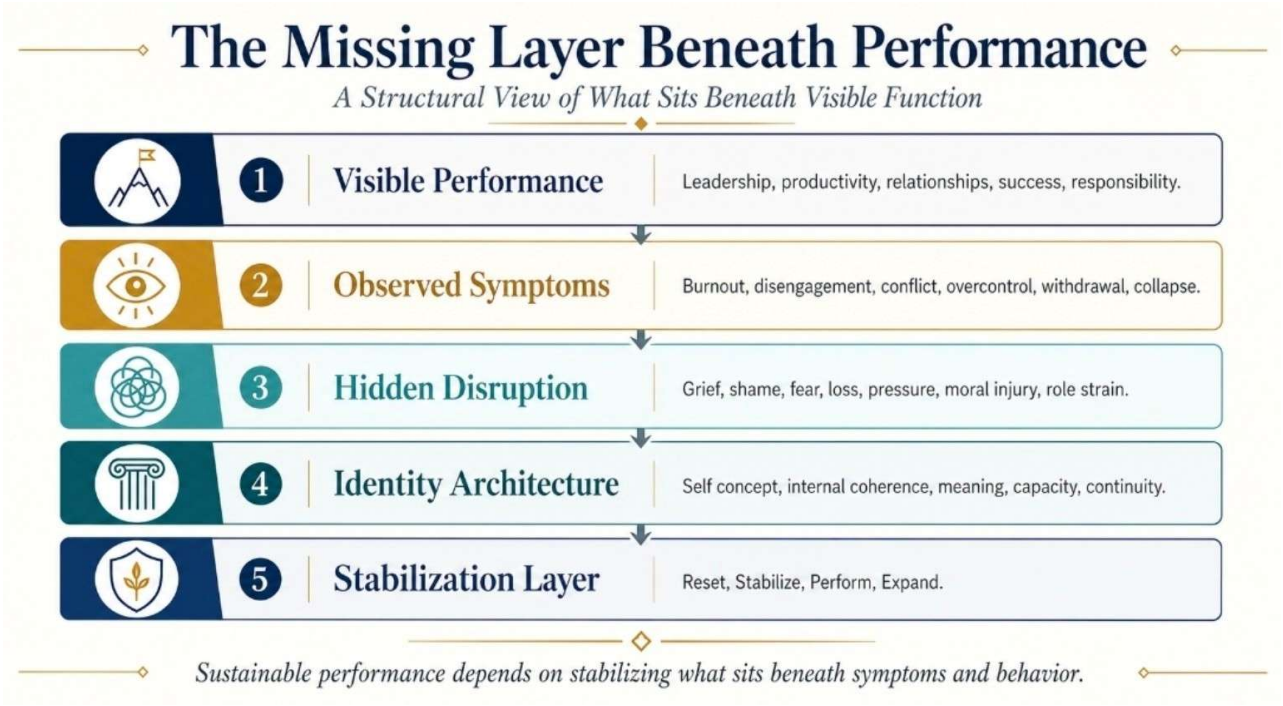

Figure 1. The Missing Layer Beneath Performance. Conceptual framework image supplied by Dr. Tasha Mac; not a validated causal sequence.

Split Role Identity and Unequal Judgment

The second supplied framework image, *Split Role Identity*, distinguishes the public, provider, performer, survivor, spiritual, private, wounded, and leader selves from a more coherent organization of identity. Its relevance to men is immediate. A man may be evaluated through the provider or performer role while grief, fear, dependency needs, physical change, shame, or moral conflict are forced into a private self that receives little recognition.

The figure does not claim that every role should dissolve into one fixed identity. Identity can be plural and context-dependent. The proposed goal is not sameness across every setting. It is sufficient coherence that roles no longer require the person to deny reality, abandon values, conceal risk, or maintain performance at an unsustainable cost.

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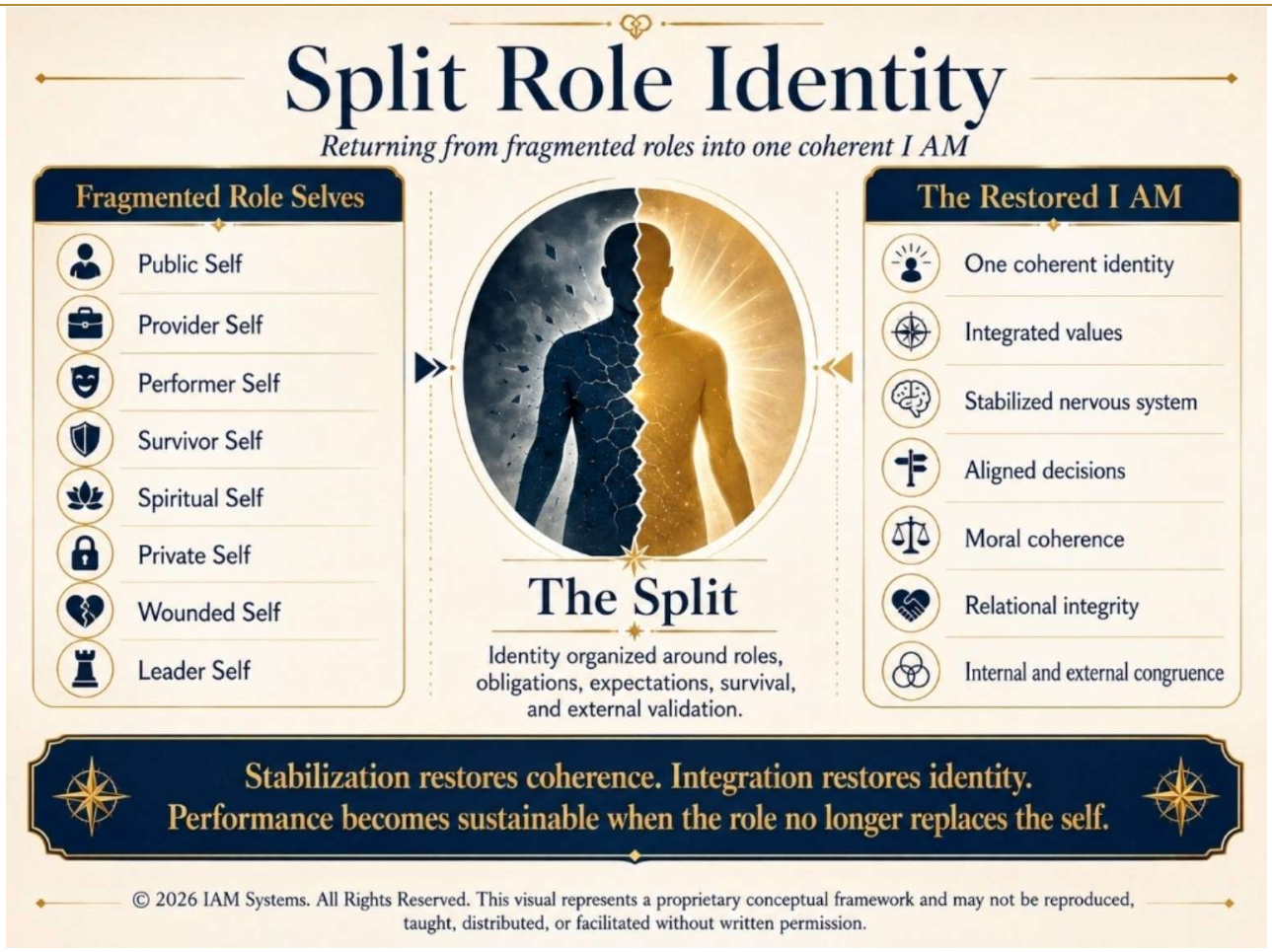

Figure 2. Split Role Identity. Conceptual framework image supplied by Dr. Tasha Mac; identity plurality should not be mistaken for pathology.

This is also where gendered judgment becomes visible. Society may describe a woman's internal rupture through care, hormones, vulnerability, and treatment, while describing a man's comparable distress through threat, weakness, irresponsibility, or character. That does not mean the underlying conditions or acts are identical. It means the same internal domains should be available for investigation before gendered stereotypes decide what the behavior must mean.

What Must Be Measured Separately

A defensible assessment should distinguish at least nine domains.

Loss and grief. What person, relationship, role, capacity, future, status, or former reality has become unavailable?

Responsibility and guilt. What does the person believe they did, failed to do, allowed, or could not prevent?

Shame. Has judgment moved from the action or condition to the whole self?

Moral injury. Has an event disrupted moral identity, meaning, trust, spiritual belief, or the person's ability to understand themselves as morally human?

Clinical state and acute risk. Are psychosis, suicidality, mania, intoxication, withdrawal, severe depression, cognitive impairment, or immediate danger present? This domain requires appropriately qualified assessment.

Biological and physiological context. What roles may be played by hormones, sleep, pain, medication, neurological conditions, illness, exhaustion, substance use, or other bodily changes? These factors should be evaluated, not presumed.

Stigma and anticipated consequence. What labels, judgments, exclusions, employment risks, custody concerns, or relational losses shape what the person is willing to reveal?

Identity division. Which former, current, moral, relational, occupational, stigmatized, and emerging identities remain active, and where do they conflict?

Recognition context. Who acknowledges the loss, changed identity, biological reality, moral complexity, risk, and continuing humanity of the person? Who denies, restricts, condemns, or silences those experiences?

These domains may interact, but interaction does not establish equivalence. Without separation, an assessment may mistake shame for grief, interpret stigma as resistance, classify moral injury as depression, use hormones as an excuse, or treat identity division as a lack of accountability.

Implications for the Grief Pathway System

For the Grief Pathway System™, the evidence supports examining recognition context alongside loss. A grief pathway may differ when grief is publicly acknowledged, privately recognized, morally complicated, socially prohibited, institutionally restricted, concealed for protection, overshadowed by stigma, or entangled with responsibility for harm.

This would not create a hierarchy of grief or grant legitimacy to violence. It would clarify the conditions under which grief is being carried and the barriers that shape its expression. The Shaw et al. (2026) study directly supports the coexistence of grief, stigma, continuing bonds, and identity reconstruction in one specific group. Extending that insight to other male populations is a Reset Studios hypothesis requiring independent study.

Implications for the Identity Architecture Model

For the Identity Architecture Model™, the evidence supports distinguishing identity loss from identity conflict, division, foreclosure, and reconstruction. The male participants in the forensic study were not simply missing a former identity. They were negotiating incompatible identities under conditions of responsibility and stigma. Rilling et al. (2025) also shows that a major male role transition can involve biological change, while Üzümçeker (2025) shows that gender-role expectations can shape the social cost of seeking help.

Together, these findings justify measuring role expectations, former and current identity, biological context, stigma, disclosure cost, moral coherence, and sustainable functioning separately. They do not validate the IAM or prove that identity integration prevents mental illness, suicide, or violence.

Implications for Identity Integration Science

Identity Integration Science™ should test a precise proposition: some people may experience measurable identity disruption, internal strain, and rising performance cost before they meet a clinical threshold, disclose distress, or lose visible functioning. Identity-aware language may help some men engage sooner, but that engagement advantage must be tested against conventional mental-health language rather than assumed.

A future study could compare two ethically equivalent entry messages. One would invite men to discuss stress and mental health. The other would invite them to examine identity change, role strain, loss, capacity, and the cost of maintaining performance. Researchers could then measure uptake, disclosure, stigma, referral acceptance, safety identification, and sustained engagement. The study should include referral pathways so that identity language never becomes a route around needed care.

What Advocacy for Men Should Look Like

Men need spaces where support is not available only after diagnosis, public failure, arrest, hospitalization, or attempted suicide. Those spaces can exist in workplaces, athletic organizations, faith communities, barbershops, veterans' organizations, fatherhood programs, reentry programs, professional associations, and community institutions. They should permit men to enter through language of identity, purpose, grief, role change, responsibility, bodily change, and capacity while maintaining access to licensed clinical care.

Safe space does not mean a place without standards. It means a setting where a man can tell the truth before the truth becomes evidence of incompetence. It means receiving nurture without being infantilized, accountability without dehumanization, assessment without automatic labeling, and referral without shame.

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Institutions also need protocols for what happens after disclosure. Telling men to speak is inadequate if the response is ridicule, job loss, forced exposure, moral simplification, or a list of resources with no warm handoff. The question is not only why men do not speak. It is what the institution has demonstrated will happen when they do.

The Larger Point

Men are not helped when silence is mistaken for strength. They are not helped when visible control is mistaken for internal coherence. They are not helped when responsibility becomes a reason to deny grief, or when grief is used to avoid responsibility. They are not helped when every internal conflict is reduced to a diagnosis, and they are not helped when identity language is used to avoid diagnosis where clinical risk is present.

The Lindsay Clancy case should not be used to declare that women escape accountability or that men in different jurisdictions would inevitably be sentenced to death. It should prompt a more disciplined question: which forms of context are socially available to women, which are available to men, and how do those recognition patterns influence assessment, help-seeking, prosecution, and public judgment?

The forensic grief study leaves us with a related truth. A man can be responsible for harm and still experience grief. He can feel guilt without having resolved moral injury. He can be stigmatized without having lost all capacity for change. He can carry several conflicting identities while appearing controlled from the outside.

Men also have bodies that change, roles that collapse, identities that fracture, and histories that shape what safety means. Recognizing those realities does not excuse violence. It may help institutions identify disruption earlier, offer support more intelligently, and respond before distress has only one remaining language: symptoms, disappearance, self-destruction, or harm.

The missing layer is not an argument against mental health. It is an argument against waiting for mental illness to become the only socially acceptable explanation for why a man is no longer internally stable.

Identity awareness can open the door. Clinical care must remain available when the person's condition requires it. Accountability must remain present when harm has occurred. Science must measure each domain separately so that compassion does not become confusion and punishment does not become blindness.

Because men deserve recognition before collapse—not recognition only after the world has decided what their suffering means.

Source verification updated October 7, 2026.

Evidence Boundary

The peer-reviewed studies cited here do not validate Identity Integration Science™, the Identity Architecture Model™, the Grief Pathway System™, or a universal sequence from disruption to collapse. They support specific distinctions among grief, identity division, gendered help-seeking, biological transition, and capital-case outcomes. The Reset Studios applications identified in this article are proposed hypotheses for assessment and program development and require independent, prospective validation.

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Safety Note

Identity awareness is not a substitute for clinical assessment. If someone is experiencing psychosis, suicidal thoughts, or immediate danger, contact emergency services or, in the United States, call or text 988 for the Suicide and Crisis Lifeline.

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Stabilization precedes performance, transformation, and sustainable growth.

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