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Gender role socialization of clinical social workers and its effect on the treatment of male alexithymia

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ABSTRACT

The purpose of this exploratory, qualitative study was to gain a deeper understanding of how the gender role socialization of clinical social workers affects their experience of treating men with alexithymia. The study used two semi-structured, in-person interviews with six licensed independent clinical social workers to gather qualitative data about their attitudes, beliefs and experiences of gender role socialization, as well as their experience of treating men with alexithymia.

The findings suggest a clinician's experience of struggling with their gender role schema may lead to increased empathy toward men with alexithymia. Personal struggle with gender role was a prominent theme in this study, with nearly all participants identifying a past or ongoing struggle to reconcile gender role schemas consisting of traits traditionally considered both masculine and feminine.

Results further suggest this struggle serves as the basis for participants' understanding of issues faced by men with alexithymia and tailoring interventions to account for the needs and expectations of this population. In particular, this finding appeared particularly strong among male and LGBTQ respondents, who respectively draw on their personal struggle with gender role and adversity from having their sexuality challenged by the dominant culture. This study's findings emphasize the importance of clinical social workers and students engaging in critical examination of their relationship to traditional gender roles.

GENDER ROLE SOCIALIZATION OF CLINICAL SOCIAL WORKERS AND ITS

EFFECT ON THE TREATMENT OF MALE ALEXITHYMIA

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I

Introduction

Gender role socialization, the process by which individuals develop beliefs about the roles and expectations associated with each gender group, is an intrinsic component of individual development in every society known to social science (Stockard, 1999). It follows that clinical social workers, as members of larger societies, are subject to gender role socialization and the development of their own beliefs and expectations about gender roles. It is reasonable to conclude that these socialized attitudes may form the basis for particular strengths or biases in clinical social workers' treatment of individuals or specific populations.

Male alexithymia is a sub-clinical construct used to describe men who have difficulty identifying and expressing their own emotions and the emotions of others. Literature suggests the etiology of male alexithymia is not well understood and a dearth of literature exists. However, male alexithymia is thought to be a complex product of a client's constitutional characteristics and environmental circumstances, including the client's identification with traditional gender roles (Fischer & Good, 1997; Levant & Pollack, 1998). Given the shared influence of gender role socialization on the etiology of male alexithymia, as well as its influence on clinical social workers, I became interested in exploring how the gender role socialization of clinical social workers influences their treatment of men with alexithymia. Specifically, I explored the research question: "How

does the gender role socialization of a clinical social worker affect their experience of treating men with alexithymia?"

It is important to define several key terms in order to understand the topic this research addresses. For the purpose of this study, the operational definition of the phrase *gender role socialization* refers to the clinical social worker's (hereafter referred to as clinician) attitudes, impressions or personal experiences related to the process of developing their beliefs about the roles and expectations associated with each gender group (Stockard, 1999). The term *experience of treating* refers to a social worker's subjective interpretation of their approach towards, process of and effectiveness in treating men with alexithymia. The term *men with alexithymia* refers to male clients, past or present, the social work participant identifies as meeting the definition of alexithymia outlined in this study, which is defined by Gregiore Zimmerman (2010) as,

> a sub-clinical construct[…] characterized by a cluster of cognitive and
>
> affective features that includes difficulty in identifying and expressing
>
> feelings, a striking paucity of fantasies, difficulty in distinguishing between
>
> feelings and physical sensations, and a cognitive style that is utilitarian and
>
> externally oriented. (p. 1)

Due to the features of alexithymia, clinicians treating this condition face a particular challenge accessing the affective content necessary for accurate evaluation and effective treatment (Brooks, 1998). Given the function traditional gender role socialization appears to play in the etiology of alexithymia, it is possible the features of a clinician's own gender role socialization, regardless of the clinician's sex, additionally influences their subjective experience of treating male alexithymia. This hypothesis is

supported by previous research indicating potentially detrimental effects on clinical interpretation, countertransference and other facets of practice related to a clinician's gender role socialization (Deering and Gannon, 2005; Teri, 1982; Wester and Vogel, 2002; Wisch and Mahalik, 1999). The possible effects of a clinician's gender role socialization on their treatment of male alexithymia have particular salience for social work, given it is a predominantly female field, as well as the prevalence of alexithymia as a male condition correlated with the adoption of traditional male gender roles (Fischer & Good, 1997; Levant & Pollack, 1998).

Understanding the relationship between a clinician's gender role socialization and their experience of treating male alexithymia may uncover clinical biases as well as opportunities for improving the treatment of this condition. Findings may be of particular utility in understanding the impact of client-clinician gender role interactions on the treatment of male alexithymia within the female-dominated field of clinical social work.

A second reason for conducting this study lies in the lack of literature directly addressing the research question. The aforementioned literature has highlighted the role of traditional male gender role socialization in the etiology of alexithymia as well as the impact of gender role socialization on clinical practice. However, little, if any, research has been undertaken to examine the effects of a clinician's gender role socialization on their experience of treating male alexithymia. One possible reason literature has not addressed this question is that exposure of clinical biases related to gender role socialization, and particularly those related to traditional gender roles, may contradict clinical ideals of progressive values and self-awareness (Brooks, 1998).

Utilizing an exploratory research design and qualitative methods, I conducted 12 interviews with six licensed independent clinical social workers (LICSWs), four of whom identified as male and two whom identified as female, who are treating or have experience treating men with alexithymia. A semi-structured interview guide was utilized to collect data. Interview questions focused on the clinician's experience of their own gender role socialization, beliefs about their own gender role identity, and experience of treating male alexithymia. Thematic analysis was utilized to interpret the data and limitations of the study are included as part of discussion. The following chapters discuss the existing literature informing this study, methodology used to explore the research question, qualitative findings, and a discussion section that attempts to interpret those findings.

CHAPTER II

Literature Review

The following literature review will examine prior research concerning the study question: "How does the gender role socialization of a clinical social worker affect their experience of treating men with alexithymia?" The first section will introduce the theory of gender role socialization and its applicability to the adult development of clinicians. The second section will examine the impact of gender role socialization on the therapeutic process. A section will follow establishing the prevalence of alexithymia in men and justifying its relevance to the field of clinical social work. The fourth section will outline the role of gender role socialization in the etiology of alexithymia. Finally, the last section will highlight unique challenges clinicians face when treating male alexithymia, underscoring the need to better understand the treatment of this population.

Gender Role Socialization

A central theoretical basis of the proposed study is the theory of gender role socialization. Gender role socialization is described by Stockard (1999) as the process of developing beliefs about the roles and expectations associated with each gender group. The author further asserts that gender role socialization is one of the most basic and central socialization processes of society and that every society known to social scientists is gendered. Leaper and Friedman (2006) acknowledge that while gender role socialization is conceptualized through multiple theoretical lenses, the influence of peers,

teachers, parents, the media, and larger social-structural influences remain as central mechanisms for transmitting the societal expectations and norms of gender roles.

Given the pervasiveness of gender role socialization, clinicians, like all members of societies, are shaped by gender role socialization and need to critically examine related biases. However, Brooks (1998) notes that clinician's ideals of psychotherapy consist of strong themes centered on self-awareness and value-neutral evaluation that work as psychological incentives against examining or acknowledging biases related to gender roles. In other words, acknowledging prejudices or biases based on gender role socialization contradicts many therapists' notion of competent practice. Brooks (1998) further posits that maintaining a view of competent practice that assumes a clinician's lack of gender bias is both dangerous and unrealistic. The proposed study seeks to add to our understanding of how the influence of gender role socialization might impact the therapeutic process.

In a review of research examining the influence of sex and gender role on the therapeutic process, Mintz and O'Neil (1990) suggest that clinicians are exposed to the same gender role socialization as their clients and that clinical challenges based on gender role socialization exist for clinicians whether they are male or female. The authors posit that both benefits and shortcomings in the therapeutic process may be attributed to the gender role socialization of both male and female clinicians. Additionally, the authors highlight how previous studies tended to conflate sex and gender as one in the same, and advocate for therapy process studies that examine pairings of both sex and gender between clients and therapists. This discernment between sex and gender is integrated into the proposed study, in which male- and female-identified clinicians are

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included in the study sample. Although this study sought to examine clinicians'

experience of treating male clients with alexithymia, it is believed that inclusion of both

male and female sexes in the sample will allow for distinction between themes relating to

sex and gender.

Literature on gender role socialization describes it as a central and universal

aspect of human development. Clinicians are not immune from gender role socialization,

but may be predisposed to ignore potential biases due to beliefs about being a competent

practitioner. The ubiquitous influence of gender role socialization on clinicians and the

lack of literature examining its relationship to the treatment of male alexithymia highlight

the need for the proposed study.

The Impact of Gender Role Socialization on Therapy

In a paper examining transference and resistance encountered by female therapists

working with traditionally gender-socialized men, Deering and Gannon (2005) note that

female therapists encounter unique clinical challenges. In one example, attempts by male

clients to mask their shame by "taking charge" of the therapeutic dialogue may instead be

experienced by the female therapist as an attempt by the client to place her in a

traditionally submissive female gender role. In this example, the gender role

socialization of both the client and therapist served as the framework, or "script," through

which clinical misattunements were enacted. Further study is needed to understand how

gender role socialization might similarly act as a context for clinicians' subjective

experience of treating men with alexithymia.

Biases related to gender role have been shown to exist for male clinicians as well.

Wisch and Mahalik (1999) conducted a study examining the relationship between a

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clinician's gender role conflict, client sexual orientation and client emotional expression. Results indicated that certain combinations of client gender role-related behaviors interacted with therapists' gender role conflict to affect therapist judgment. Specifically, the authors concluded that therapists rating high in gender role conflict tended to hold negative views of gay clients who expressed anger, while therapists rating low in gender role conflict tended to underpathologize gay clients who expressed sadness. This study demonstrated a relationship between male therapists' gender role socialization and their assessment of specific client populations. The proposed study seeks to explore whether a similar relationship exists between a clinician's gender role socialization and the treatment of men with alexithymia- another specific population.

In a similar study, Teri (1982) tested clinicians' ratings of client functionality in identical clinical vignettes, uniformly varying only the reported sex of the client and the client's presentation in the clinical scenario with either stereotypically "male" or "female" reactions. Results showed that clinicians negatively assessed stereotypically female reactions regardless of client sex and expected women to be more open to therapy. Therapist sex-role style was also shown to be significant when main effects were present.

Finally, in a review of literature examining the role of gender role conflict in the efficacy of male therapy trainees, Wester and Vogel (2002) contend that trainees with high gender role conflict might have difficulty making full use of empathy or use of self in the therapeutic process. Such deficits were posited to have a detrimental effect on the trainees' work with specific populations, including gay men or highly emotional men. The review also suggested that trainees with gender role conflict might poorly assess their own clinical ability. This study similarly underscores the potential for gender role to

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influence clinical effectiveness with specific populations as well as the possibility of gender role influencing a therapists' interpretation of their own effectiveness. The possibility that either of these themes may be present in the treatment of men with alexithymia warrants further study.

Previous literature has demonstrated the potential influence of gender role socialization on the therapeutic process. Clinical interpretation has been shown to be affected by a clinician's adoption of or conflict with traditional gender roles. Additionally, reactions to clients have been shown to be influenced by the client's behavior and sexual orientation within the larger context of the clinician's gender role socialization. Other studies have suggested that clinicians' experience of gender role conflict may affect their estimation of their own clinical ability and inhibit effective work with certain populations. Taken together, the literature indicates that clinical biases may exist based on a clinician's gender role socialization, and that these biases may be especially consequential for particular client populations.

Alexithymia's Prevalence in Men

While alexithymia is not a feature restricted to men, research has indicated a higher occurrence in men than in women (Levant, Hall, Williams & Hasan, 2009; Vorst & Bermond, 2001). For instance, in a meta-analysis of alexithymia literature, Levant, Hall, Berger and Hasan (2009) showed that, on average, men score higher than women on measures of alexithymia. Further, in a study confirming the reliability of the Bormond-Vorst Alexithymia Questionnaire, Vorst and Bermond (2001) found significant correlation between sex and emotionalization, showing higher emotional arousal in women and higher levels of alexithymia in men. The tendency for alexithymia to present

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more frequently in men warrants research exploring the impact of a clinician's gender role socialization as it relates to treatment of men with alexithymia. This research is particularly salient in the largely female-dominated field of clinical social work ("Demographics," 2003), elevating the potential salience of gender role socialization on the treatment of this client population.

Alexithymia's Relationship to Traditional Male Gender Roles

Previous literature has shown a link between the adoption of traditional male gender roles and the development of male alexithymia. Pollack and Levant (1998) define traditional male gender role ideology as consisting of seven norms. These norms include: avoiding all things feminine; restrictive emotionality; toughness and aggression; self-reliance; achievement and status; nonrelational attitudes toward sexuality; and fear and hatred of homosexuals. The authors further posit that the male gender role socialization process results in boys being socialized to de-emphasize feelings of vulnerability, emotions related to caring and connection as well as emotionality in general, resulting in *normative male alexithymia.* This relationship between gender role socialization and alexithymia is also supported by Fischer and Good (1997) who studied the relationship of two separate measures of traditional masculine gender roles with alexithymia and fear of intimacy. Results indicated that alexithymia and fear of intimacy were strongly related to traditional male gender roles.

Gender role conflict (GRC) is an important framework for understanding negative life consequences experienced by men who adopt traditional male gender roles. GRC is defined by O'Neil (2008) as:

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[…] a psychological state in which socialized gender roles have negative consequences for the person or others. GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self.

O'Neil (2008) further describes three types of GRC: 1) discrepancy strain, in which a person fails to meet traditional gender role standards, 2) trauma strain, resulting from a traumatic event related to gender role socialization, and 3) GRC experienced from role transitions, in which men experience GRC due to events during gender role socialization that modify or contest his existing gender role schema. O'Neil (2008) posits that GRC due to role transitions can produce both GRC as well as positive life changes.

Previous literature has demonstrated that unique clinical challenges exist for therapists treating alexithymia. These include negative countertransference reactions of the therapist as well as a client's lack of emotional awareness and expression (Brooks, 1998). Other research has shown that alexithymia has a higher prevalence in men and demonstrates the relationship between the male gender role socialization process and development of alexithymia. Given the function of traditional gender role socialization in the etiology of male alexithymia, the lack of research addressing whether a clinician's gender role socialization has significance in the treatment of alexithymia underscores the need for the proposed study.

Challenges Associated with Treating Alexithymia

Clients with alexithymia pose unique treatment challenges for clinicians. In a study examining the impact of emotional expression on the relationship between patient alexithymia and therapists' reaction to patients, Ogrodniczuk, Piper and Joyce (2008)

studied 107 subjects. Their findings indicated that as levels of alexithymia increase, patient levels of positive emotional expression decrease and negative therapist reactions to the patient increase. Results from this study indicate potential negative countertransference experienced by clinicians treating alexithymia. This finding highlights the need for further research examining how a clinician's gender role socialization affects their countertransference reactions when treating men with alexithymia.

Further, specific treatment challenges may be associated with male clients suffering from alexithymia. In a study examining the impact of gender role conflict, traditional masculine ideology, alexithymia and age on attitudes toward help seeking, Berger, Levant, McMillan, Kelleher and Sellers (2005) found that although there was not a significant relationship between alexithymia and attitudes toward psychological help seeking, there was a significant relationship between traditional masculine ideology and negative attitudes toward psychological help seeking. As previous literature has shown that alexithymia is correlated to the adoption of traditional male gender roles (Pollack & Levant, 1998), it may be hypothesized that complex relationships exist between a client's gender role socialization, his attitudes toward help seeking and its influence on the clinician's experience of treating male alexithymia.

Summary

Gender role socialization is one of the most basic and central processes of human development. As with all human beings, clinicians are shaped by the same forces of gender role socialization as their clients, but may be predisposed to overlook biases associated with their beliefs about gender roles. Previous research has shown that aspects

of clinical judgment including countertransference, clinical interpretation, and a clinician's valuation of their own effectiveness can be affected by the clinician's gender role socialization.

Previous literature has shown a link between the adoption of traditional male gender roles and the development of male alexithymia. Evidence also suggests that alexithymia has a higher occurrence in men and presents unique treatment challenges including a clinician's negative countertransference reactions as well as difficulty with evaluation and treatment due to the client's lack of emotional awareness and expression.

Given the function gender role socialization plays in both the etiology of male alexithymia and the practice of psychotherapy, it would be pertinent to examine whether relationships exist between a clinician's gender role socialization and their experience of treating of male alexithymia. A lack of literature examining this specific question justifies the proposed study. Additionally, the proposed research question holds particular salience when considering the treatment of a male-associated condition within the female-dominated field of clinical social work ("Demographics," 2001). In this context, the salience of gender role-related dynamics in treatment may be heightened and themes related to the intersection of sex and gender role socialization may have particular value for the field of social work.

CHAPTER III

Methodology

This qualitative study investigated the following question: "How does the gender role socialization of a clinical social worker affect their experience of treating men with alexithymia?" The purpose of this study was to explore whether a clinician's gender role socialization influenced their experience of treating male alexithymia. This study was devised as a qualitative, exploratory design using semi-structured interviews. Qualitative methods are often used when little is known about a research question, when a topic intrinsically involves emotional depth, and to understand the subjective experiences of participants (Padgett, 1998; Engel & Schutt, 2005).

Previous literature has studied the impact of clinicians' gender role socialization on clinical practice, as well as the role of gender role socialization on the etiology of male alexithymia. However, a search of the literature returned no studies examining how a clinician's gender role socialization impacts their experience of treating male alexithymia. Additionally, the research question was narrowly focused on clinicians' experiences of treating men with alexithymia, a topic of considerable subjectivity and emotional depth. For these reasons, qualitative methods were selected; emerging themes from this study lay the framework for later quantitative studies.

Sample

Participants in the study were clinical social workers who met the following criteria: held an LICSW license, had five or more years of post-licensure experience, identified as either male or female and were currently treating or had experience treating men with alexithymia. Clinicians with less than five years of experience were excluded from the study. This time frame was selected by the researcher as a reasonable period of time in which participants may have gained a sufficient level of professional experience following licensure. Professional experience was chosen as criteria by the researcher to isolate alexithymia specific clinical challenges from challenges that may be related to clinical inexperience.

Quota sampling was employed to include at least two clinicians of color (defined by the National Association of Social Workers (NASW) as identifying as Mexican American, Native American, Asian American, Hispanic/Latino or African American/Black) in order to exceed the national demographic makeup of the social work field, as reported by the NASW, (Demographics, PRN 2:2, 2003). The purpose of quota sampling was to ensure underrepresented perspectives of clinicians of color were included in an understanding of the phenomena, especially since clinical social workers are predominantly white ("Demographics," 2013). Further, initial quota sampling was employed to secure an equal proportion of male and female clinicians. This gender quota was not representative of the study population, which is predominantly female. However, an equal representation of male and female clinicians was initially pursued to explore the gender role socialization phenomena, particularly whether emerging themes have any relationship to the sex of the therapist.

Purposive selection was utilized to enroll six participants, who were interviewed twice for this study to achieve a complete understanding of the participants' experiences (Padgett, 1998). Clinicians were initially selected via *Psychology Today's* online therapy directory, set to search within one mile of zip code 02138. This sampling frame was selected for geographical convenience in relation to the limited time frame allowed to complete the study. Each participant's online profile was examined to ensure they met eligibility requirements. Systematic random sampling was used to minimize researcher selection bias, in which every third clinician listed was evaluated for selection, with the goal of identifying 25 potential participants. Email contact information was sought for each participant via a search engine, as *Psychology Today* did not provide contact information in search results.

However, during initial attempts to identify participants and before approval by the Smith College School for Social Work Human Subject Review Committee (SCSSW HSR), it was determined the complexity of instituting systematic random sampling and the need to conduct an internet search for participant contact information was prohibitively inefficient. In consultation with the thesis advisor, it was also determined systematic random sampling was not ultimately necessary as this study's goal was to understand the lived experience of clinicians treating male alexithymia, rather than to seek generalizability of results. In consultation with the thesis advisor and SCSSW HSR, potential participants identified using the previous method were retained and a new recruitment methodology was implemented.

This new methodology utilized convenience sampling and snowballing techniques to identify additional participants. Utilizing this new methodology, the researcher

contacted clinicians known to him via email to request participant referrals who met eligibility requirements (See Appendix D). These clinicians were also invited to participate if they met eligibility criteria and expressed an interest in participating. However, to minimize the risk of participant bias or coercion, clinicians who had a current professional relationship or a relationship involving power differentials with the researcher were not eligible for participation. Potential participants referred for inclusion were encouraged to contact the researcher or were contacted by the researcher with the referring clinician's consent (See Appendix D).

As potential participants were identified, each was sent an email introducing the researcher and study, along with a link to a SurveyMonkey eligibility survey. Enhancement of survey participation was informed by the work of Monroe and Adams (2012), incorporating strategies such as short, multiple introductory emails to engage participants in the survey. Interested candidates completed the short survey gathering information regarding the clinician's sex, race, years of licensed practice and experience treating male alexithymia. Survey results were evaluated on a rolling basis for conformity to eligibility requirements and sample quotas until six qualified candidates were identified for participation. No verification was made of survey responses unless participants contacted the researcher with specific questions.

Of the six participants, two identified as female and four identified as male. Of these participants, one female and two males identified as LGBTQ. Although the initial gender quota sought a ratio of fifty percent female participants, respondents to recruitment methods tended to identify as male and efforts to recruit additional female participants were limited by time constraints. Similarly, although nine clinicians of color

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were solicited for participation, four did not respond, four declined to participate, and one did not complete the survey process. Consequently, all participants identified as white.

Potential participants who met the sampling criteria and agreed to participate were emailed a consent form (Appendix C) that explained the purpose of the study, risks and benefits of participation, and federal regulations protecting confidentiality. Arrangements were then made for the participant to meet in person, at a place of the participant's convenience. The researcher provided suggestions, when necessary, regarding settings that were most likely to afford privacy. Signed consent forms were obtained in person before the first interview, and an additional copy was given to the participant to keep.

Ethics and Safeguards

Ethical standards were established to maintain the confidentiality of participants as well as the details shared in the course of interviews. No files or interview notes contained the real names of participants. Instead, a coding system was utilized to assign pseudonyms to each participant (M2, F1, etc.), and all subsequent materials employed the assigned pseudonyms in place of participant's real names. All study documents, files, and materials were stored in a locked or password-protected manner for three years by federal regulations. Following this period, the researcher will either retain the material in the manner described or have it destroyed. Clinicians were cautioned not to disclose identifying client information during interviews. Any client information revealed during interviews was redacted, and the researcher maintained the confidentiality of any disclosure of client details according to the NASW Code of Ethics.

Benefits to participants included: enhanced insight into their clinical approach, their relationship to gender role socialization, and an opportunity to discuss clinical challenges of working with an important client population. Additionally, participants contributed to the advancement of clinical knowledge regarding treatment of an important population. Potential risks to participants included the possibility of violating their professional ethical obligations toward client confidentiality by failing to disguise client-identifying information adequately. Additionally, it was possible that participants' discussion of experiences with gender role socialization, gender roles or case material could cause emotional discomfort. All participants were informed of these risks. Additionally, as all participants were mental health professionals and possessed a graduate degree, it was assumed they were familiar with and could access mental health resources available to address any discomfort.

Data Collection

Qualitative data was collected in two separate, approximately 60-90 minute, semi-structured, in-person interviews facilitated by the researcher. Semi-structured interviews allowed the researcher to focus on potential themes identified in the literature, while being open-ended enough for clinicians to elaborate on emergent themes (Padgett, 1998). All interviews were recorded on a digital audio recorder and transcribed by a transcriptionist.

Each interview was conducted in the following manner: in the first 10 minutes, the researcher explained the interview process, reviewed the consent form, and answered any questions. If the participant had no objections, they were asked to sign the consent form. At this point, the audio recorder was switched on, and participants were asked to

confirm they understood the risks and benefits to the study. During this process,

participants were also asked general questions about their practice in an informal manner.

Providing participants the opportunity to informally discuss their practice and

professional backgrounds had the effect of establishing rapport, acclimating participants

to the interview process and mitigating potential respondent bias (Padgett, 1998).

For the remaining 45 minutes of the interview, the researcher asked the

participants open-ended questions, encouraged the participants to ask clarifying

questions, and to consider the interview as a dialogue. However, participants were also

informed, in the interest of time, the interview might be redirected to new topics.

Subsequent interview questions were grouped into the following themes (to see the

complete interview guide, please see Appendix E):

- Extent of training to treat alexithymia

- The clinician's experience of identifying alexithymia in male clients

- The clinician's initial thoughts or impressions about beginning work with male clients with alexithymia

- Nature of clinical impasses

- Attitudes about treating male alexithymia

- Client participation and retention

- Clinician's perceived effectiveness of treatment

- Clinician's experiences of gender role socialization

- Clinician's assessment of their own gender role socialization

- Clinician's awareness of gender role dynamics in therapy

- Relationship between clinician's sexual orientation and gender role socialization

- Follow-up questions for clarification or elaboration on the above themes

To enhance the validity of interview questions, the interview guide was reviewed by the researcher's thesis advisor, who holds an MSW degree and is a Ph.D. candidate.

A digital voice recorder was used to document all interviews and the researcher took informal notes on a notebook, logging information such as facial expressions, tone of voice, and body language. Immediately following the interview, the researcher's log was updated to include his perceptions and thoughts during the interview. The log also included the time, length and location of the interview.

Interviews were transcribed by a transcriptionist who signed a confidentiality agreement (Appendix F) and the researcher proofread transcripts. All files resulting from interviews, including the original audio file, transcription, and interview log were encrypted and collectively saved on the researcher's password protected computer to individual folders representative of each interview.

Data Analysis

As a novice researcher, approaches to data analysis were sought that were both straightforward and suited toward uncovering the subjective experience of clinicians' gender role socialization and their treatment of men with alexithymia. Thematic analysis is one such approach commonly used in qualitative research (Padgett, 2008; Saldana, 2013). Saldana (2013) in particular notes that theming data is appropriate for most studies, especially those concerning "phenomenology and those exploring a participant's psychological world of beliefs, constructs, identity development and emotional experiences" (p.176).

Each interview was audio recorded and transcribed. Transcripts of each interview were entered into Dedoose for coding and data analysis. Holistic coding was utilized to identify latent themes by "lumping" the narrative according to stories or broad topics (Saldana, 2013). The researcher utilized a constant comparative analysis, described by Padgett (1998) as an inductive practice rooted in grounded theory which identifies initial codes from emerging themes in the data, reviews data to ensure it is coded according to the themes, and modifies or adds codes based on new data. As themes emerged from coded data, they were examined in the context of existing literature and were used to inform follow-up questions for the second round of interviews. Once all the transcripts were coded holistically, the researcher utilized thematic analysis to analyze the codes and ultimately reduce them into eight broad themes (Padgett, 2008; Saldana, 2013).

Potential biases affecting data analysis include researcher positionality and researcher bias. Researcher positionality includes clinical inexperience that may inhibit clinically informed analysis in addition to white, male, heterosexual identities held by the researcher that are informed by and promote a dominant-culture worldview. Another potential research bias includes the assumption by the researcher that differences may exist in social workers' experience of treating male alexithymia based on the clinician's gender role socialization.

Speaking specifically to researcher bias, this researcher often worked with men in both his first and second-year field placements. During these interactions, the researcher often felt uncomfortable working with male clients who exhibited a lack of emotional expression and disinterest in mental health help seeking. This researcher also identifies less with traditional gender role socialization. These combined experiences formed the

initial interest in undertaking the proposed study. However, these experiences may also serve as a bias towards confirming that male therapists who do not identify with traditional male gender role socialization have similar challenges approaching treatment of men with alexithymia.

To mitigate both researcher bias and positionality during the coding process, the researcher maintained a memo including the researcher's thoughts and ideas about emerging themes in the data (Padgett, 1998). In this way, coding decisions can be audited later by the researcher or another investigator.

CHAPTER IV

Findings

This chapter outlines the findings from semi-structured interviews with Licensed Independent Clinical Social Workers who identified having experience treating men with alexithymia. As outlined in Chapter 2 (Methodology), data from twelve semi-structured interviews were analyzed utilizing a constant comparative approach toward holistic coding and thematic analysis. Each semi-structured interview sought to answer the research question: "How does the gender role socialization of a clinical social worker affect their experience of treating men with alexithymia?" Interview questions were designed to understand participants' personal experiences and conceptualization of their gender role socialization, as well as their experience of treating men with alexithymia. Thus, findings below are grouped into two sections. The first section addresses the theme of participants' *gender role socialization* and supporting subthemes, and the second section presents participants' *experience treating men with alexithymia* and its supporting subthemes.

Gender Role Socialization

For the purpose of this study, the operational definition of *gender role socialization* refers to the clinical social worker's attitudes, impressions or personal experiences related to the process of developing their beliefs about the roles and expectations associated with each gender group (Stockard, 1999). In the course of

exploring this theme, respondents reflected on both past experiences of gender role socialization as well as their beliefs about their current gender role schema.

Thematic analysis revealed three subthemes relating to participants' perception of important aspects or experiences relating to their gender role socialization: blending of masculine and feminine traits, personal struggle with gender role, and gender role trial.

Blending masculine and feminine traits. When defining aspects of their gender role schema, all clinicians except M2 and F1, regardless of their gender identity, reported being aware of a coexistence of personal traits traditionally considered masculine as well as traits traditionally considered feminine. Identifying with—and often valuing—traits traditionally associated with another gender seemed to indicate that respondents identified less with traditional gender roles. Male participants often highlighted their possession of traditionally feminine traits such as gentleness and vulnerability, along with traditionally male-associated traits. Participant M1 describes what it means to him to be a man:

> It is embodying the masculine and the feminine. And it's not gender neutral per say but... Its… I strive to be a man who knows how to handle emotions, express emotions, understand emotions, as well as… can be really firm and really clear and directive, passionate, angry at times and reflective at times. Asking for forgiveness, taking responsibility. I mean this is the ideal male and this is something that I strive to embody.

Participant M3 identified a similar juxtaposition of assertive and nurturing traits as part of his gender role schema:

Fuck. Such an easy [question]...right? what does it mean to be a male? I like the sexuality of being a male. I like eroticism of being a male. I like bigness of my body. I like the gentleness that comes with being a man. Because I'm queer I love pushing, you know, a lot of roles. It's [They're] like, "You're a big guy!" And its [I'm] like, "Yeah I'm a hell of a bottom too, you know?" So I really love playing with that. It's just a-- such a core part of who I am, Joe. There's a part of me that feels protective, there's a part of vulnerability that comes with being a man that often doesn't get seen [...]

In contrast to male participants, participant F2 highlighted aspects of herself that she felt were traditionally associated with men:

Yeah, so I think that's part of me just, like, stepping back and saying, hey wait a minute, I know I don't want to be a dude but-- which, I really don't want to be a dude [laughs]-- but in these ways I like that masculine part of myself which I really identify to be as male in certain ways. Yeah, for example, like dating-- it's just so hard to be passive with dating for me and I just don't think… I just don't have it in me. So that would be like a really good example.

Personal struggle with gender role. All participants except F1 described experiencing an internal struggle-- either presently, in the past, or both-- about coming to terms with aspects of their gender role. While most respondents identified with and often valued gender traits not traditionally associated with their identified gender, their struggle with gender role often involved a process of understanding and accepting the coexistence

of these traditionally opposing traits. Respondent M1 describes his difficulty reconciling feelings of sensitivity with traits such as being strong and athletic, traditionally conceived as male. In the following example, he describes how he felt about his mother's pride in frequently retelling his refusal to fight a bully:

> But I don't think she realized that her telling it over and over again was problematic, although I told her many, many times. Like, "Mom do we have to go over this again?" Like, "Alright, alright, great. Like, come on, can we not talk about that again?" I think it was highlighting my sensitivity and highlighting my um... the pain of it... But probably, in retrospect, it was probably the highlighting of my sensitivity was not what I wanted her to do. You know, 'cause I was in this battle of, internal kind of slash external battle of being sensitive and strong. And that too felt irreconcilable. Kind of, like, could you be both?

In a similar way, participant F2 describes how she is aware of aspects of herself traditionally considered masculine, and how she is in the process of considering the proper balance of masculine and feminine traits within herself:

> Okay, well anyway, I mean I do identify as queer and even though I was born female, you know, like cis-gendered and I'm mostly heterosexual, you know, and... But I think about gender all the time. […] So I don't think I was-- I don't-- I'm not that feminine of a female you know? I don't feel that feminine, like, if I dress up in a dress, I kind of feel like I'm in drag. Well, I'm trying to train myself [laughs]-- I'm trying to learn to be more feminine, actually.

Participant M2 describes a different experience, in which he struggled to move beyond traditionally male expectations of stoicism in order to include feelings of vulnerability as part of his gender role schema:

> You know what I think, obviously as a male, sort of some of the struggles that that men go through I struggled with, that sense of vulnerability— being-- leaving myself open to being in a relationship with somebody, sort of being able to tap into other feelings... I think there certainly was an element, even earlier in my career, outside of the therapy-- sort of like, "I can handle this," you know, this stiff upper lip almost-- that sort of thing. "I can sort of take it in and deal with it" and I think through the years I've become less that way. Which I think has made me a better clinician.

Gender role trial. Another strong theme that emerged in all participants was the experience of an event or personal experience that catalyzed an examination of, and often exemplified, their struggle with their gender role schema. Participant F2 describes an incident in which her father's discomfort with her emerging sexuality caused her to examine her sense of femininity:

> Actually, one thing that I always think about was this slightly traumatic incident --was my mom took us-- her brother [was] in London-- and she took us to this store called Herod's, you know, the department store. And she bought me this amazing dress. I picked it out and I was pretty mature, you know, I had puberty earlier, I was in high school so... And it really looked great and I got home and I put it on one day and my dad was like, you know, "Get back up into your room. You're not wearing that to school.

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The boys, you know, need to be learning in school." So I think probably he had this temper thing and this kind of anxiety thing, or sexual, whatever. So I wasn't really encouraged, once I did start to be feminine, he probably got more anxious and angry towards me. Well, I just assume[d], it was my feminine-- my adult femininity.

Participant M1 recalled how his experience of watching a porn movie with other boys caused him to question how his reaction fit into the context of traditional gender socialized messages about men's relationship towards women and sex:

So I'm 14 or so… I went over to a kid's house after school or his parents were away and he popped in a porn movie and I was really disgusted by it, and probably also drawn to it. But the fact that, what I noticed was that there was a real difference-- nobody else in the room seemed to have any disgust [laughs] or shock value. There was something kind of, um… yeah it was, it was weird. It was… I was left thinking and feeling like, "Is it me? Is there something wrong with me that it was bothering me?" Like, "Why this is not cool or fun or something I really want to do much [laughs] or watch again?" So that-- that was a message of, well, if your [a] boy and this is kind of-- this is the kind of stuff that you're [boys are] really into.

Of particular note, all participants who identified as belonging to the LGBTQ community identified the experience of being LGBTQ as a significant catalyst toward their examination of their gender role schema. In particular, respondents cited their identity as LGBTQ as conflicting with dominant cultural conceptions of gender role

norms. Participant M4 describes how exploration of his identity as a gay man was intrinsically connected to an examination of his gender role schema:

> [...] What I write about in the article, have you read it? Is gender sexuality shame and group development-- very intertwined: The development of gender identity, sexual identity, so both of them become fraught as an individual in a culture is cueing what's acceptable about gender, role, and about your sexuality. I've cued both; neither was particularly acceptable on my terms. I had to struggle, I had to fight I had to figure out, thrash-- with both the core of who we are, to have either shame or shut down, or [be] closeted—it's [denying one's sexuality] dissociating a huge part of the self.

Participant M3 similarly described how his identification as gay inherently required reconciling his identification with gender role norms not supported by the dominant culture:

> […] one of the things that I would say is being a gay male, you have to look at your gender. You-- you just you can't-- you just can't not look at it, alright? If you want to reject your sexuality, that's you actively rejecting the parts of you that culture are saying are feminine. That's one of the aspects that [of] internalized homophobia. I don't want to be like that. [...] So there's a vulnerability that comes with being able to say to someone, you know, when you are queer, when you're different around these aspects of self, you really have to be able to say that those things that are-- the culture of shaming before-- are also things that are really sacred to who I am. And I'm going to take that back.

Experience of Treating Men with Alexithymia

For the purpose of this study, the operational definition of the term *experience of treating* refers to a social worker's subjective interpretation of their approach towards, process of and effectiveness in treating men with alexithymia. Participants shared their beliefs about the etiology of male alexithymia, their clinical approach toward treatment, transference and countertransference experienced during treatment, thoughts on their effectiveness, and overall thoughts about treating men with alexithymia.

Thematic analysis revealed five important subthemes relating to respondents' experience treating men with alexithymia: gender role socialization an asset to work, male alexithymia driven by shame, cultural constriction of men, empathy as countertransference, and treatment modification.

Gender role socialization an asset to work. All participants described their experience of gender role socialization and gender role schemas as an asset toward treating men with alexithymia. Male participants tended to emphasize the process of defining their own gender role schema as enhancing their ability to work with men with alexithymia. Participant M4 describes how his own experience parallels the experience of men with alexithymia in treatment and helps them feel safe and understood:

> I think I am very attuned, I grew up with men, I grew up as a man and I
> struggled with the constriction of being that 50s, early 60s-- and that
> exploded out with that maleness and then how to integrate-- I get that it's a
> struggle. It's hard, it's really hard, so I think I'm aligned in a particular way
> and I think men respond, clients respond to that safety and understanding,
> and appreciation being seasoned [in struggling] if that's --that I've done it

[struggled], that they're doing it. And I respect that-- that I have a way of

helping them do that.

Participant M1 also shares how his processing of a traditional aspect of his gender role

schema enhances his work with men with alexithymia. He describes how his experience

allows men with alexithymia to see their own gender role with more nuance:

My relationship with anger and aggression has definitely evolved. The

phrase that I love to try to kind of embody is "healthy

aggression," aggression that [pause] I used to think that almost all

aggression was bad. And I really have kind of come to believe that

aggression is necessary and required to kind of live. [...] I think a lot of the

guys that I work with don't have that impression of aggression. I think any

time that word is used in the room, in their experience it's like, it's got a

negative connotation. So one of the things I like to try and teach them is

that there is such a thing as healthy aggression where you're asserting

yourself, it's not just guys too-- it's women.

In contrast to male respondents, both female participants tended to emphasize

how men with alexithymia might conceive of them through the lens of traditionally

socialized gender roles, and how this might benefit treatment. Participant F1 describes

how traditionally gender socialized men with alexithymia may find it easier to work with

a female clinician because a female clinician may be seen as less threatening:

I think it [being a woman treating men with alexithymia] depends on the

person. I don't, you know, I think… some of them, because they could see a

man as more competitive, would have more difficulty with a man. I mean,

with some people in general, not just men like this, you know, I will ask,

"Would you be more comfortable with a man than a woman?" Because,

and some people say, you know, it doesn't make any difference but […] I

mean with some people, I think it might be easier if they didn't' see a

woman as an equal almost, it might be easier to listen. So I think it really

depends on the person.

Participant F2 also states how the traditional view of women as nurturing may enhance a

female clinician's ability to work with men with alexithymia:

But I mean even with the gay guy that I work with, I think [pause] I don't

know if it helps that I'm female, but I think it probably does just 'cause,

like, the mother thing, right? [laughs] Mhm, that-- the softness-- the

softness thing. I don't know...

Male alexithymia driven by shame. All participants except M3 described a fear

of shame as a driving force behind the symptom presentation of men with alexithymia.

Many participants described this fear specifically using the term "shame." Participant M1

alluded to his own struggle with shame while describing how a client was unable to

complete treatment due to the shame of believing he needed help with his mental health:

A lot of my work as a therapist too is, and in my own life, is trying to kind

of break through shame or shame-breaking statements or beliefs that we

have about each other or about ourselves. And I think this is a particularly

hot topic for men who, me being one of them, who are ashamed of who

they are. I mean, that's how I define shame is like the belief that there is

something inherently wrong with you, versus guilt where you believe that

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you've done something wrong behaviorally that you feel bad about. But

shame is-- is a big piece of all this. I think that keeps men guarded and… I

had a guy in treatment for couple's therapy who could not meet for more

than three or four sessions with his wife because the mere idea of coming

to therapy meant that there was something wrong. And the idea of

admitting that, of acknowledging that, of sitting with that was intolerable

[...]

Participant F2 posits that the etiology of male alexithymia may be based in a shame-

based state created by the socialized rejection of men's vulnerable feelings:

Well I would say that, you know, part of alexithymia is probably culturally-

cultural. Part of it is probably, neuropsychologic, and part of it is probably

as a result of complex trauma. And that if somebody has PTSD or even

worse than PTSD-- like complex PTSD from a series or a woven

background of non-nurturance or shaming or, you know, just like real

intense chronic disappointment, or not being gotten or not being seen…

And all that then creates a way of functioning through shame where you

really can't-- or you feel afraid of feelings. 'Cause they just weren't

tolerated right? Like for example, if somebody was beaten for crying or

being vulnerable, then they're going to be afraid of feeling-- and then

they're not going to have access to it and then over time shame is a big part

of their lives, I would say.

Similarly, participant M4 describes shame in terms of men's avoidance of vulnerability,

and the importance of creating a safe place to counteract their fear of vulnerability. He

also reiterates his that his identification as LGBTQ may be an asset perceived by prospective male clients:

> It may be that some straight men come to me looking up on Psychology Today and seeing that I'm gay-- [or maybe that] I've worked a lot with gay men, [or] not that I'm gay, but they had wondered [if I was]. And more and more straight men are coming into practice [seeking treatment] with gay men. I know it for myself, I know it for other colleagues and I think that may be a curious safety about coming in with another man who they feel they're safe with revealing places where they're vulnerable. 'Cause I think, given the socialization of men, particularly to be vulnerable with another man, is challenging.

Cultural constriction of men. All male participants highlighted the ways in which socially constructed messages about masculine gender roles constrict men in harmful ways. Participant M4 explains how society dictates what sort of behavior is acceptable for men to exhibit and how this inhibits men from being their full selves:

> There are few feelings that are okay. [If] You go into this other zone, you're not a man, no matter-- boys who try to figure out what it means to be a man-- you've got this physio- [physiology]-- and being told that they are men and they're being shaped and trying to figure out what it is to be a man. And are there specific messages that society sends about being the odd man out or what those feelings [are] [...] "Don't sit with your legs crossed beyond the knee, ankle-knee is okay. Don't lock eyes with other guys, don't twist your elbows into your hips, deepen your voice ten to two,

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don't sing like Judy Garland in Somewhere Over the Rainbow. Talk about

the Red Sox, so we're-- we're over the great green monster. Deepen your

voice to ten and two." It's very narrow. It's more constrictive. I call it, in

the show, the "masculine straight jacket." It's totally socially fabricated.

Participant M3 explains how cultural expectations of men lead to negative consequences

for them that are not only psychological, but also physical:

[...] we live in a culture where violence is not only glorified, it becomes a

hallmark of masculinity. Look at this debacle with Donald Trump. You

know what I mean? Um, mixed martial arts fighting, you know what I

mean? Where men are like-- and you can watch-- traumatic brain injury,

okay? [...] Oh look, he just broke his jaw, there you go. Oh! Just ruptured a

disc there… And how much did he make for putting his body on the line?

This also translates to deaths on the worksite, aright? Men are 80% more

likely to die on the worksite than are women. Now this isn't' to say that

women have it easy, it's not. Women get a whole different bill of rules. But

the issue is, if women were dying at the same rates that men were, their shit

would be all over the media. Men are expected to burn out faster than

women and our culture supports that. That's how I feel men get shafted.

And in another interview:

Yeah, yeah, I mean it's hard you know-- I mean a lot of the folks I've

worked with who are [have] alexithymia, paradoxically, know humiliation.

Know what its like to be ostracized. Know isolation. Know what it's like to

be ostracized because they're not getting what's someone's trying to

convey to them, which then further shuts them down. So when we're talking about [the construct of] alexithymia, we're talking about a really blunt instrument that doesn't take into consideration that a lot of the folks who are alexithymic have, in fact, relied on being alexithymic as a defense against the very feelings that people are trying to push onto them.

Empathy as Countertransference. All participants except F1 expressed empathy toward the difficulties experienced by male clients with Alexithymia. This theme was particularly strong among male participants. Many comments by male respondents conveying empathy focused on how the symptom profile of male alexithymia can be misunderstood. Participant M1:

My initial memory of this client and my experience with sitting with him was one of compassion and patience, and… This particular client was referred to me by a woman for counseling for him and his wife, and it was clear that the referring clinician, this woman, had a lot of opinions about him, leaning more towards a negative-- kind of like a pejorative, almost-- take on him. And he was... very guarded and unable to talk about himself much [...]. And he ended up working with me and his wife in couples therapy for longer than they had ever worked with anyone. And this referring clinician who had seen the wife was impressed that he had stuck it out as long as he did. And I kept on thinking to myself well, I don't know-- it may have been premature for me to even come to this-- but I felt like, well shit man-- this guy's never had a place to kind of, um-- or people to be patient with him.

Participant M3 underscores how empathy for and an appreciation of a client's cultural and socioeconomic background is essential in assessing their range of emotional expression. It may also be presumed that participant M3 was implying the importance of a clinician's awareness of the contexts of their own gender role socialization:

> For folks that I knew that grew up in South Boston, which could be very Irish, the difficulties in expressing emotion because of what was expected from them as men based on class; based on, you know, gender; based on where they lived in Southie, was really, really startling. Because these were guys, you know: [reenacting a vignette] "How you doin' Dougie?" It's like, [Dougie:]"Good" "You know, Dougie, I'm at your mother's wake- how you doin'?" [Dougie:] "You know, life's tough." …In that context, with other men, they knew exactly what he was feeling. When he would leave that environment, people assumed that this was a guy [that] was just unable to access his feelings when the fact of the matter was, they weren't familiar with the context in which he was raised…

In contrast to M1 and M3's empathy toward men with alexithymia being misunderstood, participant M4 describes empathy in the form of optimism during his initial reactions toward men with alexithymia—regarding the possibilities for both treatment and progress:

> I mean [I'm] appreciating that they got here, appreciating that it's an opportunity. So I think I'm pretty in tune and I think, somewhat-- where you may be leading is-- what's the countertransference reaction sitting with somebody who's stuck? You know, if it's the sixth stuck person in a row, I

may be a little exhausted trying to figure out how to access [the client's

emotion] but I think generally-- and I don't set myself up that way, as we

led with, at the beginning-- we take care of ourselves in this work. So I like

to think that I'm ready and that this is an opportunity and it's some of what

I think is [a] powerful...potential relationship-- something I've got to offer

and I know what I'm doing and if the person's really there to do the work,

it's really exciting.

Similarly, participant F2 describes optimism for particular types of therapy as being

effective with men with alexithymia. She also states that she is able to identify with men

with alexithymia and effectively approach treatment because of her own experience with

alexithymia:

I think that in, basically, in Boston anyway, the culture is analytical and

they can't really imagine another kind of therapy. And I mean, AEDP is

talk therapy but it's so radical, it's just so radical. Like the therapist is-- it's

about being real and there are all these methods to help people soften into

real-- their real selves with, like, feelings. It-- it brings them closer, you

know. And I have some alexithymia, I would say, so I understand it, or I've

had [alexithymia] some at times in my life, you know...

Treatment modification. All participants except M1 described tailoring their

clinical approach to fit the needs, qualities or expectations of men with alexithymia. The

particular approach or interventions cited by clinicians varied widely, but often included

shame and feelings of vulnerability as key considerations. Participant M3 describes how

he views the presentation of men with alexithymia through the lens of performativity, and

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how he uses performativity to connect with men in treatment, particularly as it helps the

feel less vulnerable:

> It's [growing up in East Boston] given me a construct and understanding of
>
> masculinity as performativity, it's also given me an appreciation of the
>
> enjoyment of masculinity. So when I want to give folks…when I'm
>
> working with folks from a class or background that's similar, not identical:
>
> [portraying a hypothetical client] "Its like so fuckin' hard, so fuckin'
>
> frustrating!" Frustrating-- I'm listening for this word. [...] Based on the
>
> structure of masculinity he learned-- because it's easier to enrage initially
>
> then it is to say "I feel vulnerable," particularly in the presence of another
>
> man. So if you [the clinician] have to do general performativity for the first
>
> fifteen, twenty minutes or for the first fifteen, twenty sessions, I'm right
>
> there with you. [Parodying a sensitive therapist] "Tell me how you feel
>
> about that…" Dumb fuck-- he's tellin' you exactly how he feels [laughs]
>
> the whole time. It's your issue, not his. You know what I mean?

Participant M4 takes an approach that similarly respects the emotional communication

style of men with alexithymia. He describes utilizing this emotional communication style

as the basis for psychoeducation to help broaden the emotional range of male clients with

alexithymia without inducing shame:

> We need to be able to start with recognizing what's going on and to use
>
> some of the language that IFS uses, you know? The different states rather
>
> than pathologizing them-- recognizing they serve a purpose. So you're not
>
> humiliating somebody for disconnecting or for using any other way to

defend against what feels unacceptable. [...] And then they get flexibility. And there are times when maybe it's okay to disconnect or okay to recognize I'm [the client is] angry, but that's a signal of something else that's going on. And they can connect that-- how the anger is a alarm system that's going off in the system and what's kind of underneath: What is it, what's it alerting you to-- to protect yourself? A guess; how are you vulnerable? If you [the client] would just recognize. And let's take it [the anger] all the way back [into past context] and then move up [to] today. What is a way to express the anger that could actually be effective and signaling: "Ouch! You know, that hurt!" Don't do that to me!" You know, whoa...okay, a boundary-- that's good. The [makes explosion noise] that's not so helpful. Lets bring it back. Let's specify what's going on but let's also respect what you've been using as a way of communicating in the world, what your interior experiences are. But we're gonna refine that, distinguish what has been stirred up.

Participant F3 describes another way of helping men with alexithymia connect with their emotional experience that promotes a safe environment to be vulnerable. She explains how she helps men connect their current experience of emotion to a younger self, and how this can elicit deeper emotional awareness:

Another thought I have is like talking to a part of them that's younger, that just got buried and look at [it] [in treatment]. That's when the feeling stopped being safe, and then they become safe again. Once that part of them feels understood in a less confusing way. Like, you could even say,

you know, "How does that part feel right now?" Or if somebody's talking about something it's [the client is] like, "You know, I was on the road and I was so mad, and then my daughter called me and she started asking me for money." And then you [the therapist] could say-- it's just one way to do this, you know-- "Can you timeline back a little bit to a time where you felt so out of control or like another time in your life, it could be ten minutes ago, it could be when you were like a baby, it could be when you were a teenager." You know and they might say, "Well I don't really remember, but I do remember one time when um [sigh] you know I lost my cat when I was ice-skating and slipped on the ice…" Yeah, it's like them not feeling alone with these things-- and then he went on to say like how alone he felt like that was what the problem really was.

Summary of Findings

Major findings from twelve interviews with six licensed independent clinical social workers who identified as having experience treating men with alexithymia have been presented in this chapter. Findings were grouped into two overarching themes and supporting subthemes that address findings relating to participants' gender role socialization and their experience treating men with alexithymia.

Supporting subthemes relating to participants' experience of gender role socialization included blending of masculine and feminine traits, personal struggle with gender role, and gender role trial. Key subthemes addressing respondents' experience treating men with alexithymia consisted of gender role socialization an asset to work, male alexithymia driven by shame, cultural constriction of men, empathy as

countertransference, and treatment modification. The following chapter will explore

interpretations of these themes in comparison to literature, describe conclusions, discuss

implications for social work, compare strengths and weaknesses of this study, and present

suggestions for future research.

CHAPTER V

Discussion

This study explored how a clinician's gender role socialization affects their experience of treating men with alexithymia. Existing literature has separately investigated the impact of gender role socialization on clinical practice, as well as the role of traditional male gender role socialization in the etiology of alexithymia. This study presents an opportunity to understand whether a relationship exists between these areas of study.

This chapter discusses findings in the following order: 1) Comparison of study findings to current literature, 2) conclusions, 3) implications of findings to the field of social work, 4) strengths and limitations of this study, and 5) recommendations for future research in the area of how the gender role socialization of clinical social workers affects their treatment of men with alexithymia and other populations.

Comparison of Study Findings to Existing Literature

The following section explores the results of this study and compares and contrasts results with existing literature. As in the previous chapter, this discussion is divided into two major themes and their subthemes. The first theme addresses results regarding the gender role socialization of clinicians, while the second theme addresses results concerning clinicians' experience treating men with alexithymia.

Gender Role Socialization. Key findings from this study regarding clinicians'

gender role socialization demonstrated that respondents did not conform to traditional

gender role schemas. Participants experienced a struggle in their past or present to

understand and accept nontraditional aspects of their gender role schema and may have

experienced gender role conflict (GRC) as a result.

Blending of Masculine and Feminine Traits: Results from this study showed

respondents identified their gender role schema as a blend of traits traditionally

associated as both masculine and feminine. Significantly, participants described this

blending as something they strive for or value in themselves.   Respondents' openness in

identifying with and valuing a blend of traditionally male and female gender traits

suggests they possessed flexible attitudes and beliefs about gender roles, rather than

subscribing to gender roles traditionally associated with their sex. Indeed, male

respondents' description of valuing feminine aspects of their gender role schema

contrasts with Pollack and Levant's (1998) description of traditional male gender norms.

These results may also be interpreted in contrasting ways against Brooks' (1998)

assertion that clinicians may not acknowledge gender role biases due to the clinical ideal

of value-neutral evaluation. In this context, participants' identification with both

traditionally male and female gender traits may symbolize a desire to identify with value-

neutral attitudes toward gender roles. However, the richness of data describing the

qualities of participants' gender role schemas, as well as their personal struggles with the

same, appears to validate that it is a product of lived experience.

Personal Struggle with Gender Role: Despite valuing their possession of both

traditionally male and female gender traits, participants clearly articulated a past or

ongoing struggle with the coexistence of these opposing qualities. This finding suggests

that while respondents identified with nontraditional gender roles, they struggled to

reconcile them against traditionally socialized gender norms. Participant's struggle with

their gender role schema may allude to an experience of gender role conflict (GRC),

described by O'Neil (2008) as negative consequences experienced by the person or others

caused by restrictive gender roles. This conclusion also indicates that clinicians are

exposed to the same gender role socialization as their clients, as asserted by Mintz and

O'Neil (1990).

Thus, results suggest that not only are clinicians subject to the same process of

gender role socialization as their clients, but clinicians may also be subject to GRC

similar to that experienced by men with alexithymia. This finding is supported by

literature suggesting GRC is associated with conflict relating to traditional gender roles

(O'Neil, 2008). Additionally, the etiology of male alexithymia has roots in the

socialization of traditional male gender roles (Pollack & Levant, 1998; Fischer & Good,

1997). Together, these studies highlight the shared influence of traditional gender roles

on both GRC experienced by clinicians as well as the etiology of male alexithymia.

Gender Role Trial: Respondents' struggles to reconcile adoption of

nontraditional and traditional gender roles were both catalyzed and exemplified by

particular experiences.   These experiences often involved a painful confrontation

between traditional and nontraditional gender roles and varied widely in form.

Significantly, participants identifying as LGBTQ described their experience of

identifying with their sexual orientation as a significant factor in confronting their

relationship with traditional gender roles.

These results are supported by O'Neil's (2008) framework of GRC experienced from role transitions, indicating that participants experienced GRC due to an event or events during gender role development that modified or contested their existing gender role schema. Thus, as previously mentioned, it is possible that respondents' experience of GRC provides a context for understanding an analogous GRC faced by men with alexithymia due that population's adoption of traditional male gender roles.

Experience of Treating Men with Alexithymia. Results from this study revealed that, regardless of identifying as male or female, respondents felt their gender role schema presented advantages in building an effective therapeutic alliance with men with alexithymia. In particular, male respondents expressed identifying with the gender role struggle experienced by men with alexithymia while participants identifying as LGBTQ expressed optimism regarding possibilities for the therapeutic alliance. Data showed that respondents tailored their treatment approach to account for the particular needs and expectations of men with alexithymia, often citing shame and fear of vulnerability as important considerations. Results also indicated male respondents were especially cognizant of how traditional male gender roles negatively impact men with alexithymia.

Gender Role Socialization an Asset to Work: Both male and female respondents described their gender role schemas as an asset toward treating men with alexithymia. Interestingly, male and female participants differed in their interpretation of why this was the case. Male participants emphasized the struggle to arrive at their present gender role schema as providing both an ability to understand and gain credibility with men with alexithymia. In contrast, female participants described the possibility that men with

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alexithymia might cast them in traditional gender roles, and these social scripts might serve as a basis for forming a therapeutic alliance.

Male participants' use of their struggle with gender role as a context for understanding men with alexithymia further supports the hypothesis that they draw parallels between their own GRC and analogous GRC faced by men with alexithymia. The literature reviewed during posthoc analysis further supports this hypothesis. In a study examining the nature of the empathetic process in psychotherapy, Hatcher, Favorite, Hardy, Goode, Deshetler and Thomas (2005) found that therapists whose life experiences were similar to the client's presenting problem made increased use of experiential reference points from their lives.

Female participants' belief that men with alexithymia would cast them in traditional gender roles corresponds to conclusions by Deering and Gannon (2005). However, the authors asserted the expectation by female clinicians of being "typecast" into traditional gender roles could lead to clinical misattunements when treating traditionally gender socialized men. Results from this study seem to indicate that female clinicians, rather than perceiving men with alexithymia pejoratively due to gender role typecasting, see traditional gender roles as potentially working toward their advantage in the therapeutic process.

Empathy as Countertransference: Participants described empathy as their initial reaction to the clinical presentation of men with alexithymia. Male participants often described how others could be judgmental or misunderstand the symptom profile of men with alexithymia. This result is particularly interesting as it relates to the finding that male participants view their personal struggle with gender role as an asset to their work,

and appears to confirm the hypothesis that male participants draw parallels between their experience of GRC and analogous GRC faced by men with alexithymia. Findings also indicated optimism expressed by LGBTQ participants regarding the therapeutic alliance with men with alexithymia. As with male participants, this form of empathy might be attributed to participants' experience of gender role struggle and resulting GRC. Only in this case, the experience of gender role struggle relates directly to identifying as LGBTQ. Indeed, LGBTQ respondents reported that their LGBTQ identity facilitated a critical examination of their gender role schema.

Literature review during posthoc analysis yielded another possible explanation for LGBTQ participants' optimism regarding their alliance with men with alexithymia. In a study examining the links between adverse life experiences and empathy, Lim and Desteno (2016) found an individual's experiences of adversity was associated with increased compassion and empathy, as well as behavior aimed at alleviating the suffering of others. In addition to facing a personal struggle with their gender role, LGBTQ participants described experiencing rejection of their sexuality by the dominant culture. It is possible, in the context of conclusions by Lim and Desteno (2016), this dual struggle represented a particularly substantial experience of adversity that enhances LGBTQ participants' overall ability to empathize with clients, including men with alexithymia.

Male Alexithymia Driven by Shame: In discussing beliefs about the etiology of male alexithymia, results indicated that participants viewed shame and feelings of vulnerability as central to the experience of men with alexithymia. Data from this subtheme, as well from the subthemes of *personal struggle with gender role* and *gender*

role trial also indicated participants were able to identify feelings of shame and vulnerability as part of developing their gender role schema.

Respondents' appreciation of shame and sense of vulnerability as a characteristic of traditional male gender role ideology, as well as a factor in the etiology of male alexithymia, are consistent with the construct of alexithymia proposed by Pollack and Levant (1998). This data suggests participants possessed an accurate understanding of the lived experience of men with alexithymia. Additionally, this subtheme appears to support findings that male participants utilize personal reference points to generate empathy for men with alexithymia, and that experiences of adversity may enhance LGBTQ participants' overall levels of empathy toward men with alexithymia.

Treatment Modification: Respondents also reported modifying their treatment approach to fit the needs or expectations of men with alexithymia. Treatment modifications varied widely among clinicians. However, modifications often took into account the shame and fear of vulnerability participants reported as central to men's experience of alexithymia. This result is congruent with Pollack and Levant's (1998) assertion that the etiology of male alexithymia is based in traditional male gender role ideology that includes a de-emphasis of vulnerable feelings.

Respondents' modification of treatment, with a particular appreciation of shame and vulnerability, seems to confirm their accurate understanding of men's experience of alexithymia. This finding is supported by results as mentioned earlier suggesting participants' ability to empathize with the issues faced by men with alexithymia are based on their personal struggles with their gender role, as well as experiences of adversity associated with LGBTQ identity. In other words, the propensity of respondents to tailor

interventions to the specific needs of men with alexithymia may be based on lived experience, as well as optimism for the therapeutic alliance.

Cultural Constriction of Men: Finally, all male participants highlighted the harmful impact of traditional gender roles in constricting men's emotional health and growth. Male participants described how men with alexithymia receive mixed messages from the dominant culture about the acceptability of nontraditional male gender roles. They also clearly expressed the physical and emotional harm that traditional male gender roles inflict on men with alexithymia. This finding appears to further support results indicating that male participants utilize their personal struggle with gender role as a reference point for understanding men with alexithymia.

Conclusions

Results from this study suggest that a positive relationship may exist between clinicians' struggles with their gender role schema and their ability to effectively treat men with alexithymia. Participants' conception of their gender role schema did not appear to conform to traditional gender roles and was a point of pride for participants. However, respondents readily described a past or ongoing struggle to make sense of their gender role schema, exemplified by challenging situations faced during gender role socialization (*gender role trials*).

Male participants cited their personal struggle with their gender role schema as a context for understanding and building rapport with men with alexithymia. Literature suggests their struggle to transcend traditional male gender roles may have resulted in GRC experienced from role transitions (O'Neil, 2008). Thus, male respondents' experience of GRC arising from confrontation with (and transcendence of) traditional

male gender roles may facilitate increased empathy with the challenges (analogous GRC) faced by men with alexithymia, which research has shown is based on the adoption of traditional male gender roles (Fischer & Good, 1997; Pollack and Levant, 1998). Empathy appeared to be particularly strong among male participants, regardless of sexual orientation. In particular, male respondents recognized the negative judgments experienced by men with alexithymia both within psychotherapy and the dominant culture, as well as the harmful impact of traditional male gender roles on men.

LGBTQ participants, regardless of sex, also described a personal struggle with gender role related to their identification as LGBTQ. GRC is often applied to understanding the relationship between men and traditional male gender roles. However, it may be concluded that results connecting male participants' experience of GRC with empathy for men with alexithymia also applies to LGBTQ respondents' experience of transcending traditional gender roles, regardless of their sex. Nevertheless, literature suggests the rejection of LGBTQ participants' sexual orientation by the dominant culture, as well as the resulting struggle with their gender role schema (*gender role trial*), may constitute a significant experience of adversity that increases their overall empathy, including empathy toward men with alexithymia (Lim & Desteno, 2016).

Findings further indicate all participants apply their empathy and understanding of men with alexithymia to their treatment approach. In particular, respondents' treatment modifications appeared to appreciate the importance of considering feelings of shame and vulnerability when working with men with alexithymia, which literature suggests are the main aspects of traditional male gender role ideology that contribute to the etiology of male alexithymia (Pollack & Levant, 1998).

Taken together, results from this study suggest a clinician's personal struggle with their gender role, regardless of sex, facilitates increased empathy toward men with alexithymia and treatment approaches that incorporate an appreciation for the unique challenges faced by this population. Additionally, personal struggles with gender role experienced by male clinicians may serve as a particularly salient context for empathizing with men with alexithymia.

Implications for Social Work

The results of this study suggest clinicians' personal struggle to transcend traditional gender roles facilitates increased empathy toward men with alexithymia, which in turn enables interventions tailored to the specific needs of this population. Data further suggests clinicians who identify as male and have experienced a struggle to transcend traditional gender roles may be especially predisposed to empathize with men with alexithymia. This study's findings emphasize the importance of clinicians' ability to confront traditional gender roles and critically examine their gender role schemas when treating with men with alexithymia.

Utilizing the results of this study, clinicians may improve treatment of men with alexithymia by educating themselves about issues of gender role and, in particular, issues faced by men due to the socialization of traditional male gender roles. Based on the results of this study, it is also essential that clinicians apply this knowledge toward challenging their gender role schema and traits associated with traditional gender roles. The author is not suggesting that clinicians disavow all traditional gender roles. Rather, it is suggested that clinicians think critically about traditional aspects of their gender role schema they find limiting, confusing, or harmful to themselves or others and work

earnestly to understand and transcend those gender roles. Clinicians should also consider the influence of shame and feelings of vulnerability in the symptom presentation of men with alexithymia, and craft interventions that incorporate sensitivity toward these factors.

In the same vein, social work education should include content that critically examines constructs of gender and gender role socialization. Ideally, this coursework should not be limited to an understanding of current theories, but also include exercises encouraging students to examine and appraise their relationship to traditional gender roles. Particular attention might be paid to eliciting reflection on the ways traditional gender roles have negatively impacted the student or loved ones. Such exercises may serve as an early struggle to transcend traditional gender roles (*gender role trial*), and foster increased empathy among future professionals when working with men with alexithymia or other groups adversely affected by traditional gender roles.

Study Strengths and Limitations

The research question and study design effectively collected the lived experiences of clinical social workers relating to their gender role socialization and treatment of men with alexithymia. The interview guide intentionally avoided prompting participants for positive or negative dimensions of their experiences, and participants provided rich data indicating their gender role schemas and experiences treating men with alexithymia were a product of lived experience. However, it is prudent to consider the assertion by Brooks (1998) that clinicians may be biased by the profession's emphasis on self-awareness and value-neutral evaluation, particularly in a qualitative study.

The primary limitations of this study are a product of sample size (N=6) and self-selection that may have adverse effects on validity and reliability. The validity of

findings produced by this study is limited by these sample biases and may be particular to the sample studied. Future research, mainly quantitative studies, may illuminate whether results produced by this study are represented in other samples. However, the results and recommendations generated by this study are consistent with the NASW Code of Ethics and are compatible with the values of the social work profession.

All study participants either self-selected for the interviews or were referred to the study by clinicians known to the researcher. This may indicate that respondents possessed particular interest, skills or clinical experience working with men with alexithymia, or were previously interested and self-reflective about their gender role socialization. Further, the sample universally drew participants from Eastern New England, which may have a particular cultural influence on norms surrounding clinical practice and gender role socialization.

Additionally, while this study draws comparisons between the experiences of male- and female-identified clinicians, only two of six participants, identified as female. A larger sample consisting of equal proportions of male- and female-identified participants might yield different results. In particular, only one participant identified as both female and heterosexual, making conclusions regarding heterosexual, female-specific themes difficult to meaningfully analyze. Finally, all study participants identified as white or of European descent, representing a significant racial sample bias that may affect lived experiences of gender role socialization and the treatment of men with alexithymia.

Finally, researcher bias may negatively impact validity and reliability. My location as a researcher identifying as a white, heterosexual, and cisgendered male has an

impact on the study biases. As such, the limitations of my personal experience may affect my interpretation of the data. For instance, my identification as a male might cause me to prioritize findings relating to the experience of male participants while overlooking or misinterpreting the lived experience of female participants. A similar effect might impact my interpretation of LGBTQ participants. Furthermore, biases related to my positionality may have been communicated to participants during interviews, potentially affecting their responses.

A research journal was used throughout the research process to examine the personal thoughts and emotions I experienced during the research process. I was often surprised that the experiences of clinicians working with men with alexithymia differed from my own and valued the insight they generously shared. Occasionally, I had negative reactions to narratives that reflected my clinical experience and documented all reactions in the research journal. It is possible that these reactions were communicated to respondents and may have affected their responses. Finally, my valuing of clinical insight that differed from my experience treating men with alexithymia may have caused me to overlook experiences consistent with my own during data analysis.

Areas for Further Research

Time was a significant limiting factor for this study, and future research may confirm conclusions from this investigation utilizing a larger sample. As previously mentioned, this sample would ideally include equal proportions of male- and female-identified participants, with equal portions identifying as LGBTQ and those who do not. Future studies should also strive to include more ethnically and geographically diverse samples.

Given results suggesting a positive relationship between clinicians' personal struggle with transcending traditional gender roles and their empathy toward men with alexithymia, it may be prudent to investigate whether clinicians who identify as trans or gender nonconforming demonstrate equal or greater empathy toward this population. Likewise, future research might examine whether samples with similar demographics to this study show comparable results when treating trans or gender nonconforming populations, who are assumed to have significant experience confronting traditional gender roles. Finally, this study investigated the relationship between a clinician's gender role socialization and their experience of treating men with alexithymia. Subsequent studies might examine the experience of men with alexithymia relating to their treatment by clinicians who either have or have not experienced a personal struggle to transcend traditional gender roles.

References

Berger, J. M., Levant, R., McMillan, K. K., Kelleher, W., & Sellers, A. (2005). Impact of gender role conflict, traditional masculinity ideology, alexithymia, and age on men's attitudes toward psychological help seeking. *Psychology of Men & Masculinity*, *6*(1), 73–78.

Brooks, G. R. (1998). *A new psychotherapy for traditional men*. San Francisco, CA: Wiley.

Deering, C. G., & Gannon, E. J. (2005). Gender and psychotherapy with traditional men. *American Journal of Psychotherapy*, *59*(4), 351–360.

Demographics, PRN 2:2, 2003. (n.d.). Retrieved August 2, 2015, from http://www.socialworkers.org/naswprn/surveyTwo/Datagram2.pdf

Engel, R., & Schutt, R. (2005). *The practice of research in social work*. Thousand Oaks, CA: Sage Publications.

Fischer, A. R., & Good, G. E. (1997). Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles. *Psychotherapy: Theory, Research, Practice, Training*, *34*(2), 160–170.

Hatcher, S. L., Favorite, T. K., Hardy, E. A., Goode, R. L., Deshetler, L. A., & Thomas, R. M. (2005). An analogue study of therapist empathic process: Working with difference. *Psychotherapy: Theory, Research, Practice, Training, 42*(2), 198-210.

Leaper, C., & Friedman, C.K. (2006). Socialization of gender. In J.E. Grusec & P.D. Hastings (Eds.), *Handbook of Socialization: Theory and Research* (pp. 561-587). New York, NY, USA: Guilford Press.

Levant, R. F., Hall, R. J., Williams, C. M., & Hasan, N. T. (2009). Gender differences in alexithymia. *Psychology of Men & Masculinity*, *10*(3), 190–203.

Lim, D., & Desteno, D. (2016). Suffering and compassion: The links among adverse life experiences, empathy, compassion, and prosocial behavior. *Emotion, 16*(2), 175-182.

Mintz, L. B., & O'Neil, J. M. (1990). Gender roles, sex, and the process of psychotherapy: Many questions and few answers. *Journal of Counseling & Development*, *68*(4), 381–387.

Monroe, M. C., & Adams, D. C. (2012). Increasing response rates to web-based surveys. *Journal of Extension*, *50*(6), 6-7.

Ogrodniczuk, J. S., Piper, W. E., & Joyce, A. S. (2008). Alexithymia and therapist reactions to the patient: expression of positive emotion as a mediator. *Psychiatry*, *71*(3), 257–265.

O'Neil, J. M. (2008). Summarizing 25 years of research on men's gender role conflict using the gender role conflict scale: New research paradigms and clinical implications. *The Counseling Psychologist, 36*(3), 358-445.

Padgett, D. (1998). *Qualitative methods in social work research: Challenges and rewards*. Thousand Oaks, CA: SAGE Publications.

Pollack, W. S., & Levant, R. F. (1998). *New psychotherapy for men*. New York, NY: Wiley.

Stockard, J. (1999). Gender and socialization. In J.S. Chafetz (Ed.), *Handbook of the Sociology of Gender* (pp. 215–227). New York: Kluwer Academic/Plenum

.

Teri, L. (1982). Effects of Sex and Sex-Role Style on Clinical Judgment. *Sex Roles*, *8*(6), 639–649.

Vorst, H. C. M., & Bermond, B. (2001). Validity and reliability of the Bermond–Vorst Alexithymia Questionnaire. *Personality and individual differences*, *30*(3), 413–434.

Wester, S. R., & Vogel, D. L. (2002). Working with the masculine mystique: Male gender role conflict, counseling self-efficacy, and the training of male psychologists. *Professional Psychology: Research and Practice*, *33*(4), 370–376.

Wisch, A. F., & Mahalik, J. R. (1999). Male therapists' clinical bias: Influence of client gender roles and therapist gender role conflict. *Journal of Counseling Psychology*, *46*(1), 51–60.

Zimmermann, G. (2010). Alexithymia. In I. B. Weiner, & W. E Craighead. (Eds.), *The Corsini Encyclopedia of Psychology* (pp. 63-65). Hoboken, NJ: John Wiley & Sons, Inc.

Appendix A: HSR Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-
7994

January 8, 2016

Joseph Burke

Dear Joe,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jason Ostrander, Research Advisor

Appendix B: HSR Amendments Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

February 14, 2016

Joseph Burke

Dear Joe:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jason Ostrander, Research Advisor

2015-2016

SMITH COLLEGE

Consent to Participate in a Research Study
Smith College School for Social Work, Northampton, MA

....

Title of Study: How Does the Gender Role Socialization of a Clinical Social Worker Affect

Their Experience of Treating Men With Alexithymia?

Investigator(s):

Joseph Burke
Smith College School for Social Work
xxx.xxx.xxxx

....

Introduction
- You are being asked to participate in a research study investigating how the gender role socialization of clinical social workers affect their experience of treating men with alexithymia.
- You were selected as a possible participant due to your identification as a Licensed Independent Clinical Social Worker with more than five years post-licensure experience, identifying as either male or female and/or identifying as a clinician of color, and has experience treating male alexithymia.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of the study is to understand the relationship between a clinician's experience of gender role socialization and their experience of treating men with alexithymia.
- The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. The results of the study may also be used in publications and presentations.

Description of the Study Procedures
- If you agree to be in this study, you will be asked to do the following things: 1) Participate in two one-on-one interviews lasting approximately one hour each- in which you answer questions related to your personal experience of gender role socialization, current conception of your gender role(s) and experience of treating men with alexithymia.

- This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).
- I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.

Risks/Discomforts of Being in this Study
- The study has the following risks: First, failure to disguise identifying client details described in the interview risks violation of your ethical obligation towards client confidentiality. Second, discussion of your experiences with gender role socialization, gender roles or case material may cause emotional discomfort.

Benefits of Being in the Study
- The benefits of participation include enhanced insight into your clinical approach, your relationship to gender role socialization and an opportunity to discuss clinical challenges working with an important client population.
- The benefits to social work/society are: The advancement of clinical knowledge regarding an important client population

Confidentiality
- Your participation will be kept confidential. Interviews will take place in a private, confidential setting of your choosing. In addition, the records of this study will be kept strictly confidential. Audio recordings will be securely stored using password protection and/or stored in a locked, secure place and used exclusively for the purpose of transcription. Audio files will be deleted upon completion of the study as described below.

- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a locked, secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift
- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by February 30, 2015. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns
- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions

about the study, at any time feel free to contact me, Joseph Burke, at jdburke@smith.edu or by telephone at (xxx) xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

……………………………………………………………………………….

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

……………………………………………………………………………….

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

Appendix D: Recruitment Emails

Referral Request Email

Dear _____,

     My name is Joe Burke, a master's degree candidate at Smith College School for Social Work. You might remember me from (background information explaining how we are previously acquainted.)

     As part of my degree requirements, I'm conducting a qualitative study on the relationship between clinicians' gender role socialization and their treatment of men with Alexithymia. I'm interested in studying clinicians who have treated this client population and was wondering if you feel comfortable referring me to potential participants.

     For context, **Alexithymia** is defined as a sub-clinical construct characterized by a cluster of cognitive and affective features that includes difficulty in identifying and expressing feelings, a striking paucity of fantasies, difficulty in distinguishing between feelings and physical sensations, and a cognitive style that is utilitarian and externally oriented. Existing literature suggests gender role socialization plays a role in the development of male Alexithymia.

Eligible participants must:
- Hold a valid LICSW license
- Have 5 or more years of experience following LICSW licensure
- Be treating or have treated male client(s) they believe meet the above definition of Alexithymia
- Identify as either male or female

Involvement in the study would include:
- Two separate, in-person interviews consisting of one hour each
- Interviews scheduled at a time and place of the participant's convenience
- Discussion of the participant's experience of gender role socialization
- Discussion of the participant's thoughts and experiences of treating men with Alexithymia

If you know anyone (including yourself) who may be interested in participating, please have them email me. Or, with your permission, I can contact the potential participant. **Please also be aware that I am interested in including the voices of clinicians of color in my study sample.** I would greatly appreciate your help finding potential participants for this study.

Kind Regards,

Joseph Burke
Smith College School for Social Work
Class of 2016

Initial Email, Potential Participants

Dear Mr./Ms. _____,

      My name is Joe Burke, a master's degree candidate at Smith College School for Social Work. As part of my degree requirements, I'm conducting a qualitative study on the relationship between clinicians' gender role socialization and their treatment of men with Alexithymia. I am interested in clinicians who have treated this client population. I've identified you as a potential participant for my study based on the (possibility that/the recommendation of ____ that) you are a Licensed Independent Clinical Social Worker with more than five years of post-licensed experience, identify as either male or female and/or as a clinician of color, and have experience treating men with alexithymia.

      Alexithymia is defined as a sub-clinical construct characterized by a cluster of cognitive and affective features that includes difficulty in identifying and expressing feelings, a striking paucity of fantasies, difficulty in distinguishing between feelings and physical sensations, and a cognitive style that is utilitarian and externally oriented. Existing literature suggests gender role socialization plays a role in the development of male Alexithymia.

      In the coming days, I will be sending you additional information about this study as well as a link to a qualification survey. If you have any preliminary questions or concerns or do not wish to receive further communication about this study, please feel free to respond to this email.

Kind Regards,

    Joseph Burke
    Smith College School for Social Work
    Class of 2016

2nd Email, Potential Participants

Dear Mr./Ms. _____,

      As I have mentioned in a previous email, I am seeking clinicians with experience treating men with alexithymia as participants in my study. My study seeks to examine the relationship between a clinician's gender role socialization and their experience treating male alexithymia. If you are interested in participating, I have included a link to a qualification survey at the end of this email.

As a reminder:

      Alexithymia is defined as a sub-clinical construct characterized by a cluster of cognitive and affective features that includes difficulty in identifying and expressing feelings, a striking paucity of fantasies, difficulty in distinguishing between feelings and

physical sensations, and a cognitive style that is utilitarian and externally oriented. Existing literature suggests gender role socialization plays a role in the development of male Alexithymia.

Participant requirements include:

- Holding a valid LICSW license
- Having 5 or more years of experience following LICSW licensure
- Are treating or have treated male client(s) you believe meet the above definition of Alexithymia
- Identify as either male or female

If you choose to participate your involvement would include:

- Two separate, in-person interviews consisting of one hour each
- Interviews scheduled at a time and place of your convenience
- Discussion of your experience of gender role socialization
- Discussion of your thoughts and experiences of treating men with Alexithymia

Unfortunately, no compensation is available to participants.

I would sincerely appreciate your participation in this important study. If you are interested in participating, please click this link to confirm that you qualify. Thank you in advance for your help. Please respond to this email if you have questions or you no longer wish to receive communication about this study.

Joseph Burke
Smith College School for Social Work
Class of 2016

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

Reminder Email, Potential Participants

Dear Mr./Ms. _____,
        This is a friendly follow-up email regarding the possibility of your participation in my study on the treatment of male alexithymia. If you are interested in participation, please click this link to confirm that you qualify.
Benefits of participation may include enhanced insight into your clinical approach and relationship to gender role socialization, and an opportunity to discuss the clinical challenges of working with an important client population.
I would sincerely appreciate your participation in this important study. Please respond to this email if you have questions or no longer wish to receive communication about my study.

Joseph Burke
Smith College School for Social Work
Class of 2016

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

Appendix E: Interview Guide

1. Can you tell me what originally drew you to this field?

2. Can you tell me about your practice?

3. What do you enjoy most about your work?

4. What do you find most challenging about your work?

5. What kind of training have you taken for treating male alexithymia?

6. What common challenges do you associate with treating male alexithymia?

7. Could you describe how you might begin to identify that a male client has alexithymia?

8. Can you tell me about your reaction after you've assessed that a male client has alexithymia?

9. How does your experience of treating men with alexithymia compare to work with your other clients?

10. How do you feel about the effectiveness of your work treating men with alexithymia?

11. You reported on your participant survey that you identify as (male/female). Can you tell me what that identity means to you?

12. What influences do you think helped shape your identity as a (male/female)?

13. How would you say society's expectations of men and women have changed?

14. Do you believe your identity as a (male/female) influences your treatment of men with alexithymia?

15. What are your thoughts on participation and retention of male clients with alexithymia?

Appendix F: Transcriber Confidentiality Form
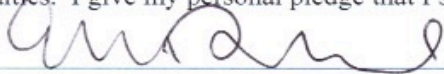
2015-2016

Volunteer or Professional Transcriber's Assurance of Research Confidentiality Form

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.

- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.

- The researcher for this project, Joseph Burke, shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Joseph Burke, for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

(signature)	Signature
2/18/16	Date
(signature)	Joseph Burke
2/17/16	Date