Masculinity and Gay Men in the Therapy Room. A look at Male Gender Role Conflict

by John McMahon

Introduction

Working with masculinity ideals and gay men within a therapy room can be a challenge. One's gender identity affects how we think, behave and communicate. The rules of 'being a man' are deep rooted, well established and socially constructed. Levant's 'Code of Masculinity' infers societal beliefs that males must (1) be autonomous and self-sufficient; (2) curb their emotions; (3) be seen as tough and aggressive; (4) seek high social status; (5) always be ready for (heterosexual) sex; (6) avoid all things 'feminine', and (7) rebuff homosexuality (2001, p.357). For gay men, identifying with this 'code' can cause more difficulty, as one tries to retain their masculine identity, whilst living with a sexual orientation that can be perceived as less male. For others, the acceptance of their same-sex sexual orientation can reduce the need to follow gendered rules. But, as therapists, how do we explore this issue? And what are the subtleties to attend to if we ask how gay men (and indeed straight/bisexual men also) relate to their masculinity.

A pivotal area of masculinity research that can help therapists work with masculinity in the therapy room was the development of Gender Role Conflict (GRC) and the Gender Role conflict Scale (GRCS) (O'Neil, Helms, Gable, David & Wrightsman, 1986). This construct looks at how certain areas of masculinity can cause conflict within the individual and highlights crucial areas that rigid male gender roles can affect. By looking at the areas affected by GRC, therapists can link these issues with perceptions of male self identity and examine how male clients relate to their perceived gendered roles. Presently 350 research studies have been completed on GRC culminating in the publication of *"Gender Role Conflict Research 30 Years Later: An Evidence-Based Diagnostic Schema to Assess Boys and Men in Counseling"* (O'Neil, 2013).

Male Gender Role Conflict

The theoretical underpinnings of O'Neil's concept are based on an interaction of environmental and biological factors promoting certain masculine values; *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 typed behaviours, and *the fear of femininity* - a fear of possessing or expressing ideals, stances or actions that are stereotypically associated with appearing feminine. These values are learned in early childhood when gender role identity is moulded by parents, peers and societal values. Any violation of, or inability to, endorse these gender role stereotypes creates the possibility of 'Male Gender Role Conflict'. There are four patterns which GRC relates to;

- Personal attitudes about achievement practised through competitiveness and power in *Success/Power/Competition* (SPC)
- Reservations and restrictions in expressing one's feelings and vocabulary used to communicate basic emotions in *Restrictive Emotionality* (RE)
- Limitations of expressing

one's feelings and thoughts and difficulties with physical contact with other men in *Restrictive Affective Behaviour Between Men* (RABBM)

- Restrictions experienced in balancing school, work, and familial relations, resulting in problems with health, working too hard, stress, and an absence of leisure time and respite in *Conflict Between Work and Family Relations* (CBWFR).

Understanding these areas can be of great use to therapists when faced with clients who are having issues that relate to these subscales and can give useful insight into how rigid their gender roles are. GRC can affect men; *cognitively* - thoughts about gender roles, stereotypes, homophobia, anti-gay positions and attitudes towards women; *affectively* - with increased reports of depression, anxiety, homonegativity, anger, low self-esteem and negative identity; *unconsciously*; and *behaviourally*; acting, responding and interacting with others.

Pivotal life stages such as getting married, having children, the death of a parent can challenge gender role assumptions. The experience of both being 'in the closet'[1] and 'coming-out'[2] can also cause difficulties for gay men in how they relate to their masculinity. This is something therapists may work on when dealing with clients going through similar situations.

Gender Role Conflict and the Gay Man

Examining GRC and masculinity with gay men can be perceived as a paradox. Gender and sexuality are two very separate entities but they are inextricably linked. On one side Wester et al. (2005) noted that gay men can be less affected by gender role because of their lack of

[1] Not telling people about ones homosexuality.
[2] Recognising and accepting one's homosexuality publicly.

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conformity. The realisation of their same-sex preference may give them a greater awareness of self, helping them to be less affected by the expectations and restrictions that hetero-normative society places on them. There is the perception that gay men lack masculinity (Connell, 2001, p. 143). O'Neil (1981a) hypothesised that homosexuality violates the gender role norms of traditional masculinity because male homosexuality is often equated with femininity. The notion that gay people can hold characteristics of the opposite sex has been discussed in the Implicit Inversion Theory (Kite & Deaux, 1987, p. 84). This related to Kimmel who noted that homoerotic desire is seen as feminine desire, which homophobia seeks to suppress (2001, p. 34).

On the other side, however, gay men continue to endorse the strong gender role paradigm and embrace their masculinity (Halkitis, Moeller & DeRaleau, 2008, p. 107). Heterosexual men equated masculinity with their sexuality and rebuked gay men for their non-confirmatory sex roles (Keiller, 2010, p. 39). Effeminacy in men has been viewed as undesirable, unattractive and to be stigmatised (Haywood, 2003, p. 131). Sánchez et al. (2010, p. 105) viewed this as coming from internalised homophobia. They reported that masculinity is an important construct for gay men who wished for themselves and perspective partners to have masculine characteristics (p. 109). Gay men felt they needed to reject previous discourses of themselves as weak, non-men and to own an identity which corresponded to their homosexuality (Duncan, 2007, p. 334). This resulted in a rejection of femininity from within the gay community itself. Hyper-masculinity or 'straight-acting' became revered and with this the retention of rigid gender roles, and possibly greater levels of GRC, seen through body shape, dress code and emotional restriction (Edwards, 2004, p. 56; Mosher, Levitt & Manly, 2006, p.97/115).

GRC in Therapy. An Irish Study on Gay Men.

GRC considerably affects men's psychological wellbeing and distress and causes difficulties in the expression of feelings. The perception that the therapeutic process means the abdication of control and power can lead to a failure in attending counselling services. Further, the stigma of seeking help can threaten male identity. Many men need factual information about restrictive gender roles to understand how GRC affects their lives. They need to be psycho-educated that GRC stems from sexist attitudes (flawed perceptions that anything perceived as feminine reduces a man's sense of self), and distorted schemas about men and emotion which will give them insight into their own emotionality. Linking the client's lack of emotional potential to their masculinity can allow therapists investigate the cause of their emotional restrictions. Highlighting this as a consequence of the social construction of masculinity, rather than as a personal deficit can promote change (Good & Mintz, 2001). When these schemas are distorted they create exaggerated thoughts and feelings about masculinity ideology in a man's life. This can be caused by the fear or pressure about conforming or not, to stereotypic ideas of masculinity. They can affect the areas of emotionality, affection, sexuality, power, success, and self reliance and through the therapeutic alliance can be assessed,

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their illogical nature explored and modified through rationality and education.

Therapists with higher levels of GRC themselves have been reported to have disliked more and empathised less with gay clients, were less likely to be available and felt less comfortable with clients who were homosexual (O'Neil, 2008). These studies imply further therapist training may be necessary to explore their gender role beliefs and preconceptions about men who do not fit their masculinity ideology. The Gay Men's Health Service in Dublin offers training to therapists working with gay/ lesbian/ bisexual/transgendered people (please see www.gmhs.ie for details).

A small exploratory study on GRC was conducted to highlight how this construct would relate to an Irish and therapeutic setting. It aimed to help therapists' link sexuality to gender and understand how societies view on gender affects gay men. It also looked to promote a healthy gender role for gay men. Men being intimate, either emotionally or physically, with another man shake the foundations of the masculine mystique and can be contrary to the fear of femininity. This can increase or decrease susceptibility to GRC. This, along with the difficulties that gay men encounter in publicly expressing affection among themselves, must be considering factors when dealing therapeutically with gay men and GRC. Looking at this study's findings and how they may relate to us as therapists may give a better example of how we can interweave the concept of GRC into our therapeutic material.
The preliminary investigation was to examine a comparable study between heterosexual and gay men to see if sexual orientation would be an influencing factor in levels of GRC. The findings within this suggest that gay men did not have statistically significantly higher rates of GRC than heterosexual men. This could be explained by the point made previously by Wester et al., (2005) that gay men can be less affected by gender role *because* of their lack of conformity through having to realise their same-sex preference. However, the answer may not be as simple as this. It is very possible that the strength of the unconscious masculine code over-rides sexual orientation. Simply put, homosexuality in men is not enough of a factor to reduce or increase levels of GRC. This could mean that the masculinity issues within the four subscales could affect men of all sexual orientations. This implies that as therapists, we must examine gendered roles and its complexities in men of all sexual orientations.

When looking if age was an influencing factor in GRC scores, an interesting finding showed that younger gay men had higher scores in Success/ Power/Competition (SPC) than their heterosexual counterparts. This gave a clearer understanding that younger gay men placed a greater importance on success, power and competition. Evidence of this in the therapy room, where the individual feels a greater pressure to succeed or compete in areas within his life, could be seen as a way of asserting his masculinity and tied to older masculinity scripts. The findings of Restrictive Emotion (RE) suggest that younger men have more difficulty with emotional expression and that older men are more comfortable with emotion, something that may come with age. For therapists, this can be important as therapy itself is emotion-led. Talking with younger clients about how they relate to their emotions can reveal how they relate to their masculinity. Interestingly, older gay men scored higher in RE than their heterosexual counterparts, the opposite to the findings in the younger groups. This would go against a possible stereotype that gay men would be more emotional than heterosexual men. As therapists, the importance of looking at our own bias around stereotypes is paramount to our own therapeutic involvement in the counselling relationship. Our own unconscious ideas around how gay men may relate to emotional expression may hinder our involvement with our clients and as a result of this bias, therapeutic processes could be missed.

Race and GRC was also examined. Men's multicultural origins can play a part in how GRC is perceived, with some cultures placing a greater importance onto gender roles. Wester (2009) noted that gay men of colour may face additional difficulties when they do not meet the male gender role as defined by their culture of origin. Their issues of religious faith can also play a factor in their GRC issues. Therapists need to consider the issue of masculinity from the perspective of other cultures as important when working therapeutically with gay men. Gaining knowledge in how homosexuality has been accepted or rejected in non-Irish clients' country of origin can strengthen empathy as well as expand our cultural competence as therapists. Previous research on African-American gay men (Crawford et al., 2002) has reported significant feelings of loneliness, isolation, depression, suicide and substance abuse.

Conclusion

The construct of Gender Role Conflict is an important theoretical concept when working with male clients, their masculinity and their sexual orientation. The embedded foundations of the 'masculine mystique', how males acquire rigid

masculinity scripts, and the 'fear of the feminine', give valuable insights into how negative aspects of masculinity can be developed and instilled. By understanding the four subscales within GRC, therapists can link client issues to their maleness ideals, and can offer a therapeutic space to give masculinity a voice. This will give important support to gay men who struggle with their sexuality and their emotional expression.

The size of the study was admittedly small (n = 40) and further studies should aim to increase the participant size to confirm this study's results and gain a more satisfactory and representational reading of GRC in gay men living in Ireland. However, these findings may go against what we would have thought about gay men. This offers us the experience of reflecting on our own possible biases, as therapists, which may rely on vague stereotypes about gay men and emotional expression, and how they communicate with their masculinity.

O'Neil (2008) suggests working with men to form a *'healthy masculinity'* to learn alternatives to sexist gender role attitudes. Highlighting strengths moves the shift away from what is wrong with men to identifying the qualities that empower men to improve human life and society and this could work in conjunction when working with gay men. This is important as it shifts from pathologising to exploring a positive masculinity. Real men can cry, can express emotions, can embrace their feminine sides and still be real men. Riggle et al., (2008) noted that a positive aspect about being gay was "a sense of freedom from gender role stereotypes and expectations and the social constructions of gender roles." By taking these positive aspects of gay life and looking at how they relate to GRC we can, as therapists, have the means and abilities to work with gay men and their masculinity in ways that can foster movement and progress in a safe and therapeutic way.

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John McMahon

John McMahon is a trained and accredited Psychotherapist/Counsellor with a BA (Hons.) in Counselling and Psychotherapy from Dublin Business School. His research interests include 'Gender in Therapy' having completed an M.Phil in Gender and Women's Studies at Trinity College Dublin. He is currently studying a PhD in Psychology at UCD undertaking research on emotional patterns in men and their implications on therapy.

Contact Details:

John McMahon

johnchris.mac@gmail.com