MASC FOR MASC – HOW DOES GENDER ROLE CONFLICT (GRC) AND MASCULINITY AFFECT THE THERAPEUTIC PROCESS FOR THE MALE THERAPIST AND THE MALE CLIENT?

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The Lo-Fi beats playlist on Spotify, STARK and my ever-supportive family. I love you all.

ABSTRACT:

Male psychotherapists undergo the same socialisation in society as males who are non-psychotherapists, and this can have implications for the therapeutic process. This study examines the role of male GRC, masculinity and their effects on the therapeutic process both for the psychotherapist and the client. This study found that the male does not escape unscathed from this socialisation simply because he has had training as a therapist. He retains bias and it is in the acknowledgement and recognising of this bias which is important for the therapeutic process. This study also considers the challenging role that the therapist has with the gay male client. Not only does he usually live in a man's world different from his own, but he also navigates it a different way and it is important for the heterosexual male therapist to recognise this, examining closely his GRC, masculinity and understanding that GRC comes not just outside the gay community for the gay client but also within it. Just as the heterosexual male therapist can be homophobic, the gay client can also be internally homophobic.

"As a culture, we perceive men not as sacred or sensitive, but as things to be hurt, repeatedly and violently, in order to test their mettle. Manhood is a prize awarded to the most scarred."

— Antonella Gambotto-Burke

CHAPTER ONE: INTRODUCTION – GENDER ROLE CONFLICT

Gender Role conflict is described by O' Neil, (2015, p42) as a psychological state in which socialised gender roles have negative consequences for the person or others. It occurs when rigid, sexist, or restrictive gender roles result in personal restriction, devaluation, or violation of others or oneself. An example of a restrictive model would be Levant's 'Code of Masculinity'.

> 'This model infers societal beliefs that males must (1) be autonomous and self-sufficient; (2) curb their emotions; (3) be seen as tough and aggressive; (4) seek high social status; (5) always be ready for (heterosexual) sex; (6) avoid all things feminine; and (7) rebuff homosexuality', (2001, p.357).

It is this incongruence between what is expected as a male in society and what realistically the male can deliver which causes this conflict. The concept of O'Neil's GRC theory is based on the masculine values that society places on the male, coupled with the interaction of the environmental and biological factors which surround him. He describes these values as the *masculine mystique*. These values form part of a developmental process where pre-teen and adolescent males acquire gender role characteristics that can lead to psychological anguish if they are used in circumstances that require less gender typed behaviours. O'Neil (2015, p4), also described the fear of femininity, whereby the male is ostracised for expressing or possessing ideals, stances or behaviours that are stereotypically associated with appearing feminine. These masculine values are learned in early childhood when GRC is moulded by parents, peers and societal values. Conflict occurs where these standards are not adhered to or endorsed by the male. O'Neil (2015, p.43) posits there are four patterns which contribute to this conflict. (1) Success/ Power/ Competition (SPC): this relates to personal attitudes about success pursed through competition and power. (2) Restrictive

Emotionality (RE): is defined as having restrictions and fears about expressing one's feelings along with restrictions in finding words to express basic emotions. (3) Restrictive Affective Behaviour Between Men (RABBM): this represents restrictions in expressing one's feelings and thoughts with other men and difficulty touching other men. And (4) Conflict between work and family relations (CBWFR): this is where there are restrictions in balancing work, school, and family relations resulting in health problems, overwork, stress, and a lack of leisure and relaxation. Gender role conflict is not just something the western white male experiences. Wester (2008, p.3) acknowledges that fact when he states that GRC occurs for older men, men of colour, men of differing sexual orientation, and men from different economic, political, and social backgrounds. And while GRC may be a geoglobal phenomenon, there are specific variations that bear further study and it cannot all be just focused on the American white male.

The aim of this dissertation is to examine the experience of two males (a therapist and a client), how they interact and how their therapeutic processes play out within the therapeutic space. It will also explore the concept of Gender Role Conflict (GRC) and its impact on them in the therapeutic space, as well as examining how masculine norms within our society (something which is learned from childhood) affect both the client and the therapists' process. Furthermore, this dissertation's aim is not to suggest that men cannot be affective therapists, nor is it an attempt to ridicule masculinity or 'toxic masculinity' which has become the *phrase de jour* in recent times. It must be acknowledged that there are times where masculinity and its values can play a part. However, at the same time, the acknowledgement that male therapists, despite their training, are subject to the same gender role socialisation as other male members of our culture, and that it can affect the work of both the established male therapist and the trainee male therapist.

CHAPTER TWO: THERAPEUTIC BIAS, THE SOCIALISED MALE AND GENDER ROLE CONFLICT

The term bias usually implies a prejudgement or a prejudice and within the therapeutic space this can be detrimental to the work between the therapist and client. This chapter will explore how therapeutic bias within the therapeutic setting can be the result of how the male is socialised and also the impact of its resulting cousin, gender role conflict.

Interestingly, in the nineteen seventies and eighties, with the little research that exists, reviews of the psychotherapy bias literature concluded that there was little evidence of bias when examining the therapeutic process (Abramowitz & Murray, 1983; Davidson & Abramowitz, 1980; Smith, 1980). Lopez (1989) stated that according to the research, patient variables such as gender and race have not been found to have an effect on clinicians' judgements or on the type of treatment provided. Abramowitz and Dokecki (1977) in addition, stated the only client variable effect that has been reported to have consistent empirical support is social class. Lower social class clients have been judged to be more seriously disturbed than middle and higher social class clients, even though no differences were found in the presenting problems. Stein et al. (1976) argued that therapeutic bias only had its basis when it came to the way how men and women were treated within the therapeutic space, more specifically in terms of treatment when levels of psychopathology have been the same for both groups or when it is statistically controlled. Lopez (1983) proposed that the major assumption underlying this bias was that these differences were not due to the actual differences between genders, age groups, or racial /ethnic groups but to the error on the part of the therapists. This early research acknowledged that a therapist's bias has a part to play within the work of therapy and it's not all solely or partly the ownership of the client.

Stemming from this research it brings one to a point today where researchers are hypothesising that therapists may not exhibit a bias in their work simply on the basis of a client's biological sex but may perceive clients as maladjusted when they violate traditional gender roles. Goldyne (2007) recognised that psychiatric expert witness work is as subject as any other human endeavour is to the

influences of biases. He posits that our origin of biases is divided into two types: (1) emotionally driven motivations that conflict with the expert's motivation to be objective and (2) non-emotional factors, including the expert's information processing style or fund of knowledge, that may impair objectivity. For example, in psychotherapy, emotions and resultant emotions may result from the therapists past experiences (for example male socialisation) or personality, from the present situation, or from provocation from others (for example gender role conflict). Non-emotional factors may originate in the therapist's biology, professional background or nonprofessional background.

A traditional male socialisation can be defined as one that focuses on (a) independence and self-reliance to the exclusion of collaborative efforts (Kiselica, 2001); (b) the restriction of emotional expression, despite the fact that men's emotional expression is just as intense as that of women (Wester, Vogel, Pressly, & Heesacker, 2002); and (c) toughness and aggression in the absence of other coping styles (Brooks, 1998). It must be noted that despite a lot of the research focusing on the western Caucasian male, and also a lot of this research being written by this subset, the research shows that the socialisation of the male and gender role conflict characteristics are evident across all cultures and not just in the west. This, however, has been contested by Wester (2008). He states that the body of work especially by Doctor James O'Neil could more robust exploration into masculinity and GRC as yet another demographic variable worthy from a multicultural perspective.

Looking further into Doctor James O'Neil's work on *the masculine mystique*, he defined this as a developmental process under which he felt most boys learned a confusing combination of potentially positive characteristics (for example, strength independence, achievement) and potentially negative characteristics (for example, suppression of emotions, aggression, avoidance of feminine characteristics) regardless of any interpersonal and intrapersonal consequences (Vogel & Wester, 2002). Although society continues to mould boys in this fashion one needs to acknowledge that there is push back from this model today. For example, this especially holds true when you examine the family unit. The traditional image of the housewife at home minding the children and

the husband at work bread winning seems like an image of days gone by not fitting with our modern world. Today one can see that the male takes more of an emotional role in nurturing the family and providing emotional support within the family unit. Fathers and husbands are no longer merely the bread winners responsible for car maintenance and repair or of dead animal disposal (Farrell, 1999). These were behaviours that were not usually taught during their development and socialisation as males. Although most men are able to adapt to these demands, nonetheless, some men will experience confusion and conflict regarding the differences between these expected behaviours and their socialised male roles. O'Neil et al. (1986) state that men are unsure about how to balance what they perceive as being masculine with the behaviours their current situation requires, and they feel ashamed of their inability to cope with such changes. This state of confusion and shame led to O'Neil coining the term, Gender Role Conflict.

The research shows that males therapists are subject to the same gender role socialisation as other males in society (Mintz & O'Neil, 1990). Thus, male therapists may experience GRC issues relating to both their clinical work with certain populations and their professional development as therapists. Examining O'Neil's GRC factor of restrictive emotionality (RE), Heppner and Gonzales (1987) hypothesised that men's socialised tendency toward RE led some men to be afraid of appearing too feminine and thus finding difficulty communicating concern and warmth. Ettkin (1981) states that no matter how much a male therapist may feel that he has gone beyond the traditional limits of gender role stereotypes, the therapist is still part of the culture and is directly and indirectly influenced by it. Scher (2001) postulated that some traditionally socialised male therapists would have difficulty expressing empathy and warmth because the vulnerability implied by such behaviour is in direct contradiction to the expectation that control, and power will characterise a man. More recently, Wester et al. (2007) demonstrated that male psychology interns experiencing increased RE had a poorer perception of their therapeutic abilities than did those male interns experiencing decreased RE. They hypothesised that the discomfort associated with the focus on emotions the transference/countertransference issues inherent to therapy and supervision violated the prescribed

male role. The fact that emotions such as empathy, intimacy and affection are central to the role of the therapist leaves traditionally socialised male therapists with issues when trying to serve certain clients because restrictive emotionality (RE) and Restrictive Affectionate Behaviour Between Men (RABBM) may lead them to constrict their behaviours in the therapeutic space in order to avoid intimacy.

Examining the factor of Success, Power and Competition (SPC) in O'Neil's Gender Role conflict scale, this factor also has the potential to affect the therapeutic process. For example, some male therapists may feel the need to perform for their client, to assert their dominance or their clinical prowess. Thus, this would result in less of a focus on the client's issues and more of an emphasis on the acting out of the therapist. Scher (2001) hypothesised that such behaviours would focus the therapy on competition rather than on collaboration. The client and therapist therefore end up as rivals rather than partners. O'Neil et al. (1995) state that this type of behaviour can have serious consequences when it comes to trainee therapists and their development in being able to be open to examining their own therapeutic performance and skills deficits. Accordingly, some male trainees could be focusing more on their feelings of fear and anxiety about violating the socialised male gender role, and less on learning through increased client contact and effectively using clinical supervision. Ladany et al. (1999) also describe how some trainees might not be willing to disclose personal information that they believe will negatively affect the supervisor's evaluation of their performance, thus decreasing the degree to which they learn and develop through supervision.

The fear of femininity is another factor that O'Neil theorised that resulted from the traditional socialisation of the male. O'Neil (1982) stated that men are thought to engage in gender role conflict patterns that restrict their roles and behaviours to stereotypically masculine ones to avoid being or appearing feminine. It is through the rigid enactment of this role which can lead to both intrapersonal and interpersonal conflict for the male therapist and the male client. For example, Heppner and Gonzales (1987) hypnotized that men's socialised tendency towards restrictive RE led

some men to be afraid of appearing too feminine and thus experience difficulty with communication, concern and warmth. This is reflected in the research in terms of a client seeking help from a therapist. Mahlaik (2003) states that several studies have confirmed that men seek psychiatric services, psychotherapy, and counselling less often than women. Many of the tasks associated with seeking help from a health professional, such as relying on others, admitting a need for help, or recognising and labelling an emotional, conflict with the message men receive about the importance of self-reliance, physical toughness and emotional control. Furthermore, Wisch et al. (1995) found that men reporting higher levels of gender role conflict expressed more negative attitudes toward seeking help after viewing a therapy session focused on feelings than after a session focused on cognitions. Mahlaik (2003) posits that some masculine ideologies are more powerful than others in determining what members of a culture take to be normative masculinity, for example, white, middle-class, heterosexual definitions of masculinity in the United States. Levant (1996) states that different men may also experience varying degrees of and forms of stress and gender role conflict as a result of particular patterns of male gender socialisation. In addition to this Wester (2008) posits, why is it some men are able to balance the demands of their gender role with situational variables while still other men experience negative consequences or engage in maladaptive behaviours? Perhaps then it is only fitting to state that one needs to acknowledge that there are men who endorse traditional masculine ideologies who may cry, that men who endorse non-traditional ideologies may make homophobic remarks, and that there are men who subscribe to masculinity norms of self-reliance may ask for help under certain conditions. Mahlaik (2003) states that it is precisely this sort of within-person and across-situation variability that needs to be understood if therapists are to adequately understand and facilitate adaptive help seeking.

CHAPTER THREE: GENDER ROLE CONFLICT, THE MALE THERAPIST AND THE HOMOSEXUAL CLIENT

Men, whether they are sexually attracted to males, females, or both, grow up influenced by powerful beliefs about how to be a man, Schwaartzberg & Rosenberg (1995). This can present challenges for the therapist when it comes to the gay client. This does not occur because of what the client is presenting per se, but because of the client's sexual orientation and what it represents for the therapist. He too has been socialised just like every male in society and part of this socialisation may have incorporated beliefs that a gay man today represents a lesser man compared to his heterosexual counterpart. In the film *Analyse This*, Billy Crystal plays the therapist to local hard man, Italian American mobster, Robert De Niro. De Niro presents to Crystal as someone who is coming to therapy on behalf of his friend. It transpires very quickly that the friend is a fictitious character and the client is in fact De Niro. De Niro is somewhat elated when Crystal realises that he is the client and feels already that a weight has been lifted of his shoulders. However, De Niro is also concerned of what this expressive wave of emotion means for him as man and relays to Crystal, 'Listen to me, if I talk to you and it turns me into a fag, I'll kill you. You understand?'. There is so much in that scene that De Niro reflects in relation to Gender Role Conflict (GRC), the stigma of a man going to therapy, defensiveness, therapy as homophobia and a heterosexual threat and the brief period of the lack of restrictive emotionality (RE). This is all encompassing for De Niro. A very short dialogue in relation to how he feels has stripped him of his identity and made him take into question or threaten his sexuality. One may posit that this is ludicrous when looked at logically, but this is the scenario for a lot of men including the male therapist and the male client experience today. De Niro's thought process must have gone like this - expressing your feelings is not masculine, its feminine. Feminine qualities are related to the homosexual male, then one must be or there is the threat of appearing, homosexual.

Mahalik (1999) states that men are socialised to believe that sexuality must be heterosexual, and they must fear and humiliate homosexuals. Socialised to be wary of friendly male overtures, many men avoid the expression of tender feelings toward the males they care for and stay away from being very personal with other men. The therapy setting is seen as the complete opposite of these values. It is a caring space which enables the client to become personal with the therapist. If the therapist, despite his training and experience, adheres to elements of these so-called values this can disrupt the therapeutic process for the gay client. Ettkin (1981) relays that no matter how much a male therapist may feel that he has gone beyond the traditional limits of gender-role stereotypes, the therapist is still part of the culture and is directly and indirectly influenced by it. Solomon (1982) states that if this the case for the male therapist, within the therapeutic space he may either avoid certain role behaviours and conflicts in the gay client, deal with them in some stereotyped or superficial way, or behave in some non-therapeutic way because of his own anxiety. For example, Wish and Mahalik (1999) found that male therapists exhibiting RE and RABBM reported less empathy toward gay men, assigned gay clients more pathological and questionable diagnoses, and had less desire to work with them within the therapy space. They concluded that the beliefs, attitudes and values associated with GRC patterns triggered countertransference reactions that interfered with the appropriate conduction of psychotherapy with gay male clients. Isparo (1986), notes that RE can plague the male therapist and that he may find it quite difficult to show some warmth and caring to another man. The male therapist then, he states, is more likely to take corrective action instead of acknowledging and sharing the experience of the gay male client. He is more likely to deal with the situation cognitively rather than sit with the client's feelings and expressing empathy towards him.

Ipsaro (1986) and Mintz and O'Neil (1990) further this hypothesis. They are of the belief that the therapist's level of RABBM should affect clinical bias as a function of the male client's sexual orientation. They illustrate this by giving the example of the homosexual male client. Because of the homophobia associated with RABBM, male therapists may find it difficult to show concern or caring

for the homosexual male client and may attribute psychopathology to the client simply as a function of the therapists' feelings of discomfort. If one turns this around, the therapist who experiences RABBM is likely to more comfortable with the heterosexual male client. Hayes (1984), examined the relationship between gender role and therapists in training and their attitudes towards male clients who adopted non-traditional gender roles. She found that both male and female therapists who were higher in GRC expressed less liking for, less comfort with, and less willingness to counsel the non-traditional male client than did low gender role conflict therapists. These high GRC therapists in training also perceived the non-traditional male client as more maladjusted than did their low GRC counterparts. Hayes (1984) notes that the GRC factor of RABBM which she termed homophobia in the study, emerged as one of the most significant predictors.

Levant (1995) examined emotions of the male and how they take on different meaning when it comes to the sexual orientation of the client. He found that the pairing of the homosexual client with anger was correlated with negative reactions. That is, less liking of, empathy for, comfort with, and willingness to see the client by the therapist who experienced GRC on all three GRC factors. Thus, male client's anger, which is one of the few socially acceptable emotions is more accepted when coming from a heterosexual client and not a homosexual client. Mahilak (1998), found that when a homosexual client was paired with a therapist who was less rigid in expressing affection to other men there was more comfort with the client and a better prognosis for the client. However, it must be acknowledged that therapists who are low on the RE and RABBM scales may tend to underpathologise clients who violate traditional gender roles. Additionally, Mahilak (1998) hypothesised that because of this these therapists are more aware of the socio-political disadvantages associated with male homosexuality. He speculates that they may try to compensate for these deficits by minimizing the difficulty the homosexual client would have in addressing their presenting issues. This can result in an underpathologising bias. Cournoyer et al. (1998) note that emotion and homosexuality in a client appears to influence therapist judgements of that client. Specifically, the therapist with GRC issues appears to utilise the defensive style of 'turning against

object' in making clinical judgements about the client who violates traditional gender roles. Overall therapists who are high on the GRC scale need to be wary of overpathologising angry homosexual clients and, whereas therapists low on the gender role conflict scale need to be wary of underpathologising sad homosexual clients. The risk being that the client's sadness may be more than just be related to issues of their sexuality. Thus, as Wish and Mahalik (1999) note, male therapists would be well advised to examine their own countertrasferential issues in the context of gender related issues. Stemming from that, Lopez (1989) states that it is very important that both overpathologising and underpathologising are looked at equally as there is tendency in the research to focus more on the overpathologising of the client, neglecting the complementary effect.

In relation to the present research most of it seems to be focused on the therapeutic experience of the heterosexual male therapist and the gay male client. What differs in the dynamic when there is a gay male therapist and gay male client. Is there generally a preference from the gay client to have a gay therapist? Does self-disclosure from the gay therapist help with the therapeutic encounter? Cabaj (1991), states that gay men are reluctant to seek therapy, because they do not wish to be discriminated against for being gay; therefore, many seek gay male therapists hopefully to avoid the pitfalls of the socialised heterosexual male. Gay males can often feel so disconnected from others, they will often hope they can avoid overt homophobia and be able to develop trust, safety and openness with a gay therapist. Cornett (1993), notes that the key dynamic that brings a gay man to a psychotherapist's office is the internalisation of the rejection and devaluation he has experienced in the heterosexual culture. This internalisation thus invokes shame for the gay client and can result in feelings of self-loathing and overt self-contempt. Furthermore, this enforces that the most important element when it comes to the gay client in psychotherapy is affirming the client.

When it comes to affirming the gay client, an important element in the therapeutic process is self-disclosure. Self-disclosure can be somewhat of an obstacle for a therapist and generally within psychotherapy the rule is feel free to disclose about one's self but make it little and at the right time.

Coolhart (2005), states that therapists' self-disclosure can be beneficial to the gay male patient in many ways and can build therapeutic connections. In addition, benefits can include, clients will not feel betrayed if the therapist 'comes out' to the patient instead of the patient finding it out the therapists sexual orientation from another source; the therapist can relate to the patient who can also has been discriminated; the therapist can join the patient as the patient feels heard and understood thus the therapist becomes a role model. An obstacle for the gay client can be whereby a heterosexual therapist, not in touch with his own process and is high on the GRC scale can sometimes see the client's sexuality as possibly the root of some of their issues and is quick to assume this. According to Coolhart, a gay therapist self-disclosing can bring a wave of relief for the gay client. There may be a relief that they will not insist that their sexuality is at the core of every issue or ignore their sexuality altogether. This can help focus on the real problems at hand for the gay client. Goldstein (2001), states that a therapist using the theory of self-psychology responds to the patient with empathy to repair any disruptions in the treatment relationship. It is in this way; the response will be non-traumatic and growth enhancing. Masculinity and the gay client also pose a challenge, not just because of its confusing representation in our society and culture but because it is a very prominent issue for the gay man within the gay community itself. Mahon (2014) states that:

> examining GRC and masculinity with gay men can be perceived as a paradox. Gender and sexuality are two very separate entities, but they inextricably linked.

The gay client can perceive gender role in two ways. They can either be less affected by it due to the lack of conformity same sex attraction brings or they can either be very affected by it mainly due to their socialisation as a man beginning in childhood and continuing into adulthood. There may be acceptance in being a gay man by the gay client but due to, for example, an upbringing by a high GRC father, they may believe that the only acceptable type of gay man is a gay man who is traditionally masculine. That is, a gay man who does not appear camp or effeminate. Historically, especially in the sixties and seventies, the gay man who came in all different shapes and sizes were accepted within the community. The AIDS crisis in the early eighties brought about a change in this

level of acceptance. Signorile (1997) believed that the HIV/Aids epidemic perpetuated the emphasis on masculinity – especially through body building – because gay men wanted to deflect the sick and weak image associated with the disease. Bailey (1996), proposed that because most gay men find effeminate men unattractive, many gay men behave in rigidly masculine ways in order to feel desirable to other gay men and to attract masculine men. Szymanski et al. (2008) hypothised that gay men who are concerned with masculinity are internally homophobic or have internalised heterosexist attitudes. Schwartzberg and Rosenberg (1998), believe that gay men who bear great shame regarding their sexuality express strong discomfort with effeminate gay men, projecting on to them their own fears of female identification. Furthermore, this resulted in a rejection of femininity from within the gay community. Edwards (2004), stated that hyper masculinity or 'straight-acting' became the revered and with this the retention of rigid gender roles, and possibly greater levels of GRC, seen through body shape, dress code and emotional restriction. The term *masc for masc* has become a prominent feature within the gay dating community, whereby gay men who identify with being masculine or straight-acting, their preference would be a partner who also conformed or embodied these labels. Sanchez et al. (2010) state that for now gay men's focus on masculinity will continue to stir controversy within the gay community – especially as research is starting to support the long-held belief articulated by Harvey Fierstein that self-proclaimed 'straight acting' gay men may be 'self-loathing'. Likewise, Haldeman (2006) noted that it has been observed that a gay man's tolerance of his effeminate gay brothers is actually a barometer of his own security.

CONCLUSION:

The current study aimed to examine how gender role conflict and masculinity affect the therapeutic process for the male therapist and the male client. It was hypothesised that both these factors caused somewhat of a negative outcome for the success of the therapeutic process. Upon one's examination of the literature available this hypothesis was supported. Male therapists therapeutic bias was caused by not examining their GRC correctly and acknowledging the role it played when serving the male client. This in turn lead to an unsuccessful outcome for the processes of both the therapist and the client. Furthermore, it was posited that this was especially detrimental for trainee therapists, who upon not looking inward at such an important stage of their training would have a knock-on effect when establishing themselves as a therapist. The importance of finding a balance must be acknowledged when it comes to male trainees. Being aware of their socialisation combined with understanding the reality of their gender privileges can facilitate this. It was hypothised that high GRC would do the homosexual client a great deal of injustice as a therapist who is high on this scale would be unable to meet the client within the therapeutic space. This is reflected in the literature especially when the male therapist is high on the RABBM scale. However, it must be acknowledged that quite a substantial amount of the research focuses solely on the white western male. It is noted that the research is lacking, and more research needs to be completed on a multicultural level. In addition, the research is also lacking when it comes to gay men's experience with masculinity. It is only in its infancy despite playing such an important role when it comes to the socialisation of both the heterosexual male and the homosexual male.

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