

Therapy: Not a Man's World

A qualitative study of the influence of male gender role conflict on male therapists and their work with clients

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Abstract

The study of Male Gender Role Conflict (MGRC) has emerged relatively recently as a distinct research area in Psychotherapy and Psychology. Gender Role Conflict (GRC) is defined as a psychological state in which socialized gender roles have negative consequences for the individual or others. GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self. Very little has been researched to date on the impact of MGRC among male therapists specifically, and this forms the basis of the study. The study sets out to research qualitatively, the influence of MGRC on male therapists, and its impact on their work with clients in therapy. Established concepts and patterns of MGRC were used to frame the research questions. Semi-structured interviews were conducted with five individual male therapists in the Greater Dublin Area. The interviews were analysed using qualitative thematic analysis. The study showed that MGRC was an influential factor on male therapists' and their work, particularly with regards to their experience of failure in therapy, the experience of strong emotions with clients in therapy, and their interaction with male clients. Failure could spillover from the professional into the personal; strong and intense client-emotions in certain circumstances could negatively impact therapists and cause or exacerbate emotional restrictiveness; masculine ideology and identity could be threatened by a fear of the feminine and this was reflected in client preference and experience; overall, the potential incongruence between masculine norms and psychotherapy practice were highlighted.

Note: the terms 'MGRC' and 'GRC' are used interchangeably throughout the thesis but denote one and the same concept.

Chapter 1

1.1 Introduction

The study of men's masculinity and gender roles received relatively little scientific attention in the psychology literature up to the 1980's. A special issue of *The Counseling Psychologist* (1978), titled *Counseling Men*, introduced men's issues to Counseling Psychology, the goal being to 'contribute to understanding male roles and the ways human services professionals can promote the growth of men' (Skovholt et al., 1978, p. 2). Up to this point, very little was known about how men's gender role socialization contributes to their psychological and emotional problems. Over the past three decades however, slowly but systemically, men's studies and the psychology of men have emerged as important areas for scientific inquiry and clinical intervention (Addis & Mahalik, 2003; Englar-Carlson & Stevens, 2006; Kilmartin, 2007; Liu, 2005; O'Neil, 1981a, 1981b, 1982; O'Neil, Good, & Holmes, 1995; Pleck, 1981, 1995; Wade & Gelso, 1998).

In 1981, O'Neil first presented a conceptual model of how men's psychological problems are related to masculine gender role conflicts (O'Neil, 1981a). It was hypothesized that men are oppressed by rigid gender role socialization processes that limit them from being fully functioning human beings (Ibid, p.431). The model firmly established men's gender role conflict (GRC) as a research and clinical area in Counseling Psychology (Betz & Fitzgerald, 1993; Enns, 2000). Later on, O'Neil developed the Gender Role Conflict Scale (O'Neil et al, 1986), which was capable of measuring GRC for the first time. Using the scale, he collected data through 232 empirical studies, which investigated GRC and its impact on men's lives, including the intrapersonal, interpersonal and therapeutic dimensions. Despite this, and the other studies mentioned above, O'Neil opines that 'men's internal experience of their masculinity has been inadequately explained in the psychological literature to date' (O'Neil, 2008, p. 403).

Skovholt et al's original call to the research community for greater understanding of

male roles, particularly in the context of ‘human service professionals’, did lead to a burgeoning of more expansive work in the field, however much remains to be done. Little research has assessed how GRC relates to men’s friendships and relationships with other men (O’Neil, 2008, p.403), or the impact of GRC in the therapeutic setting as experienced by therapists (rather than clients). Moreover, clinically oriented researchers suggest that the culture of therapy is often incongruent with men’s masculinity ideology (Rochlen, 2005) and this can significantly influence both the incidence of male therapists, and their experience as therapists. Such gaps in the research provide ample scope to parse and explore male gender role conflict (GRC) among male therapists specifically, and its influence on their work with clients in therapy.

1.2 Literature Review

Much of the research carried out in the area of GRC has been quantitative in nature, and this is outlined and reviewed below. There has been little research on male gender role conflict (GRC) among male therapists and therefore its influence on their work with clients has not been assessed very much. This presents an opportunity in the area for a qualitative approach to studying the influence of MGRC on male therapists, and its impact on therapy work with clients, particularly given the multi-faceted nature of the therapist’s role, and the many nuances of the therapeutic relationship including conscious and unconscious, and verbalised and non-verbalised phenomena.

1.2.1 Male Gender Role Conflict Defined

Pleck (1995) referred to the traditional man as one who endorses the ‘masculinity ideology’ (p.19), namely that men should have gender-specific characteristics (Thompson & Pleck, 1995). These characteristics come from an interaction of environmental and biological factors according to O’Neil (2008). Values and roles are learned in early childhood where gender role identity is fostered by parents, peers and societal norms and mores. This promotes certain masculine values such as the *masculine mystique*, ‘a developmental process under which boys acquire gender role characteristics that can lead to psychological distress if used in situations that require less gender type behaviours’ (Wester et al., 2005, p.195) Coupled with this

phenomenon, the fear of femininity, a fear of possessing or expressing ideals, stances or actions that are stereotypically associated with appearing feminine, is also a predominant influence on the developing child's psyche and sense of self. The cumulative pressure to reinforce masculine behaviour coupled with that of downplaying what might be perceived as feminine, produces a psychological conflict for the individual if he is not abiding by societal expectations.

O'Neil's (1981a) seminal work also indicated that GRC significantly relates to men's psychological problems, is experienced in an interpersonal context, and has relevance for men's home and family life (p. 76). Following greater expansion in the field of enquiry, Male GRC was subsequently defined as a psychological state in which socialized gender roles have negative consequences for the individual or others (O'Neil et al., 1995, p.166). It affects men cognitively – their thoughts about gender roles, stereotypes, homophobia, anti-gay positions and attitudes towards women; affectively – men's feelings about gender roles which correlate with increased reports of depression, anxiety, homonegativity, anger, low self-esteem and negative identity; unconsciously – how gender role dynamics beyond our awareness affect behaviour and produce conflicts; and behaviourally – acting, responding and interacting with others (Ibid, pp.166-170). GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self (Ibid, p.172). The ultimate outcome of GRC is the restriction of a person's human potential or the restriction of another person's potential.

1.2.2 Patterns of GRC

There are four empirically derived patterns of GRC, namely, Success, Power and Competition issues (SPC); Restrictive Emotionality (RE); Restrictive Affectionate Behavior Between Men (RABBM); and Conflict Between Work and Family Relations (CBWFR) (O'Neil et al., 1986; O'Neil, 1981a, 1981b, 1982). SPC describes personal attitudes about success pursued through competition and power. RE is defined as having restrictions and fears about expressing one's feelings as well as restrictions in finding words to express basic emotions. RABBM represents restrictions in expressing one's feelings and thoughts with other men and difficulty

touching other men¹. The final factor, CBWFR reflects experiencing restrictions in balancing work, school, and family relations resulting in health problems, overwork, stress, and a lack of leisure and relaxation.

1.2.3 Gender Role Conflict and its affects

In order to better understand the relationship between ‘the environmental and biological factors’ underpinning GRC and how that translates for the individual into lived values and roles, it will be important to explore and expand upon the psychological and emotional correlates of GRC. This includes exploring the impact on the individual of not conforming to or endorsing gender role stereotypes and expectations.

O’Neil (2008) asserts, ‘the personal experience of GRC constitutes the negative consequences of conforming to, deviating from, or violating the gender role norms of masculine ideology’ (p.363). These intrapersonal experiences are defined as: devaluations – negative appraisals of self or others causing lower self regard such as shame, low self-esteem, depression and homo-negativity; restrictions – limiting oneself or others to stereotypic norms of masculinity ideology or controlling people’s behaviour highlighting depression, problems with intimacy, alexithymia and self disclosure, especially around sex and sexuality; and violations – being harmed by others or by oneself when veering from or agreeing to the gender role norms of masculinity ideology, or causing psychological and physical pain (Ibid, pp. 363-365).

1.2.4 Intrapersonal Experience of GRC

There has been significant research carried out to date as to how men experience GRC (SPC, RE, RABBM, and CBWFR) as an intrapersonal reality. Mahalik (1999a, 2001a) and O’Neil & Nadeau (1999) contend that GRC is the result of distorted gender role schemas in that it affects men’s psychological wellbeing through negative social feedback and internalized, unconstructive self-judgements. Pivotal life stages and transitions such as early development and starting school, puberty and adolescence, embarking on a committed relationship, the death of a parent, the birth

¹ For the purposes of this study, the concept of ‘difficulty touching other men’ was disregarded. Given the existence and enforcement of boundaries in psychotherapy practice, physical contact is considered inappropriate, and so therapists do not enjoy a free choice regarding this phenomenon

of a son or daughter etc., can form, challenge or alter our gender role assumptions. In doing so they may also change our gender identity and create conflict if our personal reactions or modified beliefs and behaviours diverge from the societal norm. The research to date has been carried out in the following related areas:

Depression, anxiety, stress, and psychological wellbeing

In the late 1990s, men's depression finally emerged as a talking point in society and psychology. Biases about men's emotions (Heesacker et al., 1999) are probably the reason that no major works were written on men and depression until the late 1990s. Recently, both popular and scholarly books in the psychology of men have discussed men's depression (Josephson & Whiffen, 2007; Cochran & Rabinowitz, 2000; Lynch & Kilmartin, 1999; Real, 1997). The overall evidence indicates that GRC is significantly related to men's anxieties and stress. Anxiety, stress, and men's gender roles have been conceptually linked because fears about meeting masculinity norms can be stressful (O'Neil, 2008, p.383). There is also initial evidence that GRC and poor psychological wellbeing are related (O'Neil, 2008, p. 384). GRC has been defined as the opposite of psychological wellbeing because restrictive gender roles result in devaluations, restrictions, and violations of the man and others (O'Neil, 1990; O'Neil et al., 1995). GRC has implications for men's ability and willingness to form intimate relationships (Fischer & Good, 1997). Self-destructiveness, hopelessness and suicide are often the result of the inability to express emotions (Naranjo, 2001; Birthistle, 1999; Brewer, 1998).

Self-esteem, alexithymia, shame, and personality

Self-esteem is a positive impression of oneself that includes self-respect and positive self-regard. Men carefully conceal not feeling good about themselves because it can threaten their power in relationships and at work. Low self-esteem has been hypothesized as a negative outcome of GRC and gender role strain (O'Neil, 1981a; Pleck, 1995, p.13). Connected to this is the phenomenon of alexithymia (the inability to describe one's feelings with words), which is also significantly related to GRC (Berger et al., 2005; Shepard, 2002; Eicken, 2003; Fischer & Good, 1997). Certain studies have assessed GRC's relationship to shame (Thomson, 2005; McMahon, Winkel, & Luthar, 2000; Segalla, 1996; Thompkins & Rando, 2003). In these studies,

all the patterns of GRC significantly correlated with shame, with RE and CBWFR being the most strongly correlated. GRC has also been significantly correlated with personality, specifically styles of neuroticism, introversion, extraversion, openness, agreeableness, aggressiveness, narcissism, and dependency (Cortese, 2003; Schwartz, Buboltz, et al., 2004).

Other studies on men's internal functioning

Other important areas of GRC have been investigated but with fewer studies than those mentioned in the previous sections. Some studies found that either RE, RABBM, and SPC were significantly related to problematic coping methods (Bergen, 1997; Birthistle, 1999; Jones, 1998; Stanzione, 2005; Strom, 2004). These results imply that men's GRC is related to dysfunctional ways of coping, but exactly how this occurs is unclear from the research. Studies have also assessed GRC's relationship to self-destructiveness, hopelessness, and suicide. RE has significantly predicted men's chronic self-destructiveness (Naranjo, 2001) and hopelessness (Birthistle, 1999; Brewer, 1998), implying that unexpressed emotion may have severe negative outcomes. Collectively, these studies on men's internal functioning indicate that GRC is significantly correlated with numerous psychological problems for men. This expands our understanding of men's internal experience of GRC and moves us beyond the purely psychodynamic explanations of men's problems described decades ago (Adler, 1936; Boehm, 1930; Freud, 1937; Horney, 1932). The research indicates that GRC is related to depression, anxiety, low self-esteem, stress, and many other psychological experiences that can have a negative impact on men's lives.

1.2.5 Interpersonal Experience of GRC

The unconstructive thoughts and emotions associated with GRC (Mahalik, 1999a, 2001a; O'Neil & Nadeau, 1999) may often be assimilated interpersonally, allowing restriction of poor gender role socialization to affect men's relationships with others. Men's GRC has been hypothesized to negatively impact others (J. A. Hayes & Mahalik, 2000; O'Neil, 1981a, 1981b, 1982; O'Neil & Egan, 1993; Pleck, 1995) and contribute to problems such as poor parenting, marital conflicts, homophobia, antigay attitudes, sexual harassment, and violence toward women (O'Neil & Nadeau, 1999). It can also negatively affect overall interpersonal functioning, attachment, relationship

satisfaction, family dynamics, men's intimacy, self-disclosure, male friendship, and men's sexual violence towards women. The research in this area relevant to the current study is outlined below:

Overall inter-personal functioning and attachment

Interpersonal aggressive behaviour and communication (Mahalik, 2000) and problems with intimacy and sociability (Bruch et al., 1998; Sharpe et al., 1995; Berko, 1994) have been associated with GRC. O'Neil (2008) cites that GRC relates to problems with attachment, separation, individualization, dis-identification, and conflictual independence. GRC and attachment style (Cachia, 2001; Selby, 1999), and identity development (Napolitano et al., 1999), have been well documented and re-enforce Blazina & Watkins (2000) view that as GRC increases, so to do the problems of attachment and separation.

Men's intimacy, self-disclosure, and friendships

Men struggle with intimacy and self-disclosure with women and other men because of their gender role socialization. GRC has been hypothesized to restrict men's intimacy, self-disclosure, and male friendships (O'Neil, 2008, p.343). Studies have found a negative relationship between intimacy and GRC for both college age and adult men (Chartier & Arnold, 1985; Cournoyer & Mahalik, 1995; Fisher & Good, 1997; Good et al., 1995; Lindley & Schwartz, 2006; Sharpe et al., 1995; Sharpe & Heppner, 1991; Van Hyfte & Rabinowitz, 2001). Few if any studies explain how conforming to or deviating from masculine norms produces GRC in relationships, however, given the research quoted above in associated areas we can extrapolate how men struggle with such issues with women and other men because of their gender role socialization (O'Neil, 2008) and how GRC accentuates restrictions vis á vis intimacy and self-expression in relationships with other men. Berko (1994) confirms that high levels of GRC correlate with lower levels of self-disclosure. Lower RE and CBWFR have significantly predicted greater self-disclosure (Swenson, 1998). RABBM has been significantly correlated with unexpressive behavior (Horhoruw, 1991), and RE, RABBM, and SPC have been significantly related to American men's lack of intimacy and male friendship (Sileo, 1996). From the results of these initial studies, GRC significantly relates to men's lack of intimacy, self-expressions, and connection

with other men. According to O'Neil (2008), though more quantitative research is required in this area, well-designed qualitative research may also uncover the complexity of the interpersonal dynamics of GRC (p.349).

Stereotyping, attitudes toward women, egalitarianism, men's interpersonal and sexual violence toward women

Stereotypes and attitudes towards the opposite sex correlate with GRC (Blazina & Watkins, 2000; Heesacker et al., 1999). GRC has been associated with sexually aggressive behaviours (Kaplan 1992), abusive behaviours and coercion (Schwartz et al., 1998), hostility towards women (Rando et al., 1998) and self-reported violence and aggression (Amato, 2006; Chase, 2000). Studies imply that GRC is significantly related to thoughts, attitudes and behaviours that are abusive and violent towards women (O'Neil, 2008). The overall results indicate that GRC significantly relates to dysfunctional patterns in men's relationships, including interpersonal restrictions, attachment problems, and marital dissatisfaction.

At the present time, few studies explain how GRC operates in male relationships with others, particularly primary, intimate relationships. No studies have assessed how men's GRC impacts other men. Neither does research fully explain how conforming to or deviating from masculine norms produces GRC in relationships. How the cognitive and emotional restrictions of GRC result in men's behavioral conflicts with others needs to be investigated. Many studies indicate that GRC is significantly related to attitudes that are dysfunctional, but only a few studies have correlated GRC with actual destructive or violent behavior toward others (Amato, 2006; Breiding, 2003, 2004; Breiding & Smith, 2002; Kaplan et al., 1993). According to O'Neil, though more quantitative research is required in this area, well-designed qualitative research may also uncover the complexity of the interpersonal dynamics of GRC.

1.2.6 Gender Role Conflict and its impact on therapy

GRC and its implications for therapy work is a key consideration of this research. I have already acknowledged how GRC affects the individual male's psychological wellbeing, how GRC is significantly correlated with numerous psychological problems for men, and also that GRC significantly relates to dysfunctional patterns in

men's relationships with others. In the context of the therapeutic process, there can often be a different power relationship and changed levels of control, which can alter and indeed threaten male identity and the masculinity ideology.

The impact of GRC in the therapy room has been researched extensively however the primary focus heretofore has been on the experience of male clients, and not the therapist. In fact there are only a few studies carried out on GRC in the therapeutic process placing the primary focus on the therapist, his GRC levels and how they affect therapy work. Therapists' GRC and their clinical judgments of male clients have been studied in two studies (M. M. Hayes, 1985; Wisch & Mahalik, 1999). Therapists with high RABBM reported significantly less liking of male clients, less empathy with nontraditional male clients, and more maladjustment for nontraditional male clients (M. M. Hayes, 1985). Therapists reporting SPC and RABBM had significantly less liking for, empathy with, and comfort with male clients and were less willing to see clients who were homosexuals, or who were angry, but not sad (Wisch & Mahalik, 1999). Furthermore, therapists with significantly less RABBM were more comfortable seeing a homosexual client and reported better prognosis for him in therapy. In both of these studies, RABBM related to therapists' feelings and thoughts about clients who were nontraditional or homosexual. These studies suggest that training may be necessary to help some therapists resolve their RABBM and biases about men who deviate from masculinity ideology. In a more general context, proposals for working therapeutically have been mentioned (Rochlen, 2005; Blazina, 2001; Mahalik, 1999a, 1999b) recommending that GRC be used as a construct within the therapeutic process.

Despite the fact that there is a significant imbalance between the amount of research work carried out on GRC in the therapeutic setting, from a client rather than a therapist perspective, the disposition, attitudes and beliefs of clients regarding therapy, and their levels of GRC is nonetheless an important context to the overall phenomena of GRC in therapy, particularly as transmitted through transference and counter-transference between client and therapist. Studies have assessed GRC's relationship to men's defenses, treatment fearfulness, perceptions of counselors, expectations about counseling, and therapy supervision (Englar-Carlson, 2001; Englar-Carlson & Vandiver, 2001; Schaub & Williams, 2007; Wester, Vogel, &

Archer, 2004; Wisch, Mahalik, Hayes, & Nutt, 1995). A study assessing GRC's relationship to men's psychological defenses found that SPC, RE, and RABBM were significantly related to immature and neurotic defenses (projection, denial, and isolation) and that men who reported SPC and RE reported defenses that are turned against others (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998). GRC has also significantly predicted treatment fearfulness (Englar-Carlson & Vandiver, 2001), and men with higher GRC have rated counselors as significantly less expert and trustworthy (Wisch et al., 1995). GRC has also been found to significantly relate to men's expectations about counseling. Men who reported RE, RABBM, and SPC had significantly higher expectations that counselors would be an expert therapist and lower expectations of taking responsibility during the counseling process (Schaub & Williams, 2007). In one of the only studies on supervisory relationships and GRC, male supervisees who reported high RE reported significantly lower self-efficacy as counselors than supervisees with low RE (Wester et al., 2004).

According to O'Neil (2008), assessment of clients', therapists', and supervisees' GRC should be a fertile area for future clinical research (p.399). Heppner (1995) and Enns (2000) both recommend more expansive qualitative research thrusts for GRC, including in the area of therapeutic work. As the final part of the triad of primary enquiry of this research, these themes will be integrated into the study with specific focus on how GRC is experienced by male psychotherapists in themselves and during the process of their therapeutic work.

1.3 Aims & Objectives

This research aims to provide a description of the nature and extent of Male Gender Role Conflict (GRC) amongst male psychotherapists i.e. how do male psychotherapists experience certain aspects of GRC, and how does this impact on their experience and work in therapy?

This will include:

- 1) identifying and understanding patterns of Male Gender Role Conflict in male therapists, to include where relevant elements such as Success, Power and Competition Issues (SPC), Restrictive Emotionality (RE), Restrictive and

Affectionate Behaviour Between Men (RABBM), and Conflicts Between Work and Family Relations (CBWFR), are present

2) determining how male therapists experience GRC in themselves with clients in therapy, including experiences of anger, anxiety, depression, stress, sadness, hopelessness, low self-esteem, shame, and many other psychological experiences that can have a negative impact on their lives

3) exploring how this influences male therapists' attitudes and behaviour in the therapy room, and how it may positively or negatively impact their relationship and work with clients

Chapter 2

2.1 Methodological Approach

Taking into account the manifold studies mentioned in the literature review, which have assessed the nature and extent of Male Gender Role Conflict amongst various male groups and population samples, this study focussed in on the specific demographic of male therapists, and the possible influences of GRC on them and their work. McLeod (1998) defines qualitative research as ‘a process of systematic inquiry into the meanings which people employ to make sense of their experience and guide their actions’ (p.78). He continues, ‘the fundamental goal of qualitative investigation is to uncover and illuminate what things mean to people’ (Ibid, p. 78). Using a qualitative approach for this research enabled me to gain a greater understanding of the influence of Male GRC on therapists and their work with clients in therapy, and as outlined by McLeod, to ‘study real-world phenomena... with a sense of openness regarding whatever emerges’ (p.84).

I had originally envisaged taking a quantitative approach in the study, and indeed had communicated with Professor Jim O’Neil of the University of Connecticut who granted me permission to use his Gender Role Conflict Scale (O’Neil et al, 1986), for the purposes of sampling Irish male therapists. However, I later came to the conclusion that while quantitative research would provide an empirical snapshot of MGRC among male therapists as a representative group or sample, it would not reflect the centrality and primacy of their roles as therapists and their work in the field of psychotherapy; neither would it provide me with the flexibility and scope that I wanted with such a niche group, and in such a complex and multi-faceted area as therapy work, where there might well be subtle variances in meaning across the study. Furthermore, from a practical viewpoint, the total number of male psychotherapists registered with a professional body and based in the Greater Dublin Area is less than two hundred in total, and the logistics of capturing a sufficient sample from that population would have proven difficult.

The current research explored how MGRC is experienced by male therapists, its impact on them and their work in therapy. As a starting point, questions were devised

broadly in line with the theoretical sub-patterns of MGRC namely, Restrictive Emotionality (RE), Restrictive Affectionate Behavior Between Men (RABBM), Success, Power and Competition issues (SPC), and Conflicts Between Work and Family Relations (CBWFR) (O'Neil et al., 1986; O'Neil, 1981a, 1981b, 1982). Following further consultation with my supervisor, thesis class lecturer, and the carrying out of a pilot interview two weeks before the formal interviews commenced (see section 2.3 Recruitment), the draft interview questions were revised and reduced in number. Questions relating to males therapists' experience in therapy with clients were asked, including questions about the experience of success, failure, power and competition. Questions were asked regarding the impact and intensity of emotions expressed in therapy such as anger, sadness, anxiety, and erotic transference. Questions regarding male therapists' experience of male and female clients respectively were also asked, including attitudes towards nontraditional clients, and comfort levels with male clients. Finally, questions regarding the impact of therapy on male therapists' personal, family and leisure life were also discussed (See Appendix A).

2.2 Participants

The study was based on qualitative in-depth interviews with male psychotherapists based in the Greater Dublin Area of Ireland. The common criteria for all participants was that they had at least three year's experience in general counselling and psychotherapy practice, were currently in practice, and were registered with either the Irish Association for Counselling and Psychotherapy (IACP) or the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP) or both. The research comprised of five participants, which allows for further research in the area into the future. A brief description of each participant is given in section 3.1 *Introduction to the main themes of the study*.

2.3 Recruitment

The psychotherapists were recruited from a comprehensive list of accredited IACP and IAHIP male practitioners. An initial email was issued to all male therapists in the greater Dublin area, inviting participation in the study and explaining the context, focus and nature of the research, its intended purposes, and including confidentiality

and ethical safeguards. The selection process was purposive in order to meet the aim of identifying a broad range of psychotherapists where there is a mix of age, length of experience in psychotherapy, therapy background / specializations e.g. gestalt, body psychotherapy, psychosynthesis etc., and their stated focus in therapy work e.g. general counselling, anger management issues, grief/loss issues, depression/anxiety etc. These details were all available through their respective accrediting bodies' websites and in some cases, on their own website pages.

Following the receipt of twelve responses initially, I selected six male therapists, one as a standby in the event that any one participant became unavailable, and proceeded to initiate a brief telephone conversation with each prospective interviewee, to introduce myself personally, notify them that they were chosen to be involved in the research and alert them to the next stage which was to send them out an information and consent form to be agreed and signed in advance of the interviews (See Appendix B). Following the initial series of phone calls, and on issue of the information and consent form, one therapist decided to decline participating in the research, citing work reasons, and another telephoned me to opt out, saying that on reflection, 'this wasn't for him'. I contacted the 'standby' interviewee and another therapist from the original list of twelve who had expressed interest, in order to fulfil the required number of five interviewees. These two new participants were afforded the same communications and notices as the original set of interviewees.

I also carried out an initial pilot interview two weeks prior to the main interviews, with a male therapist whom I don't know personally but who was referred to me through a professional acquaintance. Following this interview I was able to edit the overall number, content and length of the interview questions, and gain practice and insight into the kind of dynamic I might expect doing the main study interviews. One key insight from this pilot interview was that my questions were originally too numerous for the timescale allowed, overly long and complex, which caused some confusion or requests to repeat the question again, and were not open-ended enough to provide ample scope for the interviewee to respond freely and without undue influence from the interviewer (See Appendix A for list of interview questions).

2.4 Ethics

I had a moral obligation to strictly consider the rights of the participants who were expected to provide information and knowledge, often of a personal and sensitive nature (Streubert & Carpenter 1999, p.44). I also considered it very important to establish trust between the interviewees and myself and to respect them as autonomous beings thus enabling them to make sound decisions (Ibid, p. 44). Following clarification of the final group of prospective interviewees, a personalised email was sent to each participant confirming their participation. An information sheet / consent form was attached requiring their signed consent to be interviewed (See Appendix B). The information sheet ensured that their consent was based on full knowledge of all material matters including the subject matter and purpose of the research, who was undertaking it, why it was being undertaken, funding sources and intentions regarding dissemination. The participants were assured of their right to withdraw from the research at any time and for any reason. Confidentiality of the information was highlighted, including procedures whereby the researcher would use appropriate and practicable methods for preserving the anonymity of data. Such methods included the removal of identifiers or the use of pseudonyms. The researcher undertook to prevent data from being published or released in a form which would permit the identification of the participants. The study selection process did not involve participants who belong to a vulnerable group, however, given the sensitive and confidential nature of therapists' work, and in order to protect the privacy of their clients, the researcher insisted prior to interviews that participants adhere to their accrediting bodies' protocols and procedures in the area of ethical standards and confidentiality.

At the beginning of each interview I encouraged the participants to read the Information Sheet carefully and drew their attention to the key points therein. I invited them to ask me questions concerning any aspect of my study, or the interview process. I made it clear that if they wished to change their minds, at any time, either before or during the interview, they were free to do so. In relation to confidentiality, the participants were told that all the interviews were confidential but with the same exceptions pertaining to both IACP and IAHIP psychotherapy codes of practice; that the resulting interview transcripts would be locked in a filing cabinet;

that each participant would be given a code number to ensure that I would be the only person who could identify the interviewee. I told them that the audio recordings of the sessions would be destroyed once a transcript was created. I made them aware that notes from the interviews might be saved, for the purpose of future research, but in that case the same level of confidentiality would apply to the storage and use of materials. Five years after the completion of this thesis all data will be deleted from hard drives and hard copies will be shredded. I included my own contact details and that of my supervisor for further clarification for the participants. Each participant was then asked to sign the Information and Consent Form stating that they had read it and agreed with its contents.

2.5 Semi-Structured Interviews

The method chosen for gathering data was through semi-structured interviews to allow for examination of each participant's individual experience of MGRC and the exploration of their personal experience and therapy-work contexts. McLeod (1998) stresses that the qualitative interviewer must pay attention not only to what the interviewee says, but also to how it is said, 'The interviewer must also be aware of non-verbal signs such as gestures, facial expressions and tone of voice' (p.124). Semi-structured interviews enabled me to have a certain amount of control over the questions asked while at the same time allowing the participants a certain freedom in their responses. The interviews were concentrated on themes rather than being rigidly designed. Open-ended questions were used to provide participants with 'ample opportunity to express their feelings' and 'to respond in their own words' (Polit & Hungler, 1999, p.334). The interview sessions were digitally-recorded. Each interview lasted approximately fifty minutes.

'The goal of any qualitative research interview is... to see the research topic from the perspective of the interviewee, and to understand how and why they come to have this particular perspective' (Cassell & Symon, 2006, p.11). In order to further facilitate my understanding of each therapist's perspective, prior to each interview, I completed a brief, discretionary questionnaire with each interviewee which provided some further information about their precise accreditation, therapy school of origin, length of practice/service, age, nature of client base, psychotherapy specializations and focus of work (See Appendix C). These details were helpful in getting a better context and

insight about the individual therapist and updating any previous information gleaned from their given online details.

2.6 Thematic Analysis

Braun and Clarke's (2006) thematic analysis technique was used: 'Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data' (p. 79). Having completed the five interviews with male psychotherapists I transcribed them verbatim. The somewhat time-consuming process of transcribing, together with repeated readings of the text, enabled me to get to know the data in detail. Even though the research questions were influenced by MGRC theory, I began the analysis by using open coding in which I created categories that emerged from the dataset (Gibson, 2006). Again, although they were directed by the research questions, the codes themselves were not predetermined (Maguire & Delahunt, 2009). Once I had combined the transcripts of all the interviews, I inserted a column to the right of the transcript, where I was able to code aspects of the data, which I felt were note-worthy and relevant. This column enabled me to keep track of where, in the transcript, these codes occurred and how frequently they featured in the different interviews. Having coded the data I assigned separate colours to the codes in order to match the relevant codes with the relevant themes as I developed them.

I chose my themes because they described 'the bulk of the data' (Joffe, 2012, p.219), and occurred consistently throughout all the interviews as opposed to just occurring in one particular interview (Braun & Clark, 2006, p.86). I reconsidered my themes a number of times, and eventually decided to confine myself to three, because I felt that these three themes, could easily incorporate a number of sub-themes, which would in turn, easily encompass the coded data selected. In arriving at my findings and conclusions I took an 'essentialist approach' to my analysis which enabled me to include the language and experience of the therapists as articulated by them (Braun & Clark, 2006, p.112).

2.7 Adequacy and Trustworthiness

Streubert and Carpenter (1999) describe trustworthiness as, 'establishing credibility and reliability of qualitative research' (p.333). Qualitative research is trustworthy when it accurately represents the experience of the study participants. Trustworthiness

of data is demonstrated through the researcher's attention to and confirmation of information discovery. This is referred to as 'rigour'. The goal of rigour is to accurately represent the study participants' experiences (Ibid, p.28). The trustworthiness of this study was promoted through ensuring credibility of the data collection and analysis process. Credibility is demonstrated when participants recognise the reported research findings as their own experiences (Ibid, p.330). Activities increasing the probability that credible findings were produced in this study included prolonged engagement; persistent observation; triangulation, peer debriefing and case analysis (Lincoln & Guba, 1985, pp.290-330):

Prolonged Engagement

Given that over the past two years I have been working as a trainee (male) therapist in a centre with clients myself, and have also attended personal therapy as a (male) client, I had a significant grasp of the therapy environment and culture prior to embarking on the study; there was email communication with interviewees and preamble discussions about the subject matter and purpose of the study; the interview site visits themselves lasted more than one hour allowing sufficient exposure to the individual therapist's work situation and experience; and a friendly chat took place before and after each interview which gave me a greater sense of the person I was interviewing and greater interpersonal resonance.

Persistent Observation

This was facilitated through note taking during the interviews, identifying non-verbal communications from interviewees, and any relevant actions or behaviours connected with the study.

Triangulation

Triangulation of data was ensured by using the pilot interview two weeks prior to the main interviews to modify and inform subsequent interviews, and between the main interviews or 'sources' themselves.

Peer Debriefing

Peer Debriefing was possible through thesis supervision classes, where peer trainee therapists were able to feedback and critique issues arising from the research process.

Case Analysis

Individual thesis supervision with my supervisor allowed for interview content, themes and findings to be questioned, analysed and referenced.

Chapter 3

3.1 Introduction

The thematic analysis that follows emerged from five separate interviews with male psychotherapists. All participants in the study had at least three years of experience in general counselling and psychotherapy practice, were currently in practice, and were registered with either the Irish Association for Counselling and Psychotherapy (IACP) or the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP) or both. I met with each interviewee at their place of therapy work (at their invitation) with one exception where we met at a neutral venue to facilitate geographical location. Interviews were carried out during the same two week period, consecutively and with one or two day breaks in between in order to a) keep me focussed as an interviewer on the implicit and explicit issues, patterns and possible themes emerging in each interview and between interviews; and b) allow me to listen back to audio recordings following each interview and monitor any omissions or problems with questions, or any changes required.

In order to further facilitate my understanding of each therapist's perspective, prior to each interview, I completed a brief, discretionary 'personal details form' with each interviewee which provided some further information about their precise accreditation, therapy school of origin, length of practice/service, age, nature of client base, psychotherapy specializations and focus of work (See Appendix C). These details were helpful in getting a better context and insight about the individual therapist and updating any previous information gleaned from their given online details. A synopsis of these details is provided below:

T1: is 30 yrs old and is a single gay male. He comes from an integrative and psychoanalytic psychotherapy perspective. His therapeutic focus is in general counselling and psychotherapy. He has been practicing as a therapist for four years. He sees on average 30% male and 70% female clients.

T2: is 52 yrs old and is a single heterosexual male. He comes from a humanistic, integrative and rogerian psychotherapy perspective. His therapeutic focus is general and includes depression, anxiety and relationship issues. He has been practicing as a therapist for nine years. He sees on average 40% male and 60% female clients.

T3: is 65 yrs old and is a married heterosexual male. He comes from an integrative psychotherapy and psychosynthesis perspective. His therapeutic focus is general and includes issues around life-meaning and life-patterns. He has been practicing as a therapist for fifteen years. He sees on average 20% male and 80% female clients.

T4: 40 yrs old and is a partnered heterosexual male. He comes from a Gestalt therapy, sensory-motor and body-focus therapy perspective. His therapeutic focus is general and includes helping the person in discovering their authentic self. He has been practicing as a therapist for nine years. He sees on average 40% male and 60% female clients.

T5: 60 yrs old and is a partnered heterosexual male. He comes from a humanistic, integrative, object relations, rogerian and body psychotherapy perspective. His therapeutic focus is general and includes creative approaches to accompanying the client. He has been practicing as a therapist for twenty years. He sees on average 50% male and 50% female clients.

3.2 The experience of failure in therapy

The experience of failure in therapy as a theme relates primarily but not exclusively to a distinct pattern of MGRC, namely, Success, Power and Competition issues (SPC). SPC primarily attempts to describe personal attitudes about success pursued through competition and power. During the study I was curious to discover to what extent, if any, do male therapists hold these attitudes towards success, power and competition? Furthermore, do such attitudes impact on the therapy process, and if so, how? However, as the interviews proceeded, and with further data analysis it became clear that power and competition issues seemed of secondary concern to therapists. Rather, their attitudes towards failure, and the experience and impact of failure, seen either as

the failure of therapy or sometimes as ‘personal failure’, were of a much greater concern for them. What emerged was an insight into the positive and negative impact of failure, its influence on therapists intrapersonally, and its impact on the therapy process itself.

Failure was not seen as the inevitable result of not being successful, or indeed the opposite of success in therapy work, but it could be viewed from two perspectives: Firstly, the majority of participants described failure as happening where individual client goals were not achieved, or expected outcomes were not reached through the therapy process; Secondly, all therapists were unanimous in ascribing the overall quality of the therapeutic relationship, in this case poor, as the best barometer of failure. Three out of five therapists could readily recall cases of ‘failure’ with clients, however in all cases, the examples provided came from relatively early on in their therapy work as practitioners, and only one gave an example of more recent work that he felt had failed in some way. Four out of five therapists gave an example of ‘failure’ with a male client and only one used a female client example.

Failure was defined in many different but related ways such as, the client not opening up; the client not developing trust in the therapist; misunderstandings between client and therapist; misconceptions about the therapy process; the client closing down; when relationship isn’t possible; no connection with the client; no movement with the client; and the client not engaging:

it’s a feeling that there hasn’t been either a congruence or there has been a misunderstanding (T3)

for me I find difficult when a person is not engaged or at times finds it so difficult to be here... and in some way has to be taught how to be a client and has a lot of misperceptions about what this is (T3)

I suppose for what he was coming to therapy for, he found it quite helpful and supportive on a surface level... he didn’t really see it as a failure but I did, because he struggled to go deeper (T1)

There was also a tendency to identify the concept of ‘failure’ in therapy work with personal failure, which could undermine self-confidence and esteem as a therapist:

but for a very long time I couldn't get him to open up or even try to explore anything real, and that for me was a kind of failure on me as it, you know, made me constantly ask myself why cant I get him to open up (T1)

he was completely closed off and it was very frustrating and I suppose the more frustrated I got the more I felt that I wasn't helping him or I wasn't doing anything good for him (T1)

However most therapists did understand 'failure' as a necessary experience, or a 'fact of life' requiring acceptance in the therapy process:

So the relationship in terms of me being of use to you, has to reach a point where it fails, because there is a point at which I don't know what you need to do anymore than you do... if I am skilled enough to accompany you into the unknown of it and you are trusting enough to be able to risk being accompanied into it, and you may not be, either way it seems to me, there is a result (T5)

Moreover, one therapist went so far as to describe failure as a welcome phenomenon in the therapeutic process:

I enjoy when it breaks down because that is when the work can really get going...you cant have what you initially think is a 'good' therapy session where it is all ideal and all lovey dovey and great, but that is never gonna work (T5)

The positive impact of failure was also discussed, and described as a call to greater self-care; accepting that you don't have all the answers; knowing the limits of therapy; and learning from failure. Two participant's commented that their own capacity to learn from failure and affect personal change can reflect the degree to which he can facilitate growth and change with clients. This relates to a similar idea echoed in Karl Jung's adage that 'you can go with another only as far as you have gone with yourself':

like where I would have come from, I would have got lost in the failure, but with the training I have been able to see maybe the wisdom in the failure. That the failure happened for some particular set of circumstances and rather than seeing it as completely a failure on my part, I am seeing it as a learning of what I might do differently the next time around... it's about how to see failure as a gift. (T4)

To be a good therapist you have to admit defeat or know when you cannot help (T1)

I would be much faster at bringing a period of therapy to a close and recognize that what I had to offer is not what the client is looking for... I have actually had a client recently where I saw and caught it much more quickly... I caught it at session three rather than a year and a half later (T4)

Two out of five male therapists, initially had difficulty and appeared uncomfortable with using the concept of 'failure' in therapy. There was significant agreement by all therapists that though failure is experienced from time to time, it can be a very absolute term, some said a 'judgemental term', and therefore does not sit easily with the fundamental principles of 'openness', 'trusting the process', and taking a 'non-judgemental' approach, which in part underpin psychodynamic psychotherapy. The therapist with most experience as a practitioner was particularly adamant on these points:

I don't think you can fail at this work, provided you are available for contact... I think the failure idea comes out of the idea that I am here to somehow fix, achieve or help a person. I don't see that as my role, I am not here to treat you; I am here to encounter and meet you and make contact with you (T5)

but I don't think of it in terms of failure, because to me failure is kind of a somewhat judgmental type of use of the language, so I don't look on myself as failing. (T5)

but I don't have a sense, just to come back to the sense of 'this thing has to work or else it fails', to me as we meet, if we can meet in a way that is useful, that is their opinion. If we meet in a way that doesn't serve or doesn't seem immediately successful, that is therapy also (T5)

Some of the negative implications of the experience of failure revolved around concepts of self-judgement; lowered self-esteem; and endings in therapy; so much so that these subsequently emerged as sub-themes during the data analysis process.

Self-Judgement

The idea of self-judgement, particularly when unconstructive or internalized, is a prominent factor in the recognition of high levels of Male Gender Role Conflict. In

many cases, talking about failure in therapy, and in particular, personal failings, incurred a change in language from use of the first person pronoun 'I' or 'Me', to the second or third person use of 'you' or 'we', or a more universal 'they' or 'all therapists':

you naturally ask yourself, you know, was it anything within me that brought us to this 'stuckness' because often with clients there will be a 'stuckness' and you wait and go through that. Um...but with this client it seemed to be that there was this block between us, so it would be a reflection on any therapist's own position, my own...um...to look at their own prejudices, to look at their own process and to wonder...er...when it felt like a failure, was any part of me contributing to that? (T3)

Self-judgement can be the product of different types of perceived failures in therapy such as not meeting the needs of the client:

I suppose when you feel that you are not meeting the needs of a client that would be my experience of failure, but I suppose I wouldn't take it on board completely as something that I am doing wrong but it would make me kind of look at the relationship from a different angle and try and see why it is not being productive, is it something to do with me, or why it's not going as well as I think it should be... (T1)

Therapists can also blame themselves for failure in the process, for example when they lack patience with the client, or put unnecessary hurry onto the process:

It is usually some degree of speediness in me that has kick started an anxiety in a client and the client would pull away (T5)

Low Self Esteem

Low self-esteem has been hypothesized as a negative outcome of GRC and gender role strain (O'Neil, 1981a; Pleck, 1995, p.13) In cases where therapists felt that their personal competence or professional integrity was questioned by a client, they related an experience of feeling less confident with the client and feeling a negative impact on their personal esteem as a therapist:

The most difficult experiences I think I have had in those places would be very strong negative projections and being challenged about my authenticity. I think that was one of the places I struggled with (T5)

a male client, academic guy, attacked me for probing too much into a sexual problem he was having... he challenged why I needed to know those details and asked if I was a 'sex expert' or just a 'general counsellor'? Even though I knew this was related to a deeper problem he was having in a relationship, and not so much about me... the very accusation niggled me... I felt undermined. (T2)

Esteem issues were also connected with power struggles in therapy, both explicit and implicit, where a therapist could feel disempowered, sometimes for no identifiable reason, and sometimes because the client triggered particular feelings from the therapist's past experience in a similar situation:

it seemed like there was a balance of power thing in there and... I felt disempowered in relation to him, which is not a very healthy place for anybody to be in. As a result, I was attempting to scramble back, and I use the word scramble back because I felt an inequality and yeah, it was more than was in my capacity (T4)

This type of disempowering experience could also have the effect of making the therapist feel 'de-skilled' or unable to progress therapy in a productive way.

Endings

Endings in therapy could sometimes be seen as personal failure, depending on the circumstances of and explanation for the ending. If the therapist agreed with, or could justify the timing and reasons for a client ending therapy, it seemed to ameliorate the sense of failure; but in the event of an abrupt or sudden ending, or an ending that 'didn't make sense' to him, he was more likely to experience it as personal failure or question himself in some way:

I still can't fathom what that was all about? One day she's sitting there, talking away... working on stuff, then all of a sudden she's gone... I kept thinking about the last session and did I miss something? (T2)

This was in contrast to what two therapists described as 'proper endings' whereby the ending was planned and worked through together with the client:

I have a client who I will be finishing soon and we're in the process of ending after two and a half years... and it is kind of confirming for me to hear from

the client, her reflecting what I have been hearing and seeing, that she is ready to go. (T3)

Most therapists were quite philosophical about endings that were in some way unsatisfactory:

you cant put it all on yourself like for your own failings because people finish for whatever reasons and you are never gonna be able to...unless they tell you the exact reason why they are finishing, which they never do. You know there are a myriad of different reasons why they don't come back and it would send you mad if you wallow in it too long (T1)

The negative impact of an ending seemed to be ameliorated where some clear reason or justification could be found, as in the case where the client was not suited to psychodynamic psychotherapy e.g. required a Cognitive Behavioural approach, or where a client clearly required another, clinical type referral e.g. psychiatric referral:

one client would come to mind that had a very difficult personality, was quite disturbed and aggressive and the relationship developed very very slowly, very tentatively and sort of it was like a person peeping out every so often to reveal a little, but it was coming to a stage where the person just couldn't go any further and we both felt we were blocked and stuck (T3)

Indeed, there was relief and satisfaction expressed when such a difficult or 'inappropriate' case eventually ended:

The one place where I have found difficulty is being with people who have been psychotic...um...and this would.....going back a few years where I wouldn't have had the skills to understand it in the beginning or...and realized you cant work with someone like this. I would have taken someone on and now...become part of their madness, that was difficult, that kind of place was difficult to negotiate. When it was over I can't say I wasn't relieved (T5)

it is mainly a reflective piece for me around how I have been in the process with them and what it is like for me to accept that. Life leads to the good, the bad and the ugly and that this relationship went as far as it could go (T3)

Summary

It is clear from the data and the examples cited above, that success, power and competition issues seemed of secondary concern to therapists. Rather, their attitudes towards failure, and the experience and impact of failure, seen either as the failure of

therapy or sometimes as ‘personal failure’, were of a much greater concern for them. Irrespective of whether therapists described failure as not achieving outcomes or incongruence in the therapeutic relationship, there is evidence to suggest that some element of failure in therapy tends to spillover into a sense of personal failure for the therapist. The sense of personal failure could be exacerbated, if not caused, by a propensity towards self-judgement which could be unconstructive or internalized. It was also something that they struggled with and might try to avoid experiencing or talking about. This was evident in the content of what many therapists said, but was also picked up in *how* they said what they said, i.e. their use of language, describing failure in the third person. In cases where therapists felt that their personal competence or professional integrity was questioned by a client, they related an experience of feeling less confident with the client and feeling a negative impact on their personal esteem as a therapist. Endings, when sudden or unjustified could also be construed as personal failure for some therapists. It is also interesting to note that failure in therapy with male clients was more prominent than with female clients and that it revolved around problems with trust, misunderstandings, and a poor / no connection in the therapeutic relationship. Failure could also be seen as necessary or welcome and this positive aspect was related to the idea of learning from failure, or mistakes, and realising one’s limits as a therapist.

3.3 The experience of strong emotions in therapy

The experience of strong emotions as a theme relates primarily but not exclusively to another distinct pattern of MGRC, namely, Restrictive Emotionality (RE). Given that RE is defined as having restrictions and fears about expressing one's feelings as well as restrictions in finding words to express basic emotions, I was curious to discover in the study to what extent, if any, do male therapists experience these emotional limitations and restrictions in themselves when faced with strong emotions in clients? To that end, I was interested in both the content of what was said during the interviews, and how it was said, in order to gauge the intensity of the experience, or the level of therapists' reaction to it. Furthermore, do such restrictions impact on the therapy process, and if so, how?

The experience of strong emotions in therapy was highlighted in a couple of significant areas, namely where anger is present, or where erotic or sexual feelings are present, either transferentially or explicitly. At first I thought that these would become major stand-alone themes of the study, however as the analysis process progressed more, a common factor seemed to emerge regarding virtually all experiences of strong emotions in the therapy room: Any emotion introduced by a client into therapy seemed to have a particularly strong or intense personal impact on the therapist when it was directed towards the therapist specifically and/or triggered the therapist's own personal history or experience. This phenomenon was described by two therapists as 'feelings dumped on the therapist'. This was mainly the case when the emotion was verbally expressed, however it could also be picked up in transference between client and therapist:

she hit right into my process and my past I suppose and my experience in life and sort of wrenched it around (T2)

pure sadness like, it connected with my...it was like, it was a parallel process to what she experienced in her life and it was devastating for me to feel that (T2)

In one case where the emotion being expressed was hopelessness, it triggered a particular experience with which the therapist had struggled some years earlier himself, and made the session much more intense for him:

there was a moment when... if I hadn't tuned out or come up for air, the despair was so heavy and unrelenting, that I'd nearly have questioned my own existence (T1)

One therapist spoke of an energetic connection that happens when a client is telling a moving story, particularly when it connects with their own experience:

there are sometimes when I can be very moved by somebody and water will come out my eyes and that is sad. I am just moved in my belly and that is the effect of it... that is just part of the confluence of being with somebody in that kind of energetic interaction (T5)

Four out of five therapists spoke about how the expression of anger in therapy was 'much worse' when it is anger is projected directly at the therapist. The projection of anger onto the therapist would often leave him holding difficult feelings long after the particular session was over. One therapist said that during an intense session he could often feel the client's strong emotions in himself physically and emotionally and that it took a 'huge toll' on him. Another therapist said that client anger directed at him was much more difficult to deal with than general expressions of anger, client anger directed towards themselves or others, or other strong emotions expressed in therapy:

I would really sort of be there with them for it, but it is very painful physically and emotionally for me to sort of sit with them and it takes a huge toll on me sometimes just to witness... once it happened where I actually broke down under the storm of anger that was coming at me and was totally demolished by the client (T2)

I am still learning to deal objectively with very strong anger... Strong sadness, strong despair, suicide ideation, while that can be difficult, it is territory I am more familiar with and...um...I am not as triggered by it as I might be by very strong anger, especially directed my way... and that is an area that has been or I have to continue to do a lot of personal work on (T4)

When relating examples of anger directed towards them in therapy, a majority of therapists said they had struggled during such sessions, and in fact had experienced

some difficulty both accessing and then processing their personal emotions in response to the anger. Three therapists said that it could sometimes trigger their own anger in response to a client or later on, after the session.

Erotic transference from client towards the therapist became ‘a lot more intense’ and even ‘embarrassing’ if verbalized directly to the therapist, and where it connected with them personally e.g. where it was mutual or reminded them of previous relationships or sexual attractions:

It is very hard to stay in the moment and to concentrate when it is fairly in your face...yeah, it is difficult, it is...um...it is embarrassing, it is kind of, kind of brings you back to your teenage years... it is difficult to deal with (T1)

The majority also stated that when erotic transference from a client towards them got verbalized, it made it harder to concentrate. In one case this experience could lead to his ‘disappearance’ from the room:

It is more my own fantasy, a flash... And a lot of times when those sorts of things happen I sort of say, why did I disappear there?... There are just sort of moments of when I disappear from the room for a bit and they are either my own pressure or it is something that is going on between us (T2)

All therapists were adamant that they rarely had any problem expressing personal emotions, however with two notable exceptions: Firstly, sometimes it might be the case that they were not completely in touch with their emotions at that moment during a therapy session, and therefore they were not in a position to express how they felt (which often happened subsequently, after a therapy session, on reflection, or in supervision); Secondly, due to the special nature of the therapeutic relationship, including a ‘duty of care’ towards the client and the keeping of clear boundaries, they were not always at licence to express an emotion or proffer a personal opinion in therapy as it might be ‘unprofessional’ and ‘break the boundary’, and could have negative consequences for the client either now or later on in therapy.

The Experience of Anger

As a strong emotion expressed in therapy, anger, even when not directed at the therapist, or when it doesn't trigger or connect with the therapist's own personal history or experience, can still be a very difficult emotion to process. Three out of five male therapists said that anger is the most difficult emotion to deal with in the therapy room. Anger was defined as, 'a high intensity emotion'; 'an outburst of rage'; and 'a hidden time-bomb, waiting to explode'; by different therapists. Furthermore, almost all therapists said that the experience of anger is more difficult with men, and more challenging personally, than the experience of anger with women.

During the interviews, when asked directly about their experience of anger in therapy four out of five repeated the question back to me, 'how do I feel?', something which might be construed as a delay tactic in preparing a response. All therapists began such answers with a neutral or positive response such as 'it's fine', or 'it is what it is' suggesting a defensiveness or even an avoidance of the subject matter in question. As the question about 'their experience of anger' was probed more, it became apparent that therapists found it much easier to talk about the client than themselves, in relation to the experience of anger. This was often evidenced by a subtle change in language when talking about personal anger (and some other strong emotions but to a lesser extent) from use of the first person pronoun 'I' or 'Me', to the second or third person use of 'you' or 'we', or a more universal 'they' or 'all therapists':

Well I suppose this is a space between ourselves where hopefully a healing dialogue is about to take place... often just saying to a client, you know, I am in my seat, you are not going to knock me over no matter how angry you become, so you taking responsibility for how you are... that whatever emotions come, we will be with them and we will look after them (T3)

I suppose sometimes some of the clients would sort of get angry because you are not responding in the way they want you to respond when they are angry (T4)

Anger from male clients could also be experienced as a physical threat to the therapist, and this was another key differentiation between the experience of anger from male, as distinct from female clients:

One particular male client comes to mind. Yeah, I felt physically at risk...um...and it was quite a challenge in me internally to hold my space... rather than me getting too scared by it (T4)

Despite the negative emotional and physical impact of experiencing anger within the therapy process, all therapists were able to elaborate on certain positive consequences, including, 'having to learn how to become a container for the client's emotions'; 'balancing client needs with personal needs'; and if dealt with properly, 'being a catalyst for improvement and change in the therapeutic relationship':

but it was like my capacity at that time to stay calm...um...it helped the person express the emotion and the whole, the energy fizzled out, so the energy got to express itself without it...yeah, without it taking over (T4)

I am quite excited if I see a charge building... so if a client turns on me or is angry with me, is hostile towards me, I am very much excited by that, because there is something happening, yeah. Now that is after all the experience of therapy. (T5)

The Experience of Erotic Transference

Another experience where strong emotions were present in therapy and which drew significant discussion from all therapists was that of erotic transference between client and therapist, even when it is not expressed verbally and only picked up through the transference and countertransference between client and therapist. All therapists gave their first and main example of erotic transference as occurring from the client towards the therapist. Four out of five provided a first example as an experience of erotic transference with/from a female client. It was initially difficult for most therapists to begin to talk freely about the subject, and in two cases it was joked about light-heartedly to begin with. There was also a tendency to place more of the focus on the client or the therapy process, rather than the therapist himself. As mentioned earlier, erotic transference was described by three therapists as 'difficult' and 'embarrassing' to discuss with a client:

I suppose it is kind of the embarrassment really. It is kind of difficult. Yeah, it is kind of like being on a first date that somebody set you up on and you didn't know it was a date. It is quite difficult (T1)

the first time a client said to me that they loved me, I left the room because I blushed and I didn't want then to see me blush and I made an excuse that I had left a heater on in another room (T5)

Two therapists observed that clients could sometimes manipulate an erotic transference or potential therapist-client attraction as an avoidance strategy, and this could be difficult to work with:

I have had a couple of female clients who would use sexuality as a way to get out of a difficult situation, like if I have challenged them about something, they would try and turn on their womanly charm to get out of it... it is a difficult situation to work with someone like that. (T1)

When erotic transference is present in therapy, discussions around sex and sexuality can be affected. In this context, therapists admitted to being 'more careful' and 'more tactful' with language use; two therapists said they 'wouldn't feel as free' in this context; and three said that it has created more significant boundary issues in therapy. One therapist described how uncomfortable he has felt in situations where the client engaged in explicit sex talk, however this was also partly related to his not feeling competent or knowledgeable enough to discuss the topic:

What has unsettled me is where somebody gets into talking about what would be for me very kinky kind of stuff... an unconventional sex kind of thing. Certainly I was uncomfortable with that, largely because of my own ignorance and my lack of knowledge of what the person was talking about. Basically I felt uncomfortable talking about it (T4)

Erotic transference can present the therapist with greater insight into his own personal process and development:

I am aware of my own erotic counter transference with a few female clients and aware of how I helped myself around that to, yeah, to kind of spot it and notice it and not get lost in it... getting preoccupied with the erotic transference part (T4)

There was a time I think when I was alone for a long time and I think I had to be aware that the loneliness didn't spill over into sexual transference onto the client (T5)

If handled professionally and expertly, the experience of erotic transference can be worked with, and can be a positive development in therapy, presenting an opportunity to explore the therapeutic relationship or patterns of behaviour more deeply:

it informs me what is going on with the client, if I am feeling that evoked in me. What is also happening in the process for sexual transference to be evoked in me. Um...so I have a number of kind of I suppose techniques in the therapy room I use to help me understand it... (T4)

I am allowing that to happen, you know, apart from wanting to use me as a love object or they want to use me as a sex object, go ahead and do that, work it through and come back and we will talk it through, so I am quite open to being interjected and used in that way (T5)

Summary

The analysis presented above shows that male therapists experience emotional limitations and restrictions in themselves when faced with strong emotions in clients and that these emotional restrictions impact on the therapy process. When strong emotions are expressed by a client in the setting of the therapy room, the therapist has the dilemma of being responsible and professional towards that client, while at the same time remaining authentic and in touch with his own feelings. This tension between the two responses was shown to become intensified by strong emotions which either triggered the therapist's own vulnerability or personal history and experience, or which were directed implicitly or explicitly towards the therapist. Issues and emotions such as hopelessness, sadness, anger or sexual transference and feelings threatened to illicit a mutually strong response in the therapist and can sometimes threaten therapeutic boundaries and the therapy process itself. Many of the underlying elements of RE such as being emotionally limited or not wanting to express emotions in certain situations, were very apparent in the examples cited above, and also in my experience during the discussions.

Anger expressed in such a direct way, particularly from male clients, could be very unsettling for most therapists and might even create in them the sense of physical threat towards them. Such was the intensity of relating such experiences of anger that some therapists found it easier to talk about the client's feelings rather than their own and there could be an avoidance of getting in touch with the personal impact of anger.

This was also shown in a change in language use where many participants began to discuss the phenomenon using impersonal and third person pronouns, in a sense, distancing themselves from the experience. In many case too, therapists showed a resilience and positivity around their experience of anger directed at them through seeing it as an opportunity to learn about, and have insight into themselves, the client and the therapeutic process. Such experiences could also lead to positive change and improvement in therapy and personal development.

Erotic transference and expressed sexual attraction towards therapists could evoke shame or embarrassment during the experience and indeed, during the interviews where certain therapists became visually embarrassed or joked about the scenario they were relating to me. The experience had implications for the therapy process in many ways, including clients manipulation of the situation, boundaries being threatened and talk around sex or sexual acts becoming more restricted or problematic.

3.4 The experience of working with male clients

The experience of male therapists working with male clients as a theme finds its context primarily but not exclusively in another distinct pattern of MGRC namely, Restrictive Affectionate Behavior Between Men (RABBM) which represents restrictions in expressing one's feelings and thoughts with other men. While it might seem obvious from the outset that the phenomenon and experience of men interacting with men should be included (given its predominance in the literature), during the interviews this was not immediately apparent. Nonetheless I was curious to find out to what extent, if any, do male therapists experience these restrictions in expressing their feelings and thoughts with other men in therapy? Furthermore, if such restrictions exist then do they do they impact on the therapy process, and if so, how?

Male therapists initially avoided focusing on their experience of working with other male (clients), preferring to use the idea of 'client' in a more generic or universal sense. However, during the coding and analysis process, there was no escaping the fact that almost every part of every discussion with therapists had an underlying connection with, their direct experience with male clients in therapy; the differences between that and their experience with female clients; and how having another male sitting opposite them in the therapy room could change the content and context of therapy, their response to the client, and therapy outcomes themselves. Even the experience of my interviewing them, as a male trainee therapist in not a dissimilar setting and context as regular therapy itself, proved to be insightful in this regard, and I duly noted any potentially related non-verbal and verbal communication, messages, affectations or other issues present during the interviews.

Four out of five male therapists when asked said they preferred female clients to male clients, despite initial reticence in expressing a preference. This preference was often due to a perception that female clients were more in touch with their feelings and what was going on for them internally, and that this ultimately facilitated more congruence, better sense of connection and more progress in therapy work:

okay, I was going to say I really don't have a preference but I do...um...generally female clients because they are so much better able to connect with their stuff, with what is going on internally. I am not saying that all women do but by and large (T4)

Therapy is one of the few universal professions or I suppose services that naturally fits with female energy... it's about care, nurturing, trust, safety, many of the mothering traits we have all been raised on. This is not a man's world, but maybe it's becoming more equal (T5)

The preference for female clients was reflected in the general ratio of male clients to female clients retained by the therapists. In four cases the number of male clients retained was less than female clients (in one case 20% as opposed to 80%), and in only one case the numbers of both male and female clients retained were more or less equal. In no case did the number of male clients seen outnumber female clients. When those with larger female client numbers were asked whether this might be a deliberate or intentional client-intake choice, two therapists made the point that in general a higher percentage of women tend to present for therapy than men, and this might explain the imbalance in numbers.

Most therapists described perceived differences in their experience of both genders in therapy. Male clients were considered by a majority to be more insecure in general about expressing their emotions and feelings than female clients, and 'more guarded' and 'defensive' than female clients:

I have felt a lot of insecurity from male clients, you know, especially when you challenge a male client, it is very different from when you challenge a female client, so men would be a lot more guarded...very defensive, a lot more defensive than women. They would see it more of an attack rather than a challenge. (T1)

women are a lot more forthcoming with emotions and feelings and you know, they are nearly like an open book, the majority of the time, whereas men, I find, are more guarded. I see that they need to feel secure before they open up. (T1)

Male clients were perceived by a majority of therapists as more cerebral, and tend to 'live more in their heads' than female clients; they are less in touch with their bodies than female clients; and even in cases where they are aware of feelings, they don't

necessarily share those feelings with the therapist; as a result it takes men longer to establish trust in therapy:

it takes longer to get into emotional stuff and that because building up the relationship and trust and bond takes longer than it would with a woman, in my experience. (T1)

That would be the main difference [regarding male clients] with women I suppose. The unawareness of men...um...about their own bodies and like how heady they would be. I know that sometimes it happens, I can often, not quite have a headache after a session but my head can be a little bit...um...I feel a kind of a pressure in my head because they are so in theirs... (T4)

it would appear to me that females would certainly be more in touch with how they are feeling. Men are feeling deeply too but the process of wanting to share that is a more difficult path for them, it is a different way. (T3)

There were some exceptions to the overall lesser preference for working with male clients. It was noted by three out of five therapists that male therapists have a unique insight into male clients because of their shared gender and male experience. An example given was that of sex talk, perceived by a majority of therapists to be easier with a male client because of similar gender experience in this area. In some cases, it was mentioned that being a male therapist could invoke greater trust from a male client where the therapist was mirrored, or became a quasi-mentor or role-model figure for the client. Same gender identification could also make connecting with other men in therapy easier:

I suppose I relate to men better. I know a lot more, I suppose I can connect with them better as a human being and with women I am always interested just in how they think and how different we are (T2)

One therapist who consistently asserted no preference for either male or female clients, made the point that variety was important for therapists in order to experience the fullest possible spectrum of human issues and perspectives in therapy:

I think the variation for me is what is important. For me personally it is what is important and professionally it would be very limiting to... so I don't have a preference, I would rather have a mixture (T5)

Control, Power and Competition issues

The distinct but related influences of control, power and competition within the therapeutic relationship formed a significant part of the phenomenon of working with male clients. Male clients were seen as more competitive and engage more in 'power play' and 'game playing' than women in therapy:

I think men are more guarded, and they are more conscious of how they are portraying themselves to you as a therapist... It's a control thing. You know, a lot of times they will have a certain axe to grind, that they would, I suppose have with them in the room. There is a lot more kind of power play. (T1)

The impact of this 'power play' was often negative for the therapist, caused him to question himself and his abilities and make him insecure as a therapist and as a man:

I felt insecure around him. I questioned myself a lot more with this client than I have with any other client. I didn't feel very strong in the relationship... I knew what game he was playing with me. I knew what feelings I owned that were causing me to be sucked in and feel insecure and feel, I suppose, not skilled. (T1)

'Power play' engaged in by male clients, or perceived attempts by them to be the 'alpha male' in the therapeutic relationship, could illicit similar feelings and behaviour in the therapist to the point of a 'power struggle' or the therapist's need to control the situation:

one in particular, the two of us were like two alpha males with each other. He was so defended, he couldn't let me in at all... I would say, 'you are bloody well gonna let me in now and I am gonna get in there' and we were at that for a couple of sessions in the beginning and I was feeling really uncomfortable that this is never going to work and beginning to dislike him... (T2)

With this guy, he was coming across as very butch... and that was interfering with the relationship. He was a fairly alpha male, so he was quite, well trying to be very dominant in the relationship and all I wanted to do was say, 'not in my therapy room you don't!' (T1)

The therapist's own masculinity identity, levels of competitiveness in therapy, and need for power and control in relationship were quite significant in determining their response to similar characteristics experienced from male clients. Such characteristics can be summated in the following statements:

‘I don’t like being beaten’ (T2)
‘I like a challenge’ (T5)
‘I will do everything to get something fixed or work it out’ (T1)
‘I like being in charge’ (T2)
‘when I don’t know stuff well then, I am somehow lesser of a man’ (T4)
‘I would be quite determined and dogged’ (T2)
‘I can get angry with myself when I just sit there and take it [anger]’ (T3)
‘Sometimes I have to be careful not to over perform’ (T1)
‘part of me is afraid that men are becoming more homogenized with women and that we are losing a lot of our maleness’ (T2)

The majority of therapists said that these and similar self-descriptions and introjects relating to their idea of ‘being a man’ or ‘being a male therapist’ could impact negatively on the client or therapy process overall. This was particularly the case where both sides, client and therapist, engaged in power play, competitive thinking or control-seeking behaviour. Most believed that good supervision and personal support and processing meant that they would usually be more in touch with these feelings or so-called masculine character traits, and would not necessarily act on these feelings. Indeed, connecting with their own need to be in control, or be powerful, allowed them to relinquish that need to a certain extent, which facilitated the client doing likewise:

And I said to myself you know, just how vulnerable you [the client] must feel to be so macho and so in control of the room, so I changed my tack then and I sort of connected with my own vulnerability (T2)

It was never spoken, no. I almost said, okay, you be in charge, I am not going to even try to, I can’t be in charge here and by doing that then, when I sort of stepped out of that sort of battle with him, I was able to see him much better then. (T2)

Summary

From the analysis above, there was a strong preference expressed towards retaining female clients by four out of the five participants. This preference was often due to a perception that female clients were more in touch with their feelings and what was going on for them internally, and many therapists said this made them feel more

comfortable, facilitated more congruence and trust, a better sense of connection and more progress in therapy work. This preference was reflected in the actual lower numbers of male to female clients retained. In analyzing the experience of male therapists, emotional restrictions do seem to occur when therapists work with male clients, and this does impact on the therapy process. This is evidenced in the data where therapists perceived male clients in general as more insecure, guarded, defensive, cerebral, less in touch with their feelings and body, or if aware of their feelings, less willing to share them very openly or freely in therapy. Male clients were also perceived as engaging more in power play, games, control-seeking behaviour and being competitive in therapy. The impact of these phenomena on male therapists could illicit their own need for control and power, evoke competitive behaviour in response, and threaten their own identity and confidence. In this area in particular emotional restrictions in the therapist were noted. This could also lead to a deterioration in trust and congruence between client and therapist, and ultimately to a breakdown in the therapeutic relationship.

However, if the therapist was able to reflect on his own process, and what was actually happening in therapy, he could often let go of such feelings, be more in touch with and expressive of his thoughts and feelings, and this facilitated the client in beginning to respond in a similar fashion. There were exceptions to the expressed preference for working with female clients. Some therapists thought that common identity and experience among fellow males could sometimes facilitate more trust, ease and understanding with sensitive issues such as sexual problems, and there could exist greater mutual connection, mirroring and role-modelling. One therapist who consistently maintained an equal preference for both sexes as clients also highlighted the importance of variety when working as a therapist, particularly for greater personal growth and balanced development.

Chapter 4

4.1 Discussion

Introduction

In discussing the findings of this research, I am cognizant of the fact that the experience of each male therapist who participated in the study, represents their own individual and unique perspective and experience. Drawing out key findings from such distinctive experiences has been a delicate task. I started out with a broad framework garnered from Male Gender Role Conflict theory and I was curious to see how, and to what extent this could be applied to male therapists. I wanted to discover how these therapists experienced MGRC personally, and I also wanted to know how it impacted on their work with clients in therapy. Both questions are close to my own experience as a male therapist in training. My research showed that MGRC was indeed a phenomenon among male therapists, which influenced them both personally and in their work with clients. The way in which this happened didn't always follow exact patterns of MGRC, however it resonated with many individual aspects of MGRC as set out in the literature review.

For male therapists, the struggle with issues around professional and personal failure in therapy, how they handle strong emotions during, and in the aftermath of therapy sessions, and their sometime strained experience with other men in therapy, were all apparent in the study. These themes were all related in some way to MGRC, issues of masculine identity, and what it means to be a man practicing as a therapist. O'Neil (2008) asserts that, 'the personal experience of GRC constitutes the negative consequences of conforming to, deviating from, or violating the gender role norms of masculine ideology' (p.363). As outlined earlier, these personal experiences are defined as devaluations (negative appraisals of self or others causing lower self regard), restrictions (limiting oneself or others to stereotypic norms of masculinity ideology or controlling people's behaviour) and violations (being harmed by others or by oneself when veering from or agreeing to the gender role norms of masculinity ideology, or causing psychological and physical pain) (Ibid, pp. 363-365).

Throughout the study these phenomena could be observed either in the data collected or in my personal encounter with participants in the interviews.

Understanding and reasoning with failure

Most participants could readily identify with failure in therapy, either through failure in therapy outcomes or in the therapeutic relationship. There was sufficient data to suggest that failure in therapy could result in a sense of personal failure for the therapist. The sense of personal failure could be exacerbated by a propensity towards personal devaluation and self-judgement, which could be unconstructive or get internalized. Mahalik (1999a, p.46, 2001a, p.31) and O'Neil & Nadeau (1999, p.36) contend that GRC is the result of distorted gender role schemas in that it affects men's psychological wellbeing through negative social feedback and internalized, unconstructive self-judgements. The experience of failure was something that they struggled with and might try to avoid experiencing or talking about. This was evident in the content of what many therapists said, and in the restricted way that they said it. Failure in therapy also involved problems with trust and poor connection in the therapeutic relationship. In cases where therapists felt that they had failed professionally, for example where sudden, poor or unjustified endings occurred, or where their personal competence or professional integrity was called into question, they related feeling less personal confidence and less personal esteem.

Failure could also be seen as necessary or welcome and this positive aspect was related to the idea of learning from failure or mistakes, and realising one's limits as a therapist. In fact, where sense or reason could be made out of failure, it seemed much easier to process. Perhaps because of their training, or chosen therapeutic approaches, failure was perceived by some as being slightly at odds with core psychotherapy principles and established theory, however this did not tally with their direct and practical experience of failure in therapy, and may simply highlight a disconnect between their aspirations and ideals as therapists, and the actual lived experience and practice of therapy. While there is no concrete evidence to suggest that levels of SPC or indeed the impact of failure were any different in this study than in the general male populous, perhaps the professional necessity for ongoing training and support, personal development, personal therapy and therapy supervision, did mean that when

failure was perceived to have occurred, they could process it in a more satisfactory way.

Emotional restrictions in therapy

There is no doubt that in any walk of life, strong emotions experienced either in or from another, or in oneself, will impact on us at many levels, both positively and negatively. The study found that male therapists experience emotional limitations and restrictions in themselves when faced with strong emotions in clients and that these emotional restrictions impact on the therapy process. Strong emotions were of greater impact if they either triggered the therapist's own vulnerability or personal history and experience, or when they were directed implicitly or explicitly towards the therapist. Anger expressed in such a direct way could be very unsettling for most therapists and cause a violation, the threat of being harmed, or the threat of psychological and physical pain (O'Neil, 2008, p.364). It is worth noting here that Mahalik (2000, pp.123-146) has shown interpersonal aggressive behaviour and communication to be associated with GRC. Such was the intensity of relating such experiences of anger that some therapists found it easier to talk about the client's feelings rather than their own, or used impersonal and third-person pronouns, thus distancing themselves from the experience.

In many cases too, therapists showed a resilience and positivity around the experience of anger directed at them, through seeing it as an opportunity to learn about, and have insight into themselves, the client and the therapeutic process. Such experiences could also lead to greater personal development, and positive change and improvement in therapy. Erotic transference and expressed sexual attraction towards therapists could evoke shame, embarrassment or devaluations. It is also noteworthy in this context that problems with intimacy have been associated with GRC (Bruch et al., 1998; Sharpe et al., 1995; Berko, 1994). This study showed that the threat of intimacy in such experiences had negative implications for the therapy process in many ways, including clients' manipulation of the situation, boundaries being threatened, and talk around sex or sexual acts becoming more restricted or problematic.

The conflict of masculinity and femininity

The strong preference expressed in the study towards retaining female clients over male clients by the vast majority of participants was somewhat surprising. This preference was often due to a perception that female clients were more in touch with their feelings and what was going on for them internally, and many therapists said this made them feel more comfortable, facilitated more congruence and trust, a better sense of connection, and more progress in therapy work. The preference was reflected in the actual lower numbers of male to female clients retained. This preference might also hint at the fact that male therapists experience restrictions and can be uncomfortable in expressing their feelings and thoughts with other men in therapy, and choose to do so more with female clients. Though this link between preference for female clients and restrictions in expressing emotions with male clients is somewhat speculative and inconclusive, it has been shown that male therapists with high RABBM reported significantly less liking of male clients (M. M. Hayes, 1985, pp.116-118). Wisch & Mahalik (1999) also reported that male therapists reporting SPC and RABBM had significantly less liking for, empathy with, and comfort with male clients (p.67).

Another reason for this preference for working with female clients might be the fear of femininity (Pleck, 1995), a fear of possessing or expressing ideals, stances or actions that are stereotypically associated with appearing feminine (p.165). For male therapists, who through rigorous training and self-development may be in touch with their feminine side (as well as the masculine), just being in the therapy room with another man, particularly if he feels pressure to reinforce masculine behaviour, might be quite challenging or cause a psychological conflict. This conflict between masculine and feminine identities could get played out in therapy with male clients. This is evidenced in the data where therapists perceived male clients in general as more insecure, guarded, defensive, cerebral, less in touch with their feelings and body, or if aware of their feelings, less willing to share them very openly or freely in therapy. Male clients were also perceived as engaging more in power play, games, control-seeking behaviour and being competitive in therapy. Many of these perceived traits tend to be associated with masculine identity. The impact of these phenomena

on male therapists would be to evoke their own masculine responses such as a need for control and power.

This theme corresponds significantly with many studies carried out in the area of MGRC. Berko (1994) confirms that high levels of GRC correlate with lower levels of self-disclosure (p.134). Lower RE and CBWFR have significantly predicted greater self-disclosure (Swenson, 1998, p.94). RABBM has been significantly correlated with unexpressive behavior (Horhoruw, 1991, p.67), and RE, RABBM, and SPC have been significantly related to men's lack of intimacy and male friendship (Sileo, 1996, pp.75-77). A study assessing GRC's relationship to men's psychological defenses found that SPC, RE, and RABBM were significantly related to immature and neurotic defenses (projection, denial, and isolation) and that men who reported SPC and RE reported defenses that are turned against others (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998, p.106). And GRC has been found to accentuate restrictions vis á vis intimacy and self-expression in relationships with other men (Ibid, p.111)

There were exceptions to this lesser preference for working with other males in therapy. Some therapists thought that common identity and experience among fellow males could sometimes facilitate more trust, ease and understanding with sensitive issues such as sexual problems, and there could exist greater mutual connection, mirroring and role-modelling. One therapist who consistently maintained an equal preference for both sexes as clients also highlighted the importance of variety when working as a therapist, particularly for greater personal growth and balanced development. Also, in situations of incongruence or even conflict with another male in therapy, if the therapist was able to reflect on his own process, and be more in touch with and expressive of his thoughts and feelings, this could facilitate the client in beginning to respond in a similar fashion.

Masculinity in the world of therapy

Pleck (1995) referred to the traditional man as one who endorses the 'masculinity ideology' (p.19), namely that men should have gender-specific characteristics (Thompson & Pleck, 1995, p.22). These characteristics come from an interaction of

environmental and biological factors, and masculine values and roles acquired in early childhood (O'Neil, 2008, p.17). These gender role characteristics can lead to psychological distress if used in situations that require less gender type behaviours' (Wester et al., 2005, p.195) It can be argued that the therapeutic encounter is a situation which demands less gender type behaviours in that the therapist's position requires him to put aside any predisposed roles, values, biases or judgements, and be open and objective with clients. According to Corey (2001), psychotherapy and counseling demands, 'a practitioner who is willing to shed stereotyped roles and be a real person in a relationship' (p.15). And Jacobs (2010) notes, 'counsellors rightly stress the necessity of unconditional regard – the ability to accept others, whatever they say or do, without preconditions' (p.18). This includes equanimity regarding the treatment of clients irrespective of whether they are male or female. For a therapist to act on his own individual gender role identity without regard to the core conditions of psychotherapy practice might well cause a conflict with these principles. Indeed, this tallies with some research that suggests that the culture of therapy is often incongruent with men's masculinity ideology (Rochlen, 2005, p.44) and this can significantly influence both the incidence of male therapists, and restrict men in their work as therapists.

To practice therapy can be a difficult and challenging experience. It involves years of self-development, personal therapy, supervision and support. It can be a very lonely endeavour, particularly when difficult or intense emotional issues have to be contained and held in the therapy room. Therapy may be practiced and attended by men, but the therapeutic encounter can be more difficult for male therapists given its incongruence with masculine ideology and identity, and in the context of societal norms, expectations, and pressure on 'men to be men'. As the title of this thesis suggests, quoted verbatim from one participant, therapy is not a man's world.

4.2 Limitations

The breadth of the MGRC research spectrum, and the relative size and scope of previous quantitative efforts to assess individual levels of GRC in males, meant that I would never be able to capture fully how the many patterns and phenomena of MGRC influence male therapists and their work in therapy with clients. A quantitative study with a larger collection of male therapists might have given me a

more empirical measurement of the levels of MGRC amongst male therapists. I also considered pre-screening the current study interviewees with a MGRS Scale assessment which would give me empirical data on each individual's levels of MGRC (SPC, RE, RABBM and CBWFR). I could then have cross referenced this information with data collected and analysed through the qualitative interviews, in order to establish a link between personal levels of MGRC and its relative impact on therapists' experience, attitudes and behaviour in therapy with clients. However this was not possible or practical within the parameters of this masters thesis. Given the fact that much of the participants' experience of MGRC in therapy related to the therapeutic relationship, I would have been interested to find out what their clients' experiences of this were like, and indeed how their own GRC impacted on the process. For confidentiality reasons, the need to respect client anonymity, and other practical reasons however, it was not feasible to attempt to gain access to therapists' clients.

4.3 Recommendations

Men's identity and male masculinity issues have only emerged into the common psyche and discourse in recent decades because since time immemorial there was no felt need to distinguish them, or see them as anything other than 'the norm'. Because of heterogeneity and a male-dominated culture, the problems of being a man, and the unique challenges of balancing the masculine with the feminine have largely been silenced by the claxon of power and control. Male therapists occupy a rare profession which insists on continuing personal psychological development as a basis for good work and best practice. The very work of therapy with clients is in and of itself a context for personal growth and insight. They enjoy the benefits, as well as the challenges and struggles of facing their deepest selves, as well as clients, in the therapy process. They are also at the forefront of working with other men's struggles and problems, quietly yet concertedly, and can provide a unique perspective on the inner struggle of men and their needs in the world of today.

However, relatively little is known about the experience and work of male therapists in Ireland. There are very few male therapists either in training or practicing in comparison with female therapists. The lack of regulation of psychotherapy, and the fact that it is the most privatized of all the caring services (Boyne, 2003, p.10) means

that a lot is still not known about the experience of therapists in this work. Training is necessary to help some therapists resolve their issues around masculine identity, and also biases about men who deviate from masculinity ideology. The Irish psychotherapy accrediting bodies IACP and IAHIP should initiate specific training for male trainee therapists and therapists which focuses on issues of masculinity, male gender role conflict and its effects, and any perceived barriers to becoming a therapist, or thriving as one. Greater ongoing support also needs to be put in place for therapists to help them in what can be quite isolating and lonely work.

4.4 Further Research

Skovholt et al's original call to the research community for greater understanding of male roles, particularly in the context of 'human service professionals', is still as relevant today as it was over thirty years ago. A large scale quantitative analysis of the impact of MGRC on male therapists in Ireland would provide insight and direction regarding men's issues and internal psychological conflicts and struggles in the profession. This would go some way to beginning a dialogue about what restrictions or impediments might exist for men in being good therapists, or just to becoming therapists. It would also address the question, is the culture of therapy incongruent with men's masculinity ideology?

Appendices

Appendix A – Semi-structured Interview Questions

1. What would you say constitutes success for you as a psychotherapist?
2. How do you experience failure in your work with clients?
3. Do you ever experience competition with clients?
4. How would you rate yourself as compared with other therapists?
5. Can the concept of power influence work with clients?
6. How do you feel when faced with strong or intense emotions in clients?
7. Which emotion expressed in therapy do you personally find most difficult to deal with?
8. In supervision, have you ever struggled in receiving negative feedback?
9. How have you experienced erotic transference with clients in therapy?
10. How do you feel when a client describes sex and sexual experiences explicitly?
11. On balance which clients do you tend to prefer, male or female?
12. Do you see any differences between male and female clients?
13. Have you ever felt uncomfortable working with a male client?
14. Have you ever felt uncomfortable working with a female client?
15. What is your experience of working with gay male clients?
16. Has your work negatively affected the quality of your leisure or family life?
17. What impact does stress have on your life and work?
18. How do you relax?

Appendix B – Information Sheet & Consent Form

It has been requested that you take part in an interview regarding a qualitative study of male gender role conflict among male therapists and its influence on their work with clients. The interview will form part of a thesis that makes up some of the requirements for a Masters in Psychotherapy. It will be of 1 hour's duration, and will involve a questions and answer format between you and an interviewer about your experiences. The interview will be recorded and then transcribed. The recordings are to be used for the purpose of this study only, and will be destroyed after the project's completion.

Participation in this study is voluntary. The information contained within this sheet is yours to keep should you need to refer to it later. There is no obligation to take part in this study. If at any stage you feel you need to leave you are entitled to do so. You can also withdraw within one month of participation and request to have your data destroyed, by contacting me at the contact details below. After this period some of the data may have already been included in the write up of the thesis. The study is anonymous and no clues to your identity will appear in the thesis (pseudonyms will be used). Any extracts from what you say that are quoted will be entirely anonymous.

The data will be kept confidential for the duration of the study. The results will be presented in the thesis. They will be seen by my supervisor, a second marker and the external examiner. The thesis may be read by future students on the course. The study may be published in an academic journal.

At the end of the interview I will discuss with you how you found the experience and how you are feeling. I don't foresee any negative consequences for you in taking part. However, if you or anyone you know would like to talk to someone in confidence contact your GP who will recommend someone. Approval for this research study has been obtained from the Dublin Business School Ethics Committee. My thesis supervisor is Susan Eustace: *(contact details here)*

If you need any further information on the study you can contact me: Brian Gillen: *(contact details here)*

If you agree to take part in the study, please sign the consent section below:

Consent Section:

I hereby consent to partake in the research study outlined above. I confirm that I have read and understood the information sheet. I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving a reason. I understand that my identity will remain confidential at all times. I am aware of the potential risks of this research study. I am aware that an audio recording will be made of my interview. I understand that the information contained within this research will be used as part of the researcher's thesis.

Interviewee Name: _____

Signed: _____

Date: _____ / _____ / _____

Appendix C – Personal Details Form

1. Name: _____ (Ref Code: _____)

2. Date of birth: ____/____/____

3. Psychotherapy accreditation:

IACP IAHIP Other (please specify) _____

4. Duration of practice as a therapist: _____ years

5. Psychotherapy practice location: _____

6. Male/Female Client ratio: ____ / ____

7. Psychotherapy specializations / focus of work:

- _____
- _____

8. Education / therapy background:

9. Family / relationship status:

Single Partnered Married Children Other _____

10. Contact details:

Email: _____ Mobile: _____

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