Clinical Psychology Forum

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SOME TIME AGO Martin Seager got in touch with me to see about producing a special issue on ‘Male Psychology’. Honestly, my initial thought was along the lines of… ‘yeah that’s all we need, more male dominance’. That was ignorant of me as it failed to acknowledge that even though men do tend to be overly present in powerful positions, this doesn’t negate specific needs; males are over-represented in suicide statistics, prison populations, and other areas important to wellbeing. Men are often also marginalised from service provisions and research in areas such as eating disorders and self-harm. These reflections got me thinking further on how we could respond to these needs whilst also ensuring we don’t do so at the expense of other less powerful voices. For example, it is a disgrace that we live in a time where we still see massive pay and role disproportionality between men and women; it is offensive that we choose to hold structural barriers built around binary perspectives on gender, which exclude and alienate anyone who has a non-binary experience of life; there is much work to be done inside and outside of clinical psychology. After much thought and much discussion the idea was born (or evolved) of having a special issue on ‘Gender’.

You could see this special issue as split into three parts: Male Psychology, Women in Psychology, and Gender Diversity. Indeed, that’s how it was designed and managed. This is in part pragmatic, ensuring balance and managing the workload. However, I prefer to see the issue as a whole; one in which various discussions about the psychology of gender are explored through a range of different lenses. There are ethical, clinical, academic and personal perspectives presented in the pages, and I am hugely grateful to Annette Schlösser, Martin Seager and Christina Richards for overseeing the publication and recruiting some fabulous articles from some great authors. I have learned much from reading these pages and I hope you do too.

This issue brings together personal and intellectual experiences relating to the key issues. We can all too easily focus on one to the neglect of the other, but if we spend time getting to grips with our views on any topic, we know that the reality is none of us are ‘a blank slate’. We are all influenced by our personal and our academic pursuits. Often it is our personal experiences which influence our academic path, even if we aren’t fully connected with how or why. We all have biases and that’s okay, as long as we use our psychological skills and training to help us in our goal of living as reflective practitioners. This is a goal which one can rarely achieve alone, support systems are vital. I hope the content of this special issue will be a springboard for reflection, and I hope you will discuss your reflections with those around you so that the content can live on through the conversations you have with others in your personal as well as your professional life. Happy reading.

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Teaching philosophy of science

MANY THANKS to Lofgren et al. for their article in the May 2016 issue. As a counselling psychologist who has entered clinical psychology training and abandoned it, the article offered validation and triggered reflection, so I share some of my observations, questions and suggestions in the hope for further dialogue.

One of my first observations/questions was: Why leave teaching of philosophy of science to such a ‘late’ and restricted stage in the study of psychology as clinical training? Undergraduates are required to submit a final year thesis; it makes sense that teaching philosophy (not just of science) as part of psychology would mediate what I have seen as a metaphorical divorce between the two in psychology’s struggle to appear (and be funded) as more scientific than other social sciences. Science and philosophy are each an integral part of the other. Teaching philosophy during undergraduate psychology programmes will go some way towards closing the gap the authors report: that currently, where taught, philosophy of science tends to be part of qualitative research methods, poorly integrated with the rest of the programme, and thus its meaningfulness, not just for research but also practice, is not fully realised.

I think we must acknowledge the ‘generation gap’ that emerges but is not discussed in the article. Practitioner psychologists of my generation, clinical more so than counselling, were ‘brought up’ in a predominantly quantitative paradigm. I believe this is partly the reason why nearly half of the trainees in the article found the teaching slightly or not at all interesting. How do we convey meaningfully what trainers do not understand and employ sufficiently in their own interpretation of psychological science?

I recall coming away from training on case studies – which can be a great way of presenting qualitative, reflective aspects of clinical work – with the idea that case studies are constructed from repeated measures. The importance of ‘1’ was only significant in measurable terms; there was no acknowledgement that not everything that counts can be measured and not everything that can be measured counts. I believe this has also been a major oversight in our wholesale buying into ‘evidence-based’ practice and illusions of CBT as panacea.

Whose responsibility is it to improve the status of philosophy of science and students’ experience of it within psychology? One of my conclusions from the article is that we are letting down the next generation of psychology graduates and practitioners through our ignorance of the relationship between philosophy and psychological science and practice. I agree with the authors that professional bodies have a responsibility. I would also suggest that it is equally the responsibility of course/programme directors and heads of psychology departments to shape the ‘philosophy’ of their courses, so as to integrate philosophical thinking and psychology more explicitly.

Finally, as Aristotle and his current revivers within social sciences (e.g. Bent Flyvbjerg) would suggest, and as I read that many practitioner psychologists also believe (e.g. the often quoted ideas of Schoen), learning, knowledge and understanding exist and develop in relation to lived experience. I don’t just mean the lived experience of our clients, but also ourselves. I am thinking of personal therapy for practitioners and of the use of clinical supervision in promoting and integrating the ways of philosophical inquiry into our making science and practising that science with those who come to us for help.

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Identifying psychological needs in children and adolescents with autism spectrum disorder and gender dysphoria

Meghan D. Thurston, Claire Millward & Hannah Barratt

Children and adolescents diagnosed with autism spectrum disorder (ASD) and gender dysphoria (GD) are being referred more frequently to clinical psychology services. A case example of an adolescent who has been diagnosed with ASD and GD is outlined and issues regarding the clinical management are discussed.

Clinical psychologists are increasingly hearing about gender identity concerns in children and adolescents diagnosed with an autism spectrum disorder (ASD). There is an emerging trend towards acknowledging and considering these issues as factors pertinent to emotional wellbeing. Consequently, it is of theoretical and clinical significance to consider their co-occurrence. Research regarding the association between gender dysphoria (GD) and ASD is growing steadily in adult populations; yet few studies have explored this in children and adolescents. This article aims to briefly summarise the current literature base, present a case example and discuss the clinical and research implications.

Studies have identified an increase in the number of referrals received for children and adolescents diagnosed with both ASD and GD (Wood et al., 2013), with the incidence of ASD being 7.8 per cent in individuals with GD (de Vries et al., 2010) compared with 1.1 per cent in the general adolescent population (Baird et al., 2006). Individuals who have been diagnosed with ASD experience higher rates of low mood and anxiety in relation to neurotypical (i.e. not perceived to be on the ASD spectrum) individuals (Strang et al., 2012). A recent survey found (in adults) that 41 per cent of transgender and gender non-conforming individuals reported an attempt at suicide compared to 1.6 per cent of the general population (Grant et al., 2010) suggesting higher levels of distress in individuals with GD. A recent systematic literature review highlighted the increased prevalence of ASD and GD (Glidden et al., 2016). ASD and GD share many characteristics and there are various hypotheses that endeavour to explain their co-occurrence. The ‘extreme male brain’ theory of ASD suggests that, as a consequence of high levels of foetal testosterone, individuals with ASD have a tendency...
to display more ‘masculine’ styles of behaviour and thinking (Baron-Cohen & Hammer, 1997). Subsequently, natal females with ASD may readily identify with being male, engage in more typically male related behaviours and feel more comfortable amongst male peers.

Alternatively, individuals with ASD have a predisposition towards distinctive interests, at times becoming all consumed by them; therefore, it is hypothesised that gender identity may be influenced by a gender specific (stereotyped) special interest (Williams et al., 1996). For example, a male diagnosed with ASD that also presents with GD may have an obsessive interest with female Disney characters, dressing and mimicking behaviours that are reminiscent of fantasy princesses, for example. This is an obvious but fairly typical example. We can of course see much more subtle expressions of the experience of GD. Social interaction and a lack of sense of belonging within a typically developing peer group for both individuals with ASD and individuals with GD may occur, making it difficult to tease apart what is contributing to GD or is better explained as consistent with the presentation of ASD.

Given a high number of individuals diagnosed with ASD also experience GD, this suggests a clear clinical demand for further understanding of the specific needs of these individuals and how best they can be supported. The case presented details an adolescent diagnosed with ASD referred for support concerning their gender identity.

Case example
James is a 13 year old of mixed white and Chinese heritage and is a dizygotic twin. James first presented to services at the age of nine, when a diagnosis of ASD was given. James has received input from clinical psychology for support regarding emotional regulation, but concerns regarding gender identity were first discussed at the age of 13.

James is a natal female but identifies as a male. James stated he first felt like a male at the age of three. At home he identified himself as an eel and will refer to himself in the third person, saying, ‘the eel is sad’, for example. He described a preference for (stereotypical) male toys, interests, clothes, appearance and social expectations. His circumscribed interest was Doctor Who. He described feeling envious of his twin who was male. James had early onset puberty (aged eight) and physically appeared female; this often caused James distress and discomfort, particularly around menstruation. James had recently disclosed to his parents that he was transgendered and that at the start of the new academic year he would socially transition. Sessions with James (also attended by his mother) focused on exploring his gender identity, plans to socially transition, and how this would be managed at school. In particular, with regards to his social transition, how he would choose to express his gender identity, his choices regarding which facilities to use, and how to manage any covert or overt forms of bullying or segregation that he may experience as a consequence of his gender transition. James had suffered bullying previously due to appearance (his mixed heritage) and ASD diagnosis. Discussing this was clearly emotional for James and at times it was difficult for him to regulate or tolerate any distress. During sessions it was apparent that James was extremely well versed regarding gender and the transition process. Further literature regarding gender and transitioning was offered to James. Recommendations to school regarding how to support and manage James’s gender transition were also provided. James was referred to a specialist service for further support regarding future treatment options available to him.

Clinical management
The present case example illustrates an adolescent diagnosed with ASD and presenting with concerns regarding his gender identity and desire to socially transition. It could be argued...
that James’s GD is simply characteristic of his ASD; obsessive interests about certain stereotypical male topics with which he was able to relate to and identify, or an impairment in social relations with his female peers. It is judicious that clinicians do not overlook certain features that the individual is discussing and presenting. A sensible approach would be to explore all aspects carefully and in a way that is respectful to the individual.

While it is important for adolescents to be referred to appropriate specialist national gender service, there is often a long wait and ongoing support can be tricky for families to manage at a distance. It will be helpful if clinicians within this field could offer good practice guidance but local services can also provide appropriate and useful support. A holistic assessment is essential and awareness of possible hormone treatment prior to adolescence is a question many parents and young people want to know about. When supporting adolescents, liaison with educational staff and parents is essential. Within the UK, several schools have developed their own advice for schools (see resources section below). Further, local groups can be a source of support for the young person, their siblings and the wider family. This can be social support for the young person to meet other young people and help reduce stigmatisation or the feeling of isolation. There are few role models in the public eye and very little has been written to help young people understand what they are feeling, who they can talk to, and so on. Dr Wenn Lawson, an adult with ASD, has presented her own experiences of transitioning at national talks (Autism and Gender Dysphoria Seminar, National Autism Society) and suggested that feelings of GD can be present from a young age and do not change over time. It is not just a phase, yet there remains limited information for young people.

Future research
Future research may consider investigating the reasons why there is such a high prevalence rate between ASD and GD in adolescents compared to the general population. It would also be important to supplement this with an understanding of adolescents’ experiences of transition and how this can relate to clinical practice and support provided.

Final remarks
A collaborative and evidence-based approach to supporting young people with ASD and their families who are presenting with issues around GD is needed, particularly given the clinical needs in terms of risk of suicide, emotional regulation and support along an uncertain journey. Theoretical explanations around why there may be a relationship between ASD and GD have been discussed in the literature, but there is clearly a need for further exploration. It is important that individuals with ASD and GD have a sense of belonging and acceptance from society; this is vital for support and future directions.

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Resources
Below are some resources that may be useful when supporting an individual with ASD and GD:
- Cornwall Schools Transgender Guidance (2012).
- Mermaids.
- You Tube – The story of Jazz Jennings, a transgender girl.
- GIRES – Gender Identity Research and Educational Society (www.gires.org.uk).
- Tavistock and Portman Gender Identity Development Service.
Pre-Qualification Group Column

References
Genocide and mass sexual violence: Psychological support for women survivors in Rwanda

Jemma Hogwood & Khadj Rouf

This article highlights how sexual violence is used against women and girls during war and genocide. It outlines the longer term impacts of such violence and presents a framework for psychological intervention in Rwanda, in the aftermath of mass rape.

MASS RAPE and forced pregnancy are recognised as a weapon of war (Milillo, 2006) and have been documented in wars and genocides throughout history, such as Soviet occupied Germany (1945–1949), Bangladesh (1971) and Bosnia-Herzegovina (1992–1995). Wartime rape was finally recognised as a crime against humanity in international law following the genocide in former Yugoslavia (Buss, 2002). Genocide involves the destruction of a nation or ethnic group, perpetrated through mass killing, but also through the disintegration of culture, language, personal liberty, dignity, health and security (Lemkin, 1944). The use of sadistic practices, such as rape in war, are designed to erase the identity of the victim and cause maximum psychological damage to the community under attack. Whilst there is a human rights and legal literature around gender-based violence and rape in war, there is less about the psychological impacts upon women who suffer this crime. Zraly and Nyirazinyoye (2010) review literature indicating that rape survivors may be faced with unwanted pregnancy, gynaecological injuries, sexually transmitted infections, post-traumatic stress disorder and other psychological problems, including suicidality. Whilst women are often the target, sexual violence against men has also been documented to be widespread in war affected countries and can bring with it a myriad of physical and psychological consequences for individuals and communities (Storr, 2011).

Understanding context: The Rwandan experience

The 1994 genocide against the Tutsi in Rwanda occurred against a context of previous ethnic conflict and mass killings. The complex origins of the genocide have been linked to the impact of colonialism, and the resulting heightened ethnic divisions between the Tutsi, Hutu and Twa peoples. In the 1994 genocide, the Tutsi population was attacked. Moderate Hutus were also killed. The genocide was planned and predicted but, despite warnings, there was an inadequate international response. It is estimated that between 800,000 and 1,000,000 people died in 100 days. The genocide was widespread, and the violence was often perpetrated by people who attacked and killed or raped their Tutsi neighbours.

Rape was used as an instrument of war, and men infected with HIV were trained to rape and deliberately infect women. It is estimated that 250,000 to 500,000 women were raped (Foundation Rwanda, 2008). Twenty-two years on from the Rwandan genocide against the Tutsi, many are still impacted by those traumatic events. There are women survivors of the trauma who have felt silenced and shamed by...
Genocide and mass sexual violence

what happened to them: rape was used to systematically humiliate and damage women, and to inflict long lasting effects upon the Tutsi community. Many women became infected with HIV and/or became pregnant as a result.

For women who suffer rape, Van Ee and Kleber (2013) comment that: ‘Even after many years, the trauma of rape continues to have a major impact on women’s lives.’ Pregnancy as the result of rape can serve as a ‘living reminder’ of trauma. There is growing evidence that maternal trauma can be transmitted to children via biological as well as psychological mechanisms (Yehuda et al., 2005). Attachment between the child and mother can also be severely disrupted (Van Ee et al., 2012; Van Ee & Kleber, 2013). However, there is also evidence that some women are able to construct a positive meaning around their pregnancy despite their traumatic experiences (Van Ee & Kleber, 2013). The psychological responses that women experience, both in the short and long term, need further research. Hogwood et al. (2014) highlight that the impact of rape is multiplied if the woman becomes pregnant. They also comment that the ‘…destruction of the social fabric deprived these women of the social connections necessary to rebuild their lives and deal with the trauma’, as many people lost relatives, friends and other sources of support (p.393).

Gender-based violence in Rwanda

It is estimated that thousands of children were born due to rape after the 1994 genocide against the Tutsi in Rwanda (Torgovnik, 2009). Wax (2004) reports that survivor groups believe the number of children could be between 10,000 and 25,000. It is hard to establish exact figures due to underreporting. Few studies have explored the effect on the mother–child relationship, though there is evidence that impacts can be severe. In the aftermath, some women died by suicide, some had terminations, some carried the babies to term but gave them away and some decided to keep the children (Human Rights Watch, 1996). Women who kept their babies may have lost many or all of their relatives. Others have struggled to maintain positive relationships with their families because of deciding to keep the child. There can be complex family conflict, and there are instances of women being disowned by family because they chose to keep ‘a child of the killers’. Many women have had to continue living in communities alongside the men who raped them, and have had to raise their child in the community where they suffered victimisation. The longer-term impacts for those mothers and young people are unknown; neither is it known how many children suffer transgenerational trauma, or develop their own resilience.

Zraly and Nyirazinyoye’s (2010) ethnographic study of women who survived genocide-rape comment that ‘…the process of resilience appeared to be patterned by the culturally specific concepts…’ and that resilience was connected to ‘…an intrapsychic creative process of drawing strength from within the self in order to withstand suffering’ (p.1662).

Working with genocide survivors

Survivors Fund (SURF; www.survivors-fund.org.uk) was established in 1997 and has a range of projects to support survivors of the genocide against the Tutsi in Rwanda. The specific project for supporting women with children conceived through rape is part of a larger range of survivor support. Initially, the women requested practical help – needing financial assistance for their children to attend school. This gave women hope that their child would be able to find work and care for themselves and their mothers into old age. However, the needs of women changed over time and many started asking for help with what to tell their children about their origins. Mothers had often fabricated stories to protect their child from the truth and because it was still too painful to talk about traumatic events. Adolescence is a crucial time in identity formation and mothers faced more questions from their sons and daughters about their fathers.

SURF identified that many of the mothers had never disclosed their experiences of rape to anyone, even during previous counselling. Focus groups were conducted to explore how to best support the women. Following this, a decision was made to use a community group
A flexible, culturally adapted programme within a clear framework of session by session topics. With such complex trauma, clinicians are often working at the margins of the evidence base – an issue common to many therapists working with trauma, particularly that which has involved interpersonal violence.

Survivors’ struggles are often accompanied by severe poverty, hunger and housing issues. The women’s basic needs are often not met and it can be hard to engage in therapy effectively for this reason. Group topics can often be diverted to the current and immediate needs that women are facing. This means that the topic of disclosure has to be delayed due to more pressing issues. It is also important to understand trauma within a cultural and gendered context. For example, marriage and having children have particular significance in terms of rites of passage in Rwandan society; a girl transitions into womanhood once she has become sexually active and had children. Some of the women had been married at the time of the attacks. Some were young girls when they were raped, and were left confused about their cultural identity and the meaning of what was inflicted upon them (Mukamana & Brysiewicz, 2008).

### A framework for psychological intervention

The programme is designed to run fortnightly for six months, for a total of 12 sessions. A maximum of 10 women are accepted per group, all living in a similar geographical area, with the group being closed and run by two trained counsellors. The overall aim of the group is to provide a safe and supportive space to share stories, meet others with similar experiences and increase social support networks.

<table>
<thead>
<tr>
<th>Session</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introductions and creating a therapeutic contract</td>
</tr>
<tr>
<td>2</td>
<td>Active listening skills and supporting each other</td>
</tr>
<tr>
<td>3</td>
<td>Understanding trauma symptoms and triggers</td>
</tr>
<tr>
<td>4</td>
<td>Sharing life stories before and after genocide</td>
</tr>
<tr>
<td>5</td>
<td>Understanding how trauma can affect children</td>
</tr>
<tr>
<td>6</td>
<td>Understanding adolescence (from a child development perspective)</td>
</tr>
<tr>
<td>7</td>
<td>The rights of the child and responsibilities of parenting</td>
</tr>
<tr>
<td>8</td>
<td>Family conflict and ways to resolve it</td>
</tr>
<tr>
<td>9</td>
<td>Sexual health and sexual relationships</td>
</tr>
<tr>
<td>10</td>
<td>Considering disclosure: the advantages and disadvantages</td>
</tr>
<tr>
<td>11</td>
<td>Improving communication and practising disclosure conversations</td>
</tr>
<tr>
<td>12</td>
<td>Saying goodbye and endings</td>
</tr>
</tbody>
</table>
The women meet in their communities, which increases the likelihood of sustainable impacts, as they can continue meeting once formal counselling has finished. One group member explained the importance of the group process:

‘I always thought that I was the only one suffering from having a child that was born out of rape, but after our group discussion I got to know that it is no longer my concern as an individual, but our concern as a group. Sharing our experiences gave me more hope and strength.’

The programme only partially focuses on disclosure work, and disclosure issues are discussed near the end of the programme, after careful scaffolding around a range of earlier topics which lay the foundations for discussions about more difficult material (see Table 1). The programme includes psycho-education about trauma and understanding triggers to trauma memories. Many women experience triggers to highly disturbing memories and flashbacks, and struggle to make sense of these experiences. Explaining symptoms and triggers aids understanding and a sense of control over memories.

The programme also includes psycho-education around the responsibilities of being a parent and the rights of children. The UN Convention on the Rights of the Child is taught in schools, and provides a platform for this work. Adolescence is an emerging concept within Rwandan society, so child development concepts are introduced and discussed. These sessions also explore family conflict. One frequent theme is helping mothers learn to distinguish between the perpetrator and their growing sons, who may have physical similarities to the man who harmed them. Topics also cover learning to distinguish between adolescent mood changes and the violence perpetrated by the child’s father. Moth-

### Table 2: Selected evaluation data from 200 group members

<table>
<thead>
<tr>
<th>Measure</th>
<th>Session 1</th>
<th>Session 6</th>
<th>Session 12</th>
<th>Six month follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life satisfaction (Average rating from 0-10)*</td>
<td>2.6</td>
<td>5.2</td>
<td>7.0</td>
<td>6.8</td>
</tr>
<tr>
<td>Hope for the future (Average rating from 0-10)</td>
<td>4.0</td>
<td>5.9</td>
<td>7.6</td>
<td>7.4</td>
</tr>
<tr>
<td>Feeling a part of the community (Average rating from 0-10)</td>
<td>3.4</td>
<td>-</td>
<td>7.2</td>
<td>7.1</td>
</tr>
<tr>
<td>Relationship with child (Average rating from 0-10)</td>
<td>6.6</td>
<td>-</td>
<td>8.8</td>
<td>8.6</td>
</tr>
<tr>
<td>Experiencing difficult thoughts 'all of the time'</td>
<td>38.5%</td>
<td>-</td>
<td>5.3%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Have ‘no-one’ to talk to about my problems</td>
<td>46.6%</td>
<td>-</td>
<td>6%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

* Where 0 is the worst score and 10 is the best.
Note: These are culturally adapted measures, specifically designed for the Rwandan context and developed using an ethnographic approach.
ers often misattribute adolescent behaviour as a catastrophic sign of the child being ‘no good’ rather than framing it as normal adolescent behaviour. One group member commented:

‘The groups helped take the shame away from the fact I gave birth to a child from rape and helped me accept my child.’

An estimated 60 per cent of women who suffered rape were infected with HIV. Many women showing signs of sickness attributed this to their own ‘badness’, not realising that they were physically unwell. Sessions cover health issues: a recent development is psycho-education around menopause, as many women were unaware of the signs, symptoms and related biological changes, and were often misattributing it to traumatic experiences. This led to more intimate discussions around sexual relationships.

Only once these earlier topics had been covered in the programme, could women begin to talk about their fears of disclosing their past to their children. Earlier topics provided solid grounding to progress towards disclosure. It was extremely difficult for the mothers to explain to their child what happened, when they had never had the opportunity to talk or think about their own trauma. The other topics helped the women take steps towards thinking why disclosure might be important or necessary. Throughout the programme, it is made clear that it is the mother’s choice whether to disclose to their child, but the counsellors help to explore the advantages and disadvantages of speaking out. It appears that the majority of the mothers think that it is important for their child to know the truth, but often don’t know how to begin that conversation or what to say, and worry about the child’s reaction.

The programme has already reached 420 women, but many more would benefit from participation. Culturally adapted ways to evaluate the efficacy of the work are being developed, looking at life satisfaction, hope, relationship with children, social connectedness, and whether the mother is still experiencing distressing symptoms which are hard to manage (see Table 2). Discussions with group members to understand the impact of the counselling groups also reveal the personal experiences and benefits:

‘I always felt that no one was as miserable as me and that everybody hated me. When I joined the group, I met others like me and they became my friends, and they have helped me. Three months after the closing of the group, I approached my child during the school holidays. I knelt down and asked her for forgiveness because I have always treated her badly and left her alone. I told her why, and that it was not my fault, but it was due to problems I could not bear. Then I was able to tell her about her background because she was always asking me about her father. Before, my reaction to her questions was nothing other than beating her. Now I am alright and I live well with my child. If I had not had the chance to participate in the group, I would have committed suicide, leaving my child as an orphan, but now I try to enjoy life.’

**Summary and conclusion**

Mass sexual violence has often been used as a weapon of war and genocide, and is often underreported. There are approximately 59 million forcibly displaced people globally, around a quarter of whom are refugees (UNHCR, 2016). In the current global context of forced migration, it is important for psychologists to develop skills in working with survivors of mass violence.

We call for further resources to be allocated to the prevention of mass sexual violence and further genocide. There is also now enough data on genocide to identify warning signs for mass killing and mass rape. This can allow planned prevention and intervention responses (Jones, 2011). Responses where there is meaningful prevention work offer promising results for improved gender equality, and also seek to work with men and boys in reducing violence (Ellsberg et al., 2015).

Post-genocide work is crucial to help vulnerable populations, both in the immediate aftermath and in the longer term; people may suffer ongoing mental health problems and
transgenerational trauma, which could render wider society vulnerable to further conflict. Such work requires a multisectoral response, and psychological support is an important component of supporting victims and aiding community recovery (WHO, 2000). The example of work with survivors of the genocide against the Tutsi in Rwanda provides a framework for working with women who have suffered long-term effects from rape. Clinical psychology has much to offer, in partnership with survivors; we must pay attention to, and better understand the needs of, women who have suffered wartime rape, and their children, in order to build resilience and ensure that they are healthy, supported and integrated within their communities.

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References
Women and leadership in clinical psychology: Time for action and solutions?

Nargis Islam & Annette Schlösser

This article highlights the continuing issue of the underrepresentation of women in senior positions in the NHS and in particular the profession of clinical psychology. The paper suggests some ideas about why this might be and puts forward recommendations to address these inequalities, specifically in the context of recruiting and training future clinical psychologists.

Gender inequality is a recognised issue in organisational structures, with women holding fewer positions of management and leadership across sectors and industries. On average, women earn 9.4 per cent less than male co-workers (Office for National Statistics, 2016). In healthcare, robust evidence is emerging that a diverse workforce, valuing the contributions of all is associated with good patient care and productivity (West, 2012; Ellwood & Garcia-Lacalle, 2015). Despite this, in a traditionally female dominated sector, men continue to dominate leadership positions, particularly at an executive level in the NHS (Davies, 2011). Recently, inequalities in all industrial sectors highlight the continuing devaluation of women and reinforce the experience of women being considered economically risky or inferior choices for leadership positions compared to their male counterparts. Globally, we know that women make up 35 per cent of the average company’s workforce at a professional level, and that female representation declines as career levels rise (Mercer, 2014).

The issue of gender inequality in leadership roles in the NHS and the profession of clinical psychology, and indeed across the breadth of sectors worldwide, is by no means a new phenomenon. The Equality and Human Rights Commission (2011) identified that ‘the progress of women to positions of authority in Britain is tortuously slow’ (p.1). A recent study of NHS leadership illustrates a lack of ethnicity and gender diversity at senior level in English national NHS bodies, coining the descriptive phrase ‘snowy white peaks’ to describe the overrepresentation of white men in senior executive positions (Kline, 2014). The NHS Women in Leadership plan (Newman, 2015) cites that, while 77 per cent of NHS Trust staff are women, only 36 per cent of chief executives, 26 per cent of finance directors and 24 per cent of medical directors are women. The underrepresentation of women at these senior management and executive levels has significant implications for service quality and delivery when there is substantial evidence to suggest that equal representation of gender in leadership roles results in greater economic and organisational efficacy in both the corporate and the public sector, and better social outcomes and service user care (Patel, 2013; Ellwood & Garcia-Lacalle, 2015).

Improving gender equality and the empowerment of women is detailed in the Commonwealth’s Plan of Action for Gender Equality 2005–2015. The NHS Confederation (Newman, 2015) recently published a report on the issue of the underrepresentation of women in leadership positions in the NHS. This report recognised that, as a result of the changing health needs of the population and the pressured financial climate, there is a need to...
consider how services are delivered and to address the lack of diversity and inequality on every level of the organisation. Despite efforts to widen access to the profession, the lack of diversity remains a problem (Woolf et al., 2015). The discipline of psychology has an overrepresentation of women at undergraduate level, yet the national profile of an over-representation of men in leadership roles in psychology remains consistent with other areas (Murphy et al., 2014). Research on the psychology and economics of women in leadership for the European Parliament (Peters et al., 2013) outlines that key issues in women’s progression to leadership positions are gendered roles and the implicit biases about women held by both women and men in organisations. The issue of gender equality in leadership or decision making roles has been researched in law, economics, sociology and management/organisational psychology (Kumra et al., 2016), illustrating its multifactorial complexity. The remit of this paper is to address the issues in the context of the profession of clinical psychology, as we see the same trends of inequality in the female dominated profession of clinical psychology. We aim to put forward some possible reasons for this, drawing on research in organisational psychology and business management and suggest ways to address these inequalities within the profession, specifically how we are recruiting and training future clinical psychologists.

What are leadership and gender equality?
Leadership can be defined as ‘…the capacity to influence people, by means of personal attributes and/or behaviours, to achieve a common goal. However, while leadership is currently much discussed… there is no single definition or concept of leadership that satisfies all’ (Chartered Institute of Personnel and Development, 2015, p.1). Gender equality refers to the equal rights, responsibilities and opportunities of women and men, and implies that the interests, needs and priorities of both women and men are taken into consideration, recognising the diversity within these categories (UN Women, 2012). It is understood that there are social attributes, relationships and opportunities associated with being male and female that are socially constructed and learned through socialisation processes, and that these are context/time specific and changeable (Rao & Kelleher, 2002). Therefore, gender determines what is expected, allowed and valued in a woman or a man in a given context. Gender, alongside class, race, poverty level, ethnic group and age, are part of the broader sociocultural context, where there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, and decision making opportunities (UN Women, 2012).

What are the challenges in achieving gender equality in leadership positions?
Factors involved in gender (in)equality are multi-faceted and exist on a number of societal, organisational and cultural levels (Schuller, 2012; Evans, 2013). Several global reports have found that women are marginalised in terms of advancing to decision making roles (Mercer, 2014; Patel, 2013; Newman, 2015). Women experience specific challenges when aiming for leadership positions:

■ The double burden of improving career opportunities while also doing the majority of housework and child caring duties (Desvaux & Devillard (2008)): Bearing the responsibility for the majority of childcare throughout a woman’s career limits access to career opportunities and reduces the ability to form the self-promotional social and professional networks from which their male counterparts benefit (Patel, 2013). Furthermore, women are understood to ‘opt out’ of career advancing choices (Belkin, 2003) (i.e. women are expecting to have to make choices between work and family as they plan their career progression). This expectation limits women when it comes to taking on or even contemplating future leadership opportunities, presumably because of the perception that those positions will be too stressful when they are required to manage the double burden without organisational support.

■ Confidence: Women in general have been shown to be less confident in their abili-
ties than their male counterparts, both in self-beliefs and in the ability to communicate their competencies, even when they are equally competent at the professional role (Eagly, 2003). Research suggests that men also show a greater willingness and ability to ‘bluff’ (Guidice et al., 2009). These tendencies are hypothesised to link in part to gender bias and stereotyping (Patel, 2013). Women systematically underestimate their abilities and qualities in comparison to their male counterparts, and in addition, tend to attribute their successes to others while men tend to attribute their successes to themselves (Sandberg, 2013).

■ Explicit and implicit gender bias and stereotyping: Research illustrates that women experience a strong negative gender bias when being evaluated and selected for leadership positions, both on the basis of their level of performance and on their potential impact (Patel, 2013). They often have to work significantly harder to be perceived as equally competent as their male counterparts (Lyness & Heilman, 2008). Women are (wrongly) perceived as being less ambitious and less committed to organisational goals, due to family responsibilities. Implicit biases in how women are perceived once in a leadership role are also significant. A Harvard study showed that success and likability are positively correlated for men and negatively correlated for women (i.e. when a man is successful, he is liked by both genders, but if a women is successful she is liked less) (Heilman & Okimoto, 2007). This is understood to be in part due to the male stereotype of ‘providers’, who should be decisive and driven, whereas women, stereotypically, as caregivers are expected to be sensitive and communal.

This list is by no means exhaustive, and a more comprehensive discussion is beyond the remit of this paper. However, some of the key challenges facing women are clear when it comes to achieving parity in opportunities to progress in their profession, and clinical psychology is not immune to these factors. It therefore seems plausible to assume that the observed differences in career progression and ambition in clinical psychology between men and women is neither innate nor biological, but more likely to be a consequence of subtle psychological processes related to stereotypes held by both genders regarding the characteristics of women and men about what it means to be a leader (Peters et al., 2013).

What are the potential solutions?
Given that gender equality in professions across all sectors is understood as a human right, global and national initiatives suggest that there are organisational changes required for gender equality (Rao & Kelleher, 2002):

(i) Gender infrastructure: Policies are needed that commit organisations to gender equality through technological change, training and family friendly policies.

(ii) Organisational change: Democratising relations within the organisation and ensuring women’s voices are powerful in making systems more accountable and responsive to women’s participation are critical.

(iii) Institutional change: Focusing on women’s strategic interests through challenging the basis of women’s disempowerment is important, as is ensuring that those women who can benefit from any programme are involved in its development and implementation.

Addressing gender inequality in clinical psychology
Given the challenges discussed in the previous sections, it seems that the profession of clinical psychology, with its psychological knowledge to design, implement and evaluate healthcare services is well placed to be a forerunner in contributing to the recommended intra/interpersonal and organisational shifts that are necessary to achieve gender equality within the NHS. In an attempt to start this process we have outlined some areas that, as trainers, we recommend as areas of consideration:
1. Selection

- There are already reasons to believe that selection processes are prone to gender biases and stereotyping. There is a lack of available research and data on how this might factor into selection processes within clinical psychology selection. One could hypothesise that as the recruitment process assesses for core competencies, these may be biased towards more ‘female orientated’ qualities of greater emotional perception, to be more collaborative (than directive), facilitative and empowering (Paustian-Underdahl et al., 2014). Conversely, leadership recruitment has focused on qualities implicitly associated with men (e.g. command and control behaviours and assertion of power) (Paustian-Underdahl, Walker & Woehr 2014). This potential incongruence could perhaps in part explain the lower numbers of men coming into the profession, and also why historically they have risen with more ease to the senior positions.

- This area would benefit from further research, considering whether the process of selection includes implicit biases and stereotypes for both women and men. Making these biases explicit and using such tools as gender checklists and implicit bias training could address these issues.

2. Training

- Given some of the challenges facing women when progressing in the profession, women’s abilities to recognise and have confidence in their knowledge and skills set needs addressing. The challenge here is to empower women to recognise the tendencies to downplay their abilities, perhaps using reflective practice skills, and to help women overcome these barriers.

- Conversely, the dominant narrative about ‘think leader, think male’ needs to be highlighted and challenged, alongside its associated stereotyped and gender-biased assumptions. The role of training could include highlighting inconsistencies and implicit processes, to encourage trainees to challenge this narrative. It is equally important for male trainees to understand these factors within the context of developing their skills to ensure that their professional functioning supports equality.

- Training needs trainees to address and explore what might happen, consciously and within unconscious group processes, when the current status quo is challenged (Bion, 1998). The role and process of implicit biases could be highlighted through implicit bias training; for example, in leadership expectations. This could occur within teaching and also in reflective practice to support trainees in considering gendered responses in the development of professional identity.

- Staff teams have a modelling responsibility to trainees in all training areas, including academic, research and clinical placement experiences. Mentoring projects, such as a pilot initiative put forward recently by the DCP Leadership and Management Faculty, might also be beneficial to address reflective career progression discussions.

- Organisationally, clinical training courses could research the role of women progressing in the profession through trainee dissertations and collaborations with surrounding NHS Trusts. The NHS Women in Leadership document provides a precedent and basis for approaching HR and service leads to target inequality in the work force.

3. Post qualification – practice and career progression

- Newly qualified psychologists are in a unique position to challenge ‘old’ narratives by incorporating the concept of gender equality across clinical work and professional roles. Applying the core competency in consultation and providing a psychological framework within which to understand situations and interactions would provide opportunities to discuss and highlight these issues at an organisational level. Building confidence to move forward with this could be addressed towards the end of training in appraisals or exit interviews.
Clinical training could continue to provide support and a reflective space in the form of CPD or supervision for psychologists in the region to enable them to continue to maintain these perspectives. Local DCP branches could be instrumental in this pursuit.

Conclusion
Clinical psychology as a profession sits contextually in an environment of gender inequality. Research shows us that women inside and outside of our profession are hampered in their professional development and progression due to gender stereotypical narratives and unequal expectations. As a profession we can identify this (assessment) and are uniquely equipped to understand these processes (formulation). Our next challenge is to intervene and evaluate our interventions, in line with the analysis, formulation, intervention and evaluation model. Using our psychological theoretical knowledge, we need to harness the positive energy of those committed to a more inclusive and representative profession (e.g. the Society’s Inclusivity document) to research how implicit biases influence our work and expectation. We need to work together as a training community to address issues of gender and power explicitly in the curriculum and on placement, and to support trainees in identifying non-gendered career development paths. We need to consider selection criteria for training, and review as a profession how we prepare the empathic clinicians we recruit for leadership roles in the future.

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References
Women and leadership in clinical psychology


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Feminine and masculine personality traits: Reflections on opportunities and challenges to a career in clinical psychology

Yvonne Melia

In this paper I will reflect on traditional ‘masculine’ and ‘feminine’ traits. I will discuss the potential import of such traits to the profession of clinical psychology, considering the opportunities and challenges masculinity and femininity present across the career pathway, including entry to the profession and progression into leadership positions.

SEX-TYPED personality traits are aspects of personality seen to be associated with either ‘masculinity’ or ‘femininity’, with masculine traits being seen to reflect more instrumental personality traits (e.g. independence, assertiveness, ambition and need for dominance) and feminine traits reflecting more expressive personality traits (e.g. sensitivity to the needs of others, altruism, warmth, being sympathetic and co-operativeness) (Spence, 1993). Historically, global personality differences based on sex have been disputed (see Hyde, 2005). However, more recent research suggests limited overlap (10 per cent) between male and female distributions (Del Giudice et al., 2012) with the largest differences for univariate items found for sensitivity, warmth and apprehension (higher in females) and emotional stability, dominance, rule-consciousness and vigilance (higher in men). Masculine and feminine traits can be seen as falling on two independent continuums, with individual differences existing within gender groups (Perry & Pauletti, 2011). Whilst there will therefore be individual variance in levels of masculine and feminine traits, overall, sex differences in personality traits may still be significant.

Motivations for entering the profession and selection factors

Gender schemas are mental representations used to organise information about the sexes (Lenton et al., 2001). These schemas are used as filters in deciding whether something is for our gender or not, and are influential in decision making. Gottfredson’s (1981) career choice theory hypothesises that many occupations are perceived by children from an early age as sex-typed, and that such perceptions are influential in determining future career choices. It has been argued that even by A Level psychology may be construed as a female subject (Smith, 2011). In terms of applicants to training programmes in clinical psychology in the UK, females consistently dominate. Between 2005 and 2014, the average percentage of applicants was 83.5 per cent for females to only 16.5 per cent for males (Clearing House for Postgraduate Courses in Clinical Psychology).

The potential ‘feminisation’ of the profession has been attributed to men being deterred from considering it as a career option, perceiving it to lack prestige and be poorly paid (Willard, 2011). This would suggest that traditional masculine roles of being the breadwinner and achieving status present barriers to entry to the profession. However, men may also be reluctant to pursue a profession in applied psychology due to its potential association with the more feminine ‘caring’ aspects of the role (Morison et al., 2014). Concerns about ‘breadwinner wages’ and undertaking the ‘carer role’ are relevant to men in female-majority healthcare professions more generally in the UK (e.g. Arnold et al., 2003; McConkey et al., 2007).
Career choice will also involve a degree of self selection, and based on recent findings of significant global sex differences in personality some theorists would argue that sex-based personality differences may make particular occupations more suited to one sex or another because of the personal qualities they are perceived to be required to do the role competently (e.g. Del Giudice et al., 2012). Concern for others and empathy are perceived to be important factors in decision making in respect to becoming a clinical psychologist, with students interested in a postgraduate career in clinical psychology scoring higher on empathic concern and perspective-taking (Harton & Lyons, 2003). Overall, females were more interested in pursuing such careers and women in general consistently score higher on self-report measures for empathy than men (Eisenberg & Lennon, 1983).

Research examining the motivations of male UK trainees to become clinical psychologists (Caswell & Baker, 2008) in the main identified a mix of both more typically masculine (e.g. competitiveness) and typically feminine traits (e.g. beneficence) as incentives; for instance, respectively, the positive ethical value clinical psychology was seen to contribute to society and the people-focus of the work as well as the competitiveness involved in securing a training place in clinical psychology and therein the difficulties entering the profession. However, the most dominant group also referred to the emotive aspects of the work as a disincentive, counter to perhaps the majority of females’ motivations for choosing this career. Two minority groups, accounting for only 8 per cent and 5 per cent of the overall variance, nonetheless referred to more interesting motivations linked to possible sex-typed personality traits or gender role identification. The first of these reported motivations more in line with masculinity (being motivated by the power and status they perceived came with qualifying as a clinical psychologist), and they reported drawbacks of the profession (again, in line with possible challenges to masculinity) being the risk of their sexuality being questioned or their career choice being suggestive of some discomfort with traditional masculinity. The other minority group (5 per cent variance) were actually attracted by the distance they perceived the profession offered them from traditional masculine roles, suggesting less identification with the male gender role.

Feminine traits appear to be prized within the selection process. Schweitzer et al. (2014) identified three factors as significant for candidates’ suitability for training in clinical psychology – namely, in order of importance, awareness, (i.e. empathy, awareness of mind and self-observation), reflection (guided reflection, communication skills and self-reflection) and reasoning (writing and conceptual reasoning skills).

I would conjecture that such traits continue to be important in the assessed performance of trainees during their completion of a clinical doctorate, and in entry level positions post qualification, where emphasis is often placed at this stage on how the individual relates to and establishes relationships with clients or service users and direct work, including psychological assessment and therapy.

**Sex-typed personality traits and career progression in clinical psychology**

The profession of clinical psychology has markedly changed in terms of its emphasis on the development of core competencies. It has moved away from direct work (e.g. assessment, therapy) being central, to skills in leadership, service development, consultation, training and clinical expertise now being prized aspects of the role. The expectations placed on clinical psychologists in the marketplace have also increased, in line with their higher level banding compared to colleagues in multidisciplinary teams, and their need to prove their worth and clinical value in the context of a financially constrained NHS. Such expectations also now increasingly fall to newly qualified clinical psychologists, who may previously have had a more protected status. Resource constraints, high numbers of referrals to ser-
vices, and an emphasis on performance and payment by results also mean that a key aspect of the clinical psychologist’s role is now about supporting throughput, monitoring outcomes and evidencing the added-value of services.

Prioritisation of feminine traits at the selection stage may be short-sighted in the context of these changing roles and demands. Despite this, the generic person specification and job description for a Trainee Clinical Psychologist continues to place most emphasis on the direct work component of clinical psychology, stating that the purpose of the job is ‘to undertake and evaluate specialised psychological assessments, treatments and other types of clinical intervention with individual clients, carers, families, groups of clients etc. (see www.leeds.ac.uk/chpccp/JobDescriptionPersonSpec.pdf, p.1). Leadership is not mentioned at all and service development is referenced once, whilst personal qualities such as empathy, reflectiveness, ability to deal with the emotional demands of the role and to support clients who are highly distressed are consistently referenced. It is possible that women and/or candidates with evidence of more feminine traits will be advantaged at this stage and more attracted to the profession. However, it may mean that there is a dominance of applicants who are more motivated by the therapeutic aspects of the role.

Of course, these personal qualities are vital to being a clinical psychologist and should continue to be prized. However, what this highlights is a possible disparity between how the profession is marketed at the training stage (and the qualities valued in candidates at this stage), and what may be required in the marketplace (and certainly as clinical psychologists attain more seniority). Further inquiry is required into how well current training programmes equip trainee clinical psychologists to learn about leadership, service development, commissioning of services and policy issues significant to the profession, and progression in it via teaching and placements versus the emphasis placed on helping them become competent clinicians. Similar inquiry seems warranted into how much early career psychologists are mentored or coached to think about leadership issues and to develop the skills they need to progress into more senior roles.

In general, masculine traits (but not feminine ones) have been found to be significant predictors of career success amongst both men and women (Abele, 2003). There is a paucity of available research in respect to career success in clinical psychology. However, it is well established that mental health services continue to be shaped largely by men (King’s Fund, 2013). There is a clear need then to examine how sex-typed traits may be advantageous or limiting within our own profession. Despite the emphasis in clinical training on the development of core competencies, anecdotally the marketplace appears to be striving for something quite different, not for integrative practitioners with wide-ranging skills, but for experts, specialists, proponents of standardised, evidence-based psychological interventions who have a presence in the public domain through publishing and dissemination of their practice. Anecdotally, from my own experience and observation, it is more a masculine tendency to become proficient in a small number of key areas versus the more feminine tendency to multitask and be somewhat, but lesser, competent in a broader range of areas. Further, to go back to Del Giudice et al.’s (2012) research, potentially the higher presence of traits such as dominance and lower levels of apprehension (versus self-assuredness) in men may be beneficial to them pursuing leadership and managerial positions in clinical psychology. Lower ratings of sensitivity are also indicative of being utilitarian, objective, unsentimental and tough-minded, which may be potentially qualities that are valued more highly in leadership roles than in more junior roles where the clinical work is the focus. Clearly, leaders do need to make tough decisions, be decisive and be experts. Research extending Caswell and Baker’s (2008) findings potentially following-up the place of masculine and feminine traits in a male clinical psychologists career trajectory would be intriguing.
For instance, are those male trainees who are nonetheless in the minority but who evidence more traditional masculine roles advantaged in the workplace? Perhaps their discomfort with questions about their masculinity in the context of their choice of profession might act as a driver to move into a leadership domain where there is greater identification with their gender role. Perhaps too, those women who achieve leadership positions and status within the profession may present with more masculine traits, but again, there is a lack of research on this to reference.

However, is there not a place for emotive and feminine leadership too? Systemic and organisational change, reflective practice, clinical supervision, supporting professional resilience and robustness all require emotional containment and attention to process as much as action and management. Hypothetically, at a time when resources are constrained, there is a push for certainty so that we are investing monies available into services that have value. However, there is a place too for leaders who can tolerate a position of ‘not knowing’ rather than this being seen to diminish their status in some way. ‘Not knowing’ facilitates creativity and competence of more junior team members. These I would consider more feminine traits. Simpson and French (2005), in their paper on thoughtful leaders, helpfully emphasise that to keep members of an organisation ‘on task’ requires containment of emotion for thought, action and on-task behaviour to emerge. Thoughtful leaders also show an openness to new thoughts, occupying a space between their existing knowledge base and a position of ‘not knowing’. Finally, they mobilise others to become thoughtful leaders and manage the opposition and resistance, and feeling of persecution that can arise in others that can come from ‘not knowing’. These skills are linked to Bion’s (1962) idea of the mother’s capacity for reverie characterised by listening, waiting and patience. Simpson and French helpfully compare the position of a thoughtful leader with the active, technical and decisive leadership that perhaps is more characteristic of masculine leadership. It is possible in the current economic climate where the emphasis in organisations is on efficiency, performance and throughput that masculine leadership will prevail and be prioritised.

Important to any career is a sense of control and role satisfaction. Individuals will enter the profession of clinical psychology for a range of reasons and their progression will be directed to some extent by their interests and motivations. However, a proportion will be interested in becoming future leaders of the profession. As it stands, I would question whether the number of male leaders in a profession that is dominated by females is suggestive that the qualities prized on entry are not the same qualities prized in our leaders. There seems to have been concerns about psychology becoming feminised, to the extent it was seen to warrant an investigation by the American Psychological Association into the potential impact of this on pay and the prestige of the profession. We do not seem to have similar concerns or be similarly affronted by the potential for masculine leadership in mental health and clinical psychology to dominate and what we may lose by the absence of feminine traits at this stage of the career pathway. Neither do we have a good understanding of the barriers to progression in individuals presenting with more feminine traits, but who nonetheless may have the desire to be a future leader. Critically, early career clinical psychologists need to be given the right opportunities, experiences and mentoring. Perhaps we need to be more transparent about what the profession values in its leaders so that where possible clinical psychologists can be supported to develop these competencies and skills as part of their personal development, identified within their annual personal development review. Finally, perhaps the minority of women in leadership positions need to consider how they can inspire and be mentors for future generations of psychologists.

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References
Trans and non-binary genders: Implications for academic psychological work

Christina Richards

I WILL NOT needlessly reiterate who trans and non-binary or genderqueer people are here – for more information please see ‘Trans and non-binary genders: Implications for applied clinical psychology’ in this issue or some of my other work (Richards & Barker 2013, 2015; Richards, Barker & Bouman, 2016). Suffice to say that trans people trouble neat historical classification systems, and so have until very recently been ill-served by our profession, have been pathologised, and have been ‘othered’. Academic teaching on trans therefore tends to fall under the category of ‘abnormal psychology’ – an odious phrase, setting up as it does an ‘Us’ and a ‘Them’ of the ‘normal’ and the ‘abnormal’, with all of the attendant harm (Infinito, 2003; Sherif, 1956); indeed, positing that there is such a thing as ‘normal’ from which one can deviate, which in the case of trans (and gender more broadly), both historically and geographically, there isn’t (Feinberg, 1996; Herdt, 1996).

Research, therefore, has tended to fall into two camps. First, that from the psychological and psychiatric literature, which has examined trans people as a group to ‘treat’ (either benignly with surgeries and hormones (Gijs & Brewaeyys, 2007) or malevolently with shock ‘therapies’ and emetics (Gelder & Marks, 1969)). And secondly, as a group whose lived realities have been appropriated to buttress theorisation (ironically, both for the gender dichotomy of male and female (Raymond, 1979) and also against it (Hakeem, 2006)). In neither of these cases have trans people themselves been at the centre of the research. This is because research, not uncommonly conducted by psychologists, has been undertaken on trans ‘subjects’ rather than with trans participants or co-researchers. How then might the well-meaning clinical psychologist undertake research with these groups? It is this which this paper seeks to expand upon.

Research with trans people

Fundamentally, ethical, quality research with trans people involves trans people, takes care not to appropriate trans people’s lives and is of some actual, practical use to trans people (Richards, forthcoming, 2016a, 2016b). In regards to that last, ‘Giving a voice’ really won’t do. Who are we to be the ones doing the ‘giving’? How does that power disparity work? Do the trans people want their voices to be heard in the (not uncommonly obscure) journals that the voice is ‘given’ to? Is it actually their voice which is ‘given’ when the theorising/interpretation/statistical analysis is done?

As more trans people feel able to be out about their trans status these research problems will change due to the barriers between the (cisgender¹) researcher and the trans subject being permeated. However, there then follows work to be done in terms of structural exclusion of trans people, both from and within the academy. Aside from the old prejudices and microaggressions which are happily now subsiding (although all too many people still have personal experience of them), there are exclusions in the very nature of the research process. For example, if funding of health and mental health research is all that is available, then that will naturally be the focus of the research. Certainly, such matters are a useful line of enquiry, but one which risks the clinician-(researcher) illusion as trans people are viewed solely though that lens. Of course, this leaves the rich diversity of trans peo-
ple’s experience – just as with cisgender people when health is the sole matter under consideration – underresearched.

A further matter of structural exclusion is peculiar to qualitative research: explicit reflexivity. Reflexivity is a common part of such research, allowing the researcher, as it does, to examine their own assumptions, process, and understandings; and providing the opportunity to see how these may bias the recounting and/or interpretation of the participants’ participation (Etherington, 2004). However, if the researcher is trans (and/or indeed of any other marginalised group), explicit reflexivity carries with it potentially greater opprobrium and cost than if the person is cisgender. This is because the trans researcher who is explicit about their self, their gender and their identity in published work may be accused of undue bias, risks telling ‘confessional’ stories (Barker, 2006) and may actually be at risk of harm from prejudiced parties (McNeil et al., 2012). Certainly, their work may be read by clinical psychology clients and future employers to unknown effect. Conversely, the cisgender researcher is at risk of appearing ignorant of the topic through their lack of personal awareness, but may address this simply through a sort of shrugged *mea culpa* before carrying on with the analysis. This leaves only cisgender people, tenured trans academics and those trans people working in very specific areas of private practice being able to undertake research of this kind – which is clearly unacceptable.

We do need reflexivity within research, however. We need to know what we know, where our gaps may lie, and how we may bias the work (Luft, & Ingham, 1955). To address this I propose the use of private reflexivity with a supervisor and/or other academic or clinical psychologist who may then provide an affidavit which states that reflexivity has been undertaken. But which does not delineate what the content was. In this way researchers may actually be able to be more frank and open about potential biases without the ever present worry of who may read about them, and to what end (cf. Richards 2016a).

Quantitative research too carries with it risks of bias (and indeed reflexivity in quantitative research, as set out above for qualitative research, has much merit). Here, the bias is not so much in the analysis as in the design and the interpretation of the findings. The bias potential in interpretation of findings is simple enough to imagine – as seen in countless dubious evolutionary psychology papers which find some marginally statistically significant difference and then work backwards like some sort of Kafkaesque ‘just so’ story (Kipling, 1902) to arrive (invariably) at a point of rank misogyny which the data does not actually support. Here, the researcher’s bias affects the interpretation of the ‘static’ data. Consider the empirical work of the past which had ‘proven’ the inferiority of women, non-white people, same sex attracted people, etc. – which has now been disproven.

The design issue is a little more subtle. Imagine we want to investigate student sexuality. The simple experimental design of a thousand undergraduate programmes is to split the participants into male and female and then ask them what their sexuality is – heterosexual, gay, or (perhaps) bisexual². But what do we mean by these terms? Cisgender men and women? Trans men and women? What about sexuality? – What the participants have done? Would like to do? Have fantasised about? That one time after too many margaritas on their gap year? Their identity? Or their practice? Or both? (cf. Richards & Barker 2013). The question is, are these terms which have been arrived at before the study from the researcher’s own knowledge and understandings (and consequent biases) sufficient in and of themselves? Further questions arise: What about those people who identify as something other than male or female – they will be excluded from the study, but may well be part of the population of students whose sexuality we wish to investigate. Similarly, what about those people who are asexual, or whose primary sexual identity is BDSM³ or some other sexuality? Clearly those assumptions which we bring to qualitative research too can bias the outcome, even if we are entirely well meaning.
Conclusion
Research with trans people is an important endeavour which can pay dividends when it demonstrates the needs and lived experience of trans people in a way which has a material effect on their lives. It can inform policy and effect legal changes which open up access and close down discrimination, and as such is vital in the ongoing struggle for equal rights, both within clinical psychological theory, research and practice, and also more broadly within the UK and globally.

However, the historical position of trans people with respect to the academy, and the biases which researchers continue to be at risk of may influence research in ways which can be unhelpful. As ethical psychologists, it therefore behoves us to understand and attend to these issues as we carry on this most important work.

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Endnote
¹ A cisgender person is someone who is content to remain the gender they were assigned at birth.
² Note that the order of male and female; heterosexual, gay and bisexual also carries implicit bias (Hegerty, Lemieux & McQueen, 2010).
³ Bondage and discipline, domination and submission, sadism and masochism.

References
As increasingly seen in the media, some people are not content to remain the gender they were assigned at birth. Some of this group of people – commonly called trans people when relevant – identify within the gender binary of male and female, and so may have been assigned a female sex at birth but identify as a male, or have been assigned a male sex at birth and identify as a female. These groups of people are often termed trans men and trans women, or men with a trans history and women with a trans history, respectively, when their trans status is relevant – or simply as men and women respectively when it is not. Aside from these groups of people, there are also those who identify outside of the gender binary of male and female who are often called non-binary or genderqueer people (Richards et al., 2016). Some of this group of people may identify at a fixed point along a notional gender spectrum – say 70 per cent male, for example. Some may move within a certain range in a fluid fashion (say from 30 per cent to 65 per cent) – although it should be remembered that this ‘spectrum’ is a blunt tool at best and to polarise gender in this manner is to miss the vast majority of the complexity of gender, which may include foregrounding different genders in different circumstances or taking umbrage with the very notion of gender – especially in the binary sense. In contrast, some people do not identify with any gender and may define as neutrois. There are, of course, a variety of identity terms emerging, and so for simplicity here we’ll use the term ‘trans’ as an umbrella term to include all of the above (and non-binary when we are referring specifically to those people who identify outside of the gender binary).

Psychopathology

Historically, and sadly still in some areas, the notion of identifying as a gender other than that assigned at birth has been seen as a mental illness. This is largely an effect of issues to do with sexuality and gender moving from the ecclesiastical domain of ‘sin’ and ‘morality’ and into medical discourses towards the end of the 1800s through works such as von Krafft-Ebing’s (1886) *Psychopathia Sexualis: Eine Klinisch-Forensische Studie* (*Sexual Psychopathy: A Clinical–Forensic Study*), Ellis’s (1897–1928) seven volume series *Studies in the Psychology of Sex*, and Hirschfeld’s (1938) *Sexual Anomalies and Perversions*. Spurious theories, such as over-identification with the ‘opposite’ sex parent were posited, largely by the psychoanalytic tradition, which have since been disproved (Zucker, 2008) – sadly, at a cost to the vulnerable trans people who were ‘treated’ as a result of such baseless theorising.

More recently, the American Psychiatric Association (APA) have changed the diagnosis from gender identity disorder to gender dysphoria in recognition that being trans is not a disorder (APA, 2013a). The decision to retain the diagnosis within the fifth edition of the Diagnostic and Statistical Manual (APA, 2013b) was made on the pragmatic grounds that trans people who are seeking physical assistance in the form of hormones and surgeries, etc., need a diagnosis in order...
to be reimbursed through health insurance. It is notable also that the diagnosis includes people with gender identities outside of the gender binary through the following criteria [My italics]:

(i) A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).
(ii) A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).
(iii) A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender) (APA, 2013b).

Thus, if a psychologist considers trans identities to be ‘disordered’, or does not believe in non-binary gender identities, then they are behind the American Psychiatric Association in terms of the evolution of their thinking – a position which might usefully bear a period of introspection. Indeed, the diagnosis of transsexualism in the World Health Organization’s (WHO) International Classification of Diseases (ICD) Version 10 (WHO, 1992) is likely to be replaced with the diagnosis of gender incongruence in the ICD-11, and again will not consider it to be a ‘disorder’ and will include non-binary identities.

All this is not to say that trans people do not suffer from the general range of mental ill-health that cisgender people do. While trans people are no more likely to have major psychopathology than cisgender people (Hoshiai et al., 2010), trans people can be subject to prejudice (McNeil, 2012), which can lead to minority or marginalisation stress (cf. Meyer, 1995) – that is, stress (and associated anxiety and/or depression) which is induced though being part of an (oppressed) minority. Of course, in this case it is entirely unreasonable to attribute the pathology to an attribute of the individual such as their gender form, ethnicity, religion, etc. Rather, the aetiology of the pathology lies in the oppression faced by the individual. As psychologists, therefore, we can assist trans people by assisting with coping mechanisms when necessary; but more importantly, by advocating for a society in which such oppression no longer occurs – by treating the cause of the pathology in society, if you will.

Assistance

Many trans people need no assistance whatsoever beyond that required by the rest of the population for their mental and physical healthcare needs. Some, however, feel uncomfortable about their identities, practices, thoughts and feelings, and so wish to talk to a psychologist or psychotherapist. Quite often, this is because they have introjected a negative discourse about trans, and so believe that they are therefore ‘bad’ in some way, or that transition in to a gender role which is congruent with their gender identity would be unliveable. In these cases it can be useful to ‘unpack’ these thoughts – check the ‘I should’, ‘I must’, and ‘everyone thinks’ statements – just as you would with any other client; and also use your therapeutic power to normalise being trans. After all, trans people do seem to go on to do well with relationships, children, jobs, etc., just as cisgender people do. For those trans people concerned about the idea of living in their preferred gender role, gradual exposure in that role can be very useful – perhaps at home on your own, then with a friend, then outside, at work, with parents, and so on – whatever feels least to most difficult. There are various other interventions in Richards & Barker (2013), if you have an interest.

In addition to the psychological work, which some trans people find helpful (and it is worth reiterating here that the majority of trans people do fine without psychological input), as mentioned above, some trans people seek physical assistance. For those people with a female identity who were assigned male at birth this may consist of feminising hormones (oestrogens anti-androgens) to induce breast growth, reduce body and facial hair, reduce muscle bulk, soften skin and redistribute body fat to a more female distribution. Often, the capacity for erection, especially spontaneous erection, is lost. Some trans women have speech therapy (and sometimes surgery) to feminise their voice. Some seek an augmentation mammoplasty, although careful hormonal
management means that many do not require this. And some trans women – but by no means all – seek genital surgeries.

It is a common trope to ask trans people ‘Have you had the operation yet?’, and this crass and unnecessary question should usually be avoided by psychologists at all costs. As ever (and this hardly needs saying), enquiries about our clients’ genitals should be undertaken only with an absolute need, with a specific purpose in mind and extremely delicately. The fact a person is trans in no way alters this. Those trans women who do seek genital surgeries may have their penis and testicles removed and a vagina and labia created – with the clitoris created from the tip of the glans and situated in the usual place. The removal of the testicles, and often the use of feminising hormones, will render the woman infertile and she may wish to store sperm prior to starting hormones if she wishes to be a biologically related mother in the future. Unfortunately, trans women are still not able to have a womb and ovaries transplanted (although this may not be far off – cf. Murphy, 2015), so at present she will need another woman to gestate the foetus – either her partner or a surrogate.

Turning to trans men, the options are fairly analogous: Trans men may have masculinising hormones (testosterone) in order to induce body and facial hair, increase muscle bulk, coarsen skin, develop a deeper voice, stop menstruation, and enlarge the clitoris – and they may go bald if they have a genetic propensity for it. They may opt to have their womb and ovaries removed – and again, this, and likely masculinising hormones, will render them infertile and eggs will need to be stored beforehand if they wish to be a biologically related father in the future (cf. Richards & Seal, 2014). Trans men often wish to have a bilateral mastectomy and associated chest recontouring (cf. Richards & Barrett, 2013) in order to effect a male chest, as masculinising hormones alone will not induce this. As with trans women some – but by no means all – trans men opt for genital surgeries which may consist of releasing and sculpting the clitoris to sit more prominently (a metoidioplasty) or the creation of a phallus from a free graft (a phalloplasty), and the creation of a scrotum and testicles. The urethra can be routed through the phallus to allow the man to stand to urinate and, if he has opted for a phalloplasty, a prosthesis may be implanted to allow it to become erect.

Non-binary people may have a variety of elements of the above, in-line with their identity; however, physiology is not a pick-n-mix counter as only certain things are possible. For example, it would not be possible to masculinise a birth assigned female to the extent that they (the usual preferred pronoun, rather than he or she, for non-binary people – worth noting) had a beard, but did not go bald, as the same mechanisms induce both. Especially for younger people whose identities have been formed in the freedom of the online world, these prosaic realities can be frustrating and the job of the assisting psychologist can be to shepherd them through this developmental stage.

At present these physical interventions require the recommendation of a psychologist or psychiatrist, as per the extant guidelines for physical treatments for trans people, being the Good Practice Guidelines for the Assessment and Treatment of Gender Dysphoria (Royal College of Psychiatrists, 2013), the Standards of Care for the Heath of Transsexual, Transgender and Gender Nonconforming People (7th edn) (World Professional Association for Transgender Health, 2011); and the Interim Gender Dysphoria Protocol and Service Guideline 2013/14 (NHS England, 2013). For more information on interventions with trans people (and people of diverse sexualities) the Society’s own Guidelines for Psychologists Working Therapeutically with Sexual and Gender Minority Clients (Shaw et al., 2012) are invaluable.

The fact that trans people require a professional to sign them off for physical interventions for what is, after all, their own
body and identity is naturally contentious, with some parties arguing that trans people should have the right to self determine, and others arguing that it is important that such interventions are safe and, in a system of socialised healthcare, of benefit. For more information, the recent parliamentary Women and Equalities select committee report Transgender Equality: First Report of Session 2015–2016 (House of Commons, 2016) will give a good overview. Psychologists are consequently put in an awkward position, in which our usual claim to complete respect for the client’s autonomy runs up against a situation where a psychologist is actually in a position to significantly impinge upon that autonomy. My own view is that psychologists are well positioned to attenuate the power imbalance as far as is possible in such situations, while advocating for effective, safe practice which respects the client’s autonomy, as far as is possible, more broadly.

**Conclusion**

Trans then, appears to be moving forward, especially in urban areas of the high GDP global West, to a position of equality and acceptance. Certainly legislation, such as the UK’s Gender Recognition Act (2004) and the Single Equality Act (2010) have been a key part in this, as has the shift in thinking in medical and psychological practice from a position of ‘disorder’ and towards one of simple diversity. As with the removal of homosexuality from the DSM and ICD, media and wider discourses are following, and there are fortunately far fewer ‘shock exposés of people who choose to live in a gender other than that assigned at birth. Sadly, there is often still a story – albeit usually a celebratory rather than a denigrating one. We hope that things will continue to evolve to the point where dramas with a trans person in will have their gender as an incidental factor – as we are starting to see with (cisgender) women and people of colour – rather than being about being a woman, a person of colour, a trans person (or all three). Similarly, it will be nice to get to a place where a transition is much like a pregnancy – a major life event certainly (perhaps one with special cards), but not one which is so extraordinary as to excite unwarranted comment and intrusion, not least from psychologists and psychiatrists.

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**References**


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**DCP CPD workshops**

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[www.bps.org.uk/findcpd](http://www.bps.org.uk/findcpd)

The British Psychological Society
Learning Centre
My ode to trans activism

Jay Stewart

‘A self does not amount to much, but no self is an island; each exists in a fabric of relations that is now more complex and mobile than ever before.’ (Lyotard 1984, p.15)

What is activism?
In Touching Feeling, in relation to the ‘natural history’ of HIV and AIDS, Eve Kosofsky Sedgwick challenges ‘The fixated question: Is a particular piece of knowledge true?’ (Sedgwick, 2003, p.124), and asks instead: ‘What does knowledge do?’

My own involvement in activism has come through a shift in holding more centrally the utility and performativity of knowledge. This short article hopes to explore the interface between knowledge and activism – the point where knowledge is productive and achieves. I am interested in the point where scholarly thinking, discussion and debate bleed into some sort of action; actions that are deemed political and aim to effect some sort of change. This work gives trans subjects (and gives me) validity, purpose and power.

Activism among trans communities brings coherence to geographically disparate and fragmented groups. As trans collectives are becoming increasingly mobilised, established and organised, it is the material consequences of activism that gain us momentum. Activism can take the form of writing complaints, signing petitions, and lobbying government. Trans activists work hard to affect the large institutes and systems that hold substantial power. Sometimes these efforts work to gain a particular legitimacy through changes in the law and recognition within the public domain.

Yet activism also takes place within the minority and counter cultures of society – sometimes bearing an ethos that is anti-establishment, pro-outsider, and queer. Such activism works to achieve a critical and counter discourse to the mainstream. This sort of activism is being carved out in new spaces and platforms that respond creatively and subversively to mainstream culture and mainstream thinking.

Activism can take the form of art, performance, film, ‘zines, slam poetry, and a host of other outlets. Cutting hair can be a form of activism¹. Activism can also be located in the curation or editing of such outlets, working the space or context where meanings are shaped. Indeed activism can be in the place to preserve our places and venues where we gather as publics².

Indeed, trans people are carrying out more creative pursuits to be ‘active’ in the community, to raise visibility, and to offer ‘services’ or experiences that put trans people wholeheartedly at the centre³. Areas of activism to improve the lives of trans people in the UK include government and legislative change, health (including gender identity clinics, sexual health, mental health and suicide prevention), prisons, hate crime and murders (international), education, and the media.

Activism is in the discussions that are taking place across the various circuits of online social networks, blogs, vlogs, community events and support groups, as well as informal discussions among friends and colleagues in pubs, clubs and cafés.

Activism involves emotions too. Emotion produced by, and in the wake of, activism plays a part in our trans collectives. We feel angry, hurt, frustrated, overwhelmed, fed up, sad,
depressed, beside ourselves, strung out, exasperated, shocked. But mostly we feel angry. It is anger that gives us a necessary energy to drive forward those actions that aim to effect change – to effect the difference that we wish to make. Anger is the driver which produces and articulates impassioned positions against the status quo. It simply cannot stay this way. Things need to change.

Trans publics
Trans people gather and form a collective life that abounds with ideas and feelings. Through gathering we belong; we produce ourselves in relation to one another. Any actions taken in the name of ‘activism’ produce a ‘sociability’ (Warner, 2005). A ‘trans public’ is a ‘counter public’ (ibid.) as, like all counter publics, it is ‘defined by [its] tension with a larger public’ (ibid., p.56).

Trans publics, like all publics, are the ‘noisy, unruly and rowdy marketplace of complaints and demands’ that Bauman talks of in In Search of Politics (Bauman 1999, p.94). There is a growing riled, outraged and vehemently politicised trans public – a trans public that produces discourse and sociability across an array of networks; that calls to arms, effects change and pursues productive exchanges out of, from and through knowledge. They are the spaces where people ‘engage in struggles’ (Warner, 2005, p.12), where we form ourselves as citizens who must do something (van Zoonen, 2005, p.123).

Actions that come out of these responses range from demonstrating on the streets, satirising and subverting in a subcultural setting, and contributing to Twitter feeds. Trans people, viewers, collectives, artists, performers, writers, cultural commentators and social media-ites, among others, produce a circularity of knowledge, discourse, and importantly, a ‘sociability’ through virtual spaces. Indeed, we might reflect on how digital media and online networks have significantly shifted acts of citizenship, as Couldry tells us a ‘changing digital media landscape will in practice (not in the abstract) generate resources for more effective engagement with the political process’ (Couldry et al., 2010, p.xvii).

Ain’t I an activist?
The personal is political; the micro is the macro. For me, taking a theoretical interest in gender has brought me to activism. Picturing or contextualising my own struggles as a trans person within the wider debates of heteronormativity, power and discourse grounds me and my activist objectives. It makes my micro macro.

In the foreword to Esther Newton’s (2000) ethnographic classic Margaret Mead Made Me Gay: Personal Essays, Public Ideas, Halberstam draws on Judith Butler’s ‘uncharacteristic moment of personal confession’ that she foregrounds in her article ‘Imitation and gender insubordination’ (1993). Butler details how, as a young person, she experienced an everyday querying of the ‘realness’ of her being (Newton, 2000, p.ix-x). Halberstam points to Butler as an example of the importance of the ‘personal’ and the ‘theoretical’ coming together, ‘pick[ing] their way to theoretical understandings through their own histories of unbelonging’ (Newton, 2000, p.x).

Drawing on critical theory, scholarly writings and practices enables me to form ideas and make sense of my own subjectivity. In addition, it is within the collectives or communities where the making sense takes place. In the face of normative intensity, this ‘us’ or ‘trans public’ that I talk of is crucial to my own activism agenda.

In 2008, I co-founded the organisation Gendered Intelligence, which is a not-for-profit community interest company. Our vision is of a world where people are no longer constrained by narrow perceptions and expectations of gender, and where diverse gender expressions are visible and valued (see genderintelligence.co.uk). Gendered Intelligence has given me a framework to operate. It allows me to navigate a working life where I can draw on theoretical interests, carve out discursive and public engagement projects, and provide educational opportunities for students (from Key Stage 1 to higher education), as well as professionals.

Gendered Intelligence also identifies an ideology and a politics of knowledge (that is to ask – like Sedgwick – ‘What does
knowledge do?’). Intelligence is about an aptitude; it demands application and therefore labour around processing and thinking. Intelligence can be a process of learning, but it can also be an unlearning of the norms that are so deeply embedded (Butt, 2009; Halberstam, 2011). Thinking is an act and a practice. Howard Gardner posits that everyone can become more intelligent in the different ways or types that he sets out (Gardner, 2006). Similarly, anyone can be intelligent about gender. It too requires effort and application.

Sustained critical thinking has exposed me to the systems, institutions and machines of normativity. This exposure is the starting point to my activism. It has triggered a motivation to upset, trouble and ‘queer’ the various power structures that are tightly embedded in the realm of knowledge and what it means to know. ‘A crucial dimension of power’, Eliasoph tells us, ‘is the power to create the contexts of public life itself. This is the power to create the public itself.’ (Eliasoph, 1998, p.17)

Activism takes place in public and the aim of activism is perhaps to produce the public(s) we want to see. Activism is tricky and difficult. It requires sustenance and tenacity; grit and determination. It requires the long view, but as Lyotard tells us ‘A self does not amount to much’. So what else is there but to continue to be ‘noisy’ and ‘demand[ing]’ together?

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Endnotes
1 Open Barbers is a hairdressing service for all genders and sexualities in the London area of England. They ‘offer a personalised and warm haircutting experience with a queer and trans friendly attitude… [and] seek to promote the diversity of identities in society and celebrate people’s appearance in the way they wish to be seen.’ (See www.openbarbers.co.uk and so see www.dapperq.com/2011/09/open-barbers-is-styling-genderqueer-london.)
2 See the efforts made by Amy Lame and Ben Walters with Royal Vauxhall Tavern (www.rvt.community/the-campaign/who-are-rvt-future).
3 There are many such projects, but examples include CliniQ (www.cliniq.org.uk), a holistic sexual health and wellbeing service for all trans people, partners and friends and TAGS (www.tagswim.co.uk) who provide a series of body positive spaces for transgender and non-binary identified people, including swimming and other physical activities.

References
Challenging male gender blindness: Why psychologists should be leading the way

Martin Seager, John Barry & Luke Sullivan

Martin

AS A CLINICAL PSYCHOLOGIST who qualified nearly 30 years ago, I was taught to believe that British psychology in general and clinical psychology in particular was all about science and humanity. I was taught to believe that the full spectrum of the human condition in all its individual variation and diversity should be the object of our psychological curiosity and research. I was taught to believe that clinical psychology was about understanding and alleviating human mental suffering in all its forms, regardless of gender, age, ethnicity or creed. I was taught that the British Psychological Society stood for open-mindedness, fairness and equality, and stood against prejudice in all its forms. But does the reality match the rhetoric?

I quote from the Society’s Code of Ethics and Conduct (2009, Section IV, para. 1, p.10)

‘Psychologists should: (i) Respect individual, cultural and role differences, including (but not exclusively) those involving age, disability, education, ethnicity, gender, language, national origin, race, religion, sexual orientation, marital or family status and socio-economic status.’

When it comes to the male gender, however, our profession is disappointingly no different to the rest of society. Rather than pioneering and leading the way on the psychology of the male half of our species, our profession limps blindly and blandly along in the background, colluding with a society that keeps the spotlight firmly off any issues which adversely affect men and boys. The few pioneering initiatives that do exist in relation to men and boys are not largely to be found within the hallowed portals of the British Psychological Society, although there is now some hope that this will change.

This male gender blindness is even more striking considering that male humans:

■ Make up the vast majority of suicides.
■ Make up the majority of single homeless persons.
■ Make up the majority of people addicted to alcohol and other drugs.
■ Make up almost the whole prison population.
■ Have lower life expectancy.
■ Do significantly worse in education.
■ Are significantly more likely to die at work.
■ Are significantly more likely to die by violence.
■ Are significantly less likely to seek help of any kind.
■ Are much less likely to choose a career in clinical psychology or other caring professions.

Why such blindness to gender differences and problems affecting males? Firstly, it has to be said that we live in a post-feminist culture where we have now all been virtually brainwashed into thinking that only females can suffer because of their gender (which clearly they can and do). Gender issues, however, have come almost exclusively to mean women’s issues. This means that the whole concept of masculinity has become tainted with notions only of power and privilege, despite the fact that most males are and always were working class and relatively powerless. In fact, even in the ‘golden’ age of ‘patriarchy’ and the suffragette movement at the start of the twentieth century, most of the men who died in World War I defending our freedom also did not have the vote. The lack of working class male suffrage until 1918 is a story seldom told and is
shockingly hidden in the dominant narrative of our modern democratic society, which has depended upon so much male sacrifice. If anything is a gender issue, being required by your country to sacrifice your very life by virtue of your gender must surely be one.

From the same era, a similar picture can be seen in civilian life from the survival statistics of the Titanic disaster in 1912 which show that a woman travelling second class had a much higher chance of survival (86 per cent) even than a man travelling first class (32.6 per cent). Men travelling second class had only an 8.3 per cent chance of survival. On the other hand, 140 of 144 (97.2 per cent) females travelling first class survived. So even in those 'bad old days' of 'patriarchy', the gender story was never a simple case of male power and privilege, whether in war or peace time.

The second reason for male gender blindness ties in with the first. In addition to the reproductive role, the male gender has co-evolved in our species for the purpose of fighting, hunting, providing and protecting. The male throughout the ages has been called upon to take risks for the protection of the social group. This means that different rules, expectations and pressures have evolved within the psychology of the male and the female. There is more pressure on males to appear strong, just as there is more pressure on females to appear glamorous. These universal and ancient pressures have not changed across time and culture in our species, although the way that societies and cultures respond to these pressures (for example, what constitutes female glamour and fashion) clearly can and does vary. Because men are always under pressure to look strong there is a huge pressure in all societies not to draw attention to male vulnerability. These universal gender pressures are something recognised by all our great writers, story tellers and artists. If only psychological science could equally acknowledge gender as a universal part of the human condition, we could begin to understand, for example, why the male suicide rate is so high and why society is so much more tolerant of males being exposed to risk and danger.

For psychologists therefore to collude with a narrative that reframes gender difference and diversity as mere ‘social stereotyping’ and ignores gender inequalities affecting males is a failure to live up to our professional values and standards. It certainly does not constitute the scientific rigour and objectivity that I was led to believe was part of a proud tradition of British psychology. However, it is not too late for psychologists to do something about this. Hopefully, this will be the generation of psychologists that can study both male and female aspects of the human condition with an open mind and without gender prejudice of any kind.

John
Male gender blindness is nowhere more evident than in the relative lack of research into problems affecting the male gender. One of the most easily recognised yet least discussed sex differences is in suicide rates. Gender blindness in suicide research leaves a gap in our understanding of the causes of male suicide, leading to a gap in our ability to deliver effective solutions to men who make up nearly 80 per cent of suicides. A recent survey (Seager et al., 2014) examined the possibility that ancient rules of masculinity and femininity influence suicidality, and indeed found that two of the hypothesised rules of masculinity (being a ‘fighter and a winner’, and retaining ‘mastery and control’ over one’s life) were significant predictors of suicidality. At the same time one of the hypothesised rules of femininity (maintaining ‘family harmony’) acted significantly as a buffer against suicidality. Such knowledge can be used to help in future clinical practice and it seems likely that, for example, telling men that seeking help means taking control and not losing it might help reduce suicidality in men. This is simply because such a message honours the gendered pressure on men to be
in control rather than denying this reality, as in
the gender neutral or perhaps feminised mes-
sage that is increasingly being given to men by
mental health agencies: ‘Come on men, open
up and share your feelings!’ Telling men that
strength does not matter is no more likely to
be successful than telling women that glamour
and beauty do not matter. Rather than deny
gender difference, it is much better psychol-
ogy to widen the definition of strength for
men to include help-seeking, and to widen
the definition of beauty for women to include
a wider range of body shapes. The Campaign
Against Living Miserably is one charity that has
grasped the vital need to be gender specific in
its message to men, which is: ‘Silent does not
mean strong’.

It should be a big issue therefore for clin-
ical psychologists that men do not seek help
for their problems – whether physical or
emotional – as readily as women do (Addis &
Mahalik, 2003). Even life coaches, who might
be thought to deliver a relatively male-friendly
intervention, find similar problems with
help-seeking in men (Russ et al., in press).
Previous research suggests some ways that
might help improve male uptake, for example,
positive male role models having successful
therapy (Lemkey et al., in review). Farrimond
(2011) also found that some men can reframe
help-seeking for health issues as ‘taking
action’. This sense of ‘taking action’ is proba-
bly similar to the traditional male gender script
rule (Seager et al., 2014) of retaining mastery
and control (see above). This therefore seems
a promising area for future research into ways
of making psychological services appeal more
to men and work better for them.

There is already some research to show that
male-specific therapies can work (see Kinger-
lee et al., 2014, for an overview), but gender
differences in the needs of patients in clinical
psychology remain largely under-researched.
Thus, although Parker et al. (2011) found
a statistically significant gender difference in
outcome in a third of studies of various types of
psychotherapy for depression, they noted that
typically researchers fail to analyse treatment
outcomes by gender. This means that even in
cases where men and women show strong cor-
relations in opposite directions for a variable,
this gender difference will be obscured if the
data from men and women is combined (Lem-
key et al., in press). The Improving Access to
Psychological Therapies programme (IAPT)
shows that, of the range of therapies assessed
in the UK, men are least likely to attend coun-
selling (30 per cent of clients) and most likely
to attend employment support (46 per cent of
clients) (Health and Social Care Information
Centre, 2014). Given that employment sup-
port is more pragmatic and solution focused
than counselling, the greater numbers of men
attending suggests that this more male friendly
approach suggests that this more male friendly
approach encourages help seeking in men.

It is clearly important to know about gen-
der differences, both in uptake and outcome
in psychological therapy. However, psycho-
logical research has developed a culture of
both ‘beta-bias’ – the tendency to minimise or
overlook gender differences (Hare-Mustin &
Marecek, 1988) – and male gender blindness
(Seager et al., 2014; Russ et al., in press), and
so we must overcome both of these obstacles
before we can effectively improve psycholog-
ical services for men, and in some ways for
women too.

It is vital to highlight for both researchers
and clinicians that measuring gender differ-
ce in all its forms honours human diversity,
and certainly does not imply sexism or value
judgements. Assuming that gender differences
are mere social stereotypes is in truth very
poor science, not worthy of the standards of
a scientific profession. The crucial point is that
if clinical psychologists are to maximise the
efficacy of their interventions for all people,
they can no longer continue to remain blind
to gender difference in all its manifestations.

Luke
In 2004, I was employed by South London and
Maudsley NHS Trust as a researcher tasked
with looking at Men’s Mental Health in the
London Borough of Southwark (unpub-
lished manuscript, 2004). Prior to this I had
been working on an all male inpatient ward
as a support worker, so I was keen to make an
impression and report to the management board some interesting and helpful findings. In truth, by the end of the project I was anxious because, apart from the alarmingly high rates of suicide, I found almost nothing. No research looking specifically at men, no policies, no services for men with mental health problems and a general blindness to the psychological needs of men and boys.

I continued from this point onwards to be even more interested in working with men and set up various men’s groups with other clinical psychologists and psychiatrists. It wasn’t until later in my career as a trainee clinical psychologist that the significance of my findings finally dawned on me: the nothing I had found was the finding! In a positive way, this absence of thinking about the psychological needs of men and boys was an invitation into a whole new world of unchartered territory and every researcher’s dream... to boldly go where no one had gone before!

This wasn’t quite true and organisations like the Samaritans, the Men’s Health Forum, Mind and the Campaign Against Living Miserably were not blind to the issues and were busy starting the work to raise awareness of male suicide. Initially, the focus was on young men, although it is a fact that suicide is a problem for all men of all ages. Publications followed (Men’s Health Forum, 2002, 2010, 2011; Mind, 2009, 2010; Samaritans, 1999, 2010) and people started to shout louder and say: ‘Hey, this needs attention; we cannot continue to turn a blind eye’. All of this work has contributed towards men being recognised for the first time as an at risk group in the government’s strategy on addressing suicide (DH, 2012) and has led more recently to a debate between members of parliament on male suicide.

I have been lucky enough to be part of this movement of men and women and in 2008 joined up with Martin and John. We have since gone on to research together, build a network of people interested in male psychology, campaign on men’s issues, write for various publications, collaborate with other charitable organisations, start and host the annual Male Psychology Conference and put forward a proposal to the British Psychological Society for a Male Psychology Section. Unfortunately, the latter has struggled to capture the attention and imagination of our own profession. Surely we should be leading the way on this! To vote for the section go to http://response.questback.com/britishpsychologicalsociety/malepsychsection.

My own interest in male psychology was born from a broader interest in issues of equality. The most obvious and yet unacknowledged gender inequality for males is suicide. Suicide is the number one cause of death for men under 45, and the overall ratio of male to female suicide is almost 4:1. However, until recently suicide had not even begun to be recognised as a gender issue. We will revisit suicide in more depth later in this collection of papers.

Personally, I have been inspired by feminism in many ways and have admired how inequalities for women have been recognised and addressed. The success of feminism, however, if we are not careful, can lead to assumptions and generalisations about all males being privileged and powerful when the truth is that the vast majority are not. In that same spirit of equality we now also need to address the problems and inequalities that many men and boys face. Take for example the high rates of deprivation and exclusion from society of young boys from damaging backgrounds that go on as men to make up 90 per cent of the homeless population and 95 per cent of those housed in our prison system. We badly need psychologists to get involved in preventing this alienated group in our society from being further demonised and marginalised.

In some ways I feel a little embarrassed that it has taken so long for a scientific interest to be sparked in the male experience. This is something artists and writers have always known about. If they didn’t observe the full gender story, their plays, films and novels would be dull indeed. For me, it makes sense to open our eyes to inequalities...
for men because if we don’t, then women, children and all of us will lose out as a human family. Improving the psychological well-being of men can also only lead to an improvement in the psychological health of women and children too.

It will no doubt be a painful journey as we open our ears to the tragic stories of traumatised and vulnerable men and boys. Some real resistance is bound to continue as we challenge ourselves to be more open to male suffering, but surely we need to open our ears and our eyes for the betterment of all.

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References
Developing male-friendly interventions and services

Roger Kingerlee, Luke Woodley & John King

‘There is an increasingly strong and visible argument that boys and men need services that are specifically designed around, follows and for, their needs.’ (Wilkins, 2010)

This paper explores this domain and illustrates a little of what has been achieved in the UK, and what could be done in future.

Psychological mechanics of male avoidance

Evidence has accumulated in various scientific and other domains to suggest that there are significant differences between male and female psychologies, and that taken together these differences:

(i) account for the documented differences in male behaviour (including avoidance around psychological health); and
(ii) can and arguably should usefully inform the delivery of services to men (Kingerlee et al., 2014).

Some research suggests that human males (like many of their primate cousins) may be more concerned than females with social dominance, status and ‘winning’ (Seager et al., 2014; Sidanius & Pratto, 1999). Such hegemonic masculinities (Connell, 2005) have implications for male health behaviours (Sullivan et al., 2015). It may be that, for example, compared with women, men find it more difficult to be open and honest about their emotional difficulties. Trivers (2012), who has made major theoretical contributions to biology in the field of altruism, argues that since higher social status may be selected for in mammals, and may be key to males attracting female mates, males will be prone to deceive others and even themselves about anything that could relegate them in their social hierarchy; and conversely, males will on occasion ‘show off’ to sometimes absurd and damaging degrees to gain status (Trivers amusingly provides some of his own life examples). Given what we know about male psychologies and difficulties around help-seeking, it is not unreasonable to suggest that if men become aware of their emotional distress, they may be prone to deny any distress to themselves and others, trying to save face. Male self-deception may therefore impact behaviour in healthcare environments, the choice architecture of which may need to change, so as to nudge men towards emotional honesty with themselves and others.

On the basis of all of this, I have previously (Kingerlee, 2012) suggested that the factors affecting men may – when men encounter a stressor – produce a behavioural bias and launch them away from potentially useful (and life saving) honest reflection and towards potentially damaging, characteristic, higher risk (and sometimes life threatening) male behaviours, from substance use, aggression/anti-social behaviours, up to suicide and homicide (bearing in mind 95 per cent of the perpetrators of homicide–suicide events are male (Logan et al., 2008)). This male bias is termed the reflection abandonment mechanism (RAM) (see Figure 1).

At the individual level, the RAM predicts that, faced with emotional distress, a male will avoid psychological reflection and shear off into other, often externalising behaviours.
Anecdotal evidence suggests that such collusive patterns of mutual avoidance of men’s emotional issues are common in the UK (see Figure 2). As a clinical rule of thumb, however, in a consultation between a man in distress and a health professional, if progress is to be made, at least one person in the room needs to be interested in the man’s emotional health. Often, given the mutual biases at work, this takes conscious effort.

Fortunately, these issues have started to be addressed in the UK. A major recent report, commissioned by the Movember Foundation and produced by Men’s Health Forum and Leeds Metropolitan University, which among other things encompassed a literature review of around 9000 papers, has suggested how – given what is known about male psychologies, and male distress – services can be usefully designed and shaped to suit men better (Robertson et al., 2015). Key findings of the report (to which readers are warmly referred) include:

- Settings are critical and need to be male-friendly.
- A positive approach should be taken (versus a focus on ‘the negative’ as in some traditional clinical interventions).
- Nuances of style and language can be key to engaging males.
- Staff/facilitator characteristics should include empathy, non-judgmentalism and credibility, and fit with the intervention.
- Activities familiar to males can aid engagement.
- Partnership working can be helpful.

These principles – so admirably evident in such male friendly services as CALM (www.thecalmzone.net), and Men’s Sheds (www.menssheds.org.uk) – can also inform future best practice (Robertson et al., 2015).

In what follows we illustrate how a new intervention that consciously tries to adapt to and meet men’s psychological needs – and so is male-friendly (Figure 3) – was developed.

**Developing a male-friendly intervention for veterans**

1. **Initial discussions**

There is consensus that in the UK and elsewhere mental health services for armed forces veterans have historically not always been optimal (e.g. Jones & Wessely, 2005). This recognition informed the Armed Forces Covenant (e.g. Ministry of Defence & Veterans

Figure 1: The RAM: Male reflection abandoned by the individual

![RAM Diagram](link_to_diagram)
UK, 2015), which proposes that military personnel should, among other things, receive fair treatment from health services – an ongoing issue (Mercer, 2016). The great majority of armed forces personnel and veterans are male. In 2014, 90 per cent of the total military personnel were men (House of Commons Library, 2014).

Having worked together clinically some years previously, the first two authors (Roger and Luke) remained in touch and, meeting again in mid-2014, realised that they had a common goal: developing an intervention that would: (a) reach, and (b) be clinically useful to, the traditionally hard-to-reach, and predominantly male population of veterans in Norfolk. With Recovery principles of co-production and co-presentation firmly in mind (ImROC, 2016), we planned further meetings. We felt that together there was a good ‘fit’: Luke brought his experience of and expertise in military life and recovery from post-traumatic stress; Roger brought clinical and research interests in male psychologies and psychological trauma.

2. Developing the intervention
Over nine months we met around six times to develop the scope, content and form of the programme. It was clear initially to Luke and Roger that, combining our expertise, the intervention would be informed by experience and knowledge of:
- military culture and its psychological implications;
- living with and recovering from severe psychological trauma;
- cognitive behavioural therapy;
- mindfulness; and
- life as a male with psychological issues that required attention.

With these points in mind, we set about co-producing content for a course pilot. Given Luke’s lived experience of the issues, his experience of Recovery, and sustained
thought about the issues involved, Roger naturally often deferred to Luke’s views. On that basis, much of the eventual content of the course derived quite directly from Luke’s perspective. At times this was immediately captured by Luke talking and Roger typing. Early on in the process, we called in the help of the third author, John, a highly experienced mindfulness practitioner and trainer with over 15 years’ experience of helping veterans. John too fed directly into the developing content via three-way discussions.

Over successive meetings, the content and form of the intervention was iteratively shaped. We agreed on a 16 session structure – long enough to allow complex issues to be addressed and mindfulness skills to be woven in, but short enough to remain efficient and focused. On the basis of Luke’s lived experience, John’s mindfulness expertise and Roger’s knowledge of cognitive behavioural therapy, we decided to encompass certain key areas in the programme:

- Taking responsibility for one’s own issues.
- The interaction between military training and psychological issues (notably around hypervigilance).
- Addressing frequent maintaining factors (social anxiety (‘paranoia’), rumination, isolation and substance misuse).
- Taking a positive approach to the situation(s) involved versus a ruminative one.
- Learning to deal with traumatic stress symptoms, including flashbacks and intrusive thoughts (e.g. via grounding techniques).
- The importance of shaping one’s environment (e.g. having or acquiring personal space, when necessary, as a factor in Recovery).
- Incorporating mindfulness into the Recovery process.
- Reconnecting with others – in the group, and beyond.

Content finalised, we co-wrote an initial leaflet for the group that we felt would be male friendly. This deliberately included humour (a picture of a meditating dog, captioned (by Luke) ‘Life doesn’t have to be ruff!’), as well
as original straplines (also by Luke): ‘It’s time to stop fighting and start living’. Leaflets were circulated to colleagues and GP surgeries.

A suitable venue was identified. Bearing in mind Luke’s view that veterans often feel more comfortable with access to open spaces, we located a large room, cheaply available in a community centre, situated in the middle of a large park in Norwich. This made it easy – in case of relief or release being required from the group – for the doors to be thrown open and connection with the outdoors to be made.

Finally, we decided on a suitable name for the group, the Veterans’ Stabilization Programme which, as an acronym (VSP), Luke felt would appeal to our target audience of veterans, male or female.

3. Delivering the intervention
Our first step was to identify potential participants. This was done in part via standard NHS referral procedures – but with a difference. Once a person had been identified, we made a joint visit to them: our rationale, in line with Robertson et al. (2015) being that meeting Luke, as a male role model with experience of Recovery and happy to self-disclose, could help to encourage ‘buy in’ to the VSP. In practice, this is what happened, and four male veterans with various issues (including anxiety, depression, chronic pain and traumatic stress) agreed to participate in the group. No local female veterans had come to our attention by that point. Some of the men were quite troubled, with suicidal ideation quite prominent, though manageable in two cases.

Inevitably, the initial meeting was tentative, and we were open with group members about our slight feelings of anxiety. In fact, this helped to ‘break the ice’ for all of us. In the weeks that followed we observed some interesting phenomena.

First, the therapeutic atmosphere. On one hand, there was a focus on the delivery and learning of content throughout. But on the other hand – again in line with Robertson et al. (2015) – there was a considerable amount of humour, some of it robust. This level of humour and its nature was somewhat different to Roger and John’s experience of running clinical groups for mixed sex groups. In the circumstances, however, we felt that the humour remained respectful, sometimes defused potential tension and may, overall, have contributed to the male friendly atmosphere with which participants evidently felt comfortable.

The second phenomenon was that of mutual support. Midway through the group, it was clear that a strong esprit de corps was growing. For different reasons, two group members left. Understandably, as the sessions passed, the remaining group members had shared more of their experiences – some difficult – and trust grew. Within this, we observed that group members began to draw on their own experience and expertise to help each other, as an instinctive alliance seemed to form between men who had shared experiences. As part of this process, telephone numbers were exchanged between some group members and a collective sense of support emerged that, on reflection, we all found quite powerful. Moreover, as group facilitators, we noted that we were fulfilling different yet complementary roles. Roger tended to explain the content initially; John provided a layer of mindfulness-based reflection; and critically, Luke put the material into context, partly by drawing on his own experience, which lent credibility and weight to the discussions.

Third, self-disclosure. At the first session – understandably – most participants were notably careful about what they said, disclosing little. One (who arrived late) paced ambivalently around the room before sitting. With time, this changed markedly; and on reflection we agreed that the main driver of the change appeared to be Luke’s role-modelling in frank self-disclosure. Indeed, during the course participants said that to see and hear that ‘one of us’ had not only survived his issues but learned to thrive, was inspiring. Equally, Luke’s honesty and self-disclosure appeared to directly open the door for the other participants to be open about their own feelings – including those of anxiety and despair; feelings which in some cases they had not previously expressed for fear (among other
things) of ridicule. At times, this was moving; but (it later emerged) therapeutic. In short, regarding self-disclosure, as Robertson et al. (2015) imply, a ratchet effect was noted, as a respected role model’s self-disclosure was reciprocated without judgement, such that mutual emotional authenticity, rather than mutual denial, became the prevailing climate. Consequently, reflection was enabled; psychological solutions emerged.

4. Outcomes
For the handful of participants who completed the initial run of the programme, the outcomes were largely, if not wholly, positive. First, owing to the new psychological skills acquired, symptoms had reduced. Second, in line with Recovery notions, levels of hope and healthy feelings of control had markedly increased. Third, participants reported a new sense of belonging and engagement in the wider world – a marked change for those participants who had been suffering suicidal ideation before the beginning of the group, with the sense that they had ‘reached the end of the road’. Intriguingly, this fits with Seager et al.’s (2014) research on male scripts, in which a greater sense of belonging predicts lower suicidal ideation. Dismantling male scripts around ‘fighter/winner’ may, in this context, be therapeutic. Fourth, participants reported and evinced a new sense of purpose – as new directions were established. Follow-up information corroborated this, with one participant – previously alienated from his family – calling them all to his house for a Christmas dinner that he himself had planned and cooked: a step change for him. All of which was a stark contrast to the sense of relative disengagement and disenfranchisement among these men with which we began – often observed in men in distress (Cochran & Rabinowitz, 2000). Participants’ verbal feedback was also positive, including comments like: ‘This is the best thing I’ve ever done’. Finally, such was our collective engagement in the group that we all reflected on a painful sense of loss at the end of the intervention, but made a commitment to keeping in touch.

After the group, further developments occurred, and continue: Luke founded his own community interest company, the Walnut Tree Project (www.facebook.com/walnuttreeproject), to help act as a ‘military front door’ locally, regionally and beyond; work has been ongoing with other statutory and non-statutory providers to further develop male-friendly, military-friendly, Recovery-focused services; NHS care pathways across Norfolk have been re-engineered to simplify access for veterans; and other possibilities continue to present themselves, including that of interventions and/or services targeting female veterans who, while able to attend the VSP, may also have slightly different psychological needs which, like many issues in this area, are yet to be fully identified and researched.

Conclusion: Developing male-friendly services – avoiding the avoidable
In the light of emerging theory, practice and evidence, it is very likely that male psychologies differ to some degree from female psychologies, and that the starkest illustration of these differences occur in the suicide statistics internationally, when unconscious patterns of collusive avoidance between men and services have lethal outcomes. New ways of working with men, however, suggest that by consciously addressing men’s psychological needs and flexibly adapting services to make them male-friendly, men can be successfully engaged, reflection enabled, their wellbeing improved, and in certain instances their and others’ lives saved.

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References
Reducing male suicide

Martin Seager & Luke Sullivan

Male suicide is a major and longstanding gender inequality that is only now beginning to be recognised. New initiatives for addressing male suicide are described and the importance of this area for psychological research and practice is highlighted.

For as long as records have existed (from 1861 in the UK) the rates of suicide have been higher for men than for women. This gender gap is universal, being found in virtually every country, all age groups and at every point in time. Currently in the UK (using figures from the Office for National Statistics in 2013), men make up 78 per cent of all suicides, a gender ratio of nearly 4 to 1. If anything is a gender issue, this surely must be.

Suicide has always been a difficult subject to talk about. The act of suicide was previously considered a moral failure, a sin and even classified as a criminal offence. In England and Wales suicide was not decriminalised until 1961. In some countries suicide still remains an illegal act. Attitudes are shifting, with suicide increasingly being seen compassionately as a sign of mental suffering, but the subject to this day remains something of a taboo, which has limited our ability to fully understand the causes and to develop effective responses.

Until very recently there seems to have been a blanket resistance to acknowledging gender as an important variable in suicide research and policy both in the UK and overseas. The vast gender difference in suicide rates has been overlooked and even denied, with people quick to explain it away, for example, in terms of men’s use of more lethal methods. This blindness to the suffering of males is striking and inhibits our ability to intervene effectively. But perhaps it also provides the largest clue to what is going on.

In recent years, as suicide itself has attracted more attention, there is now growing recognition, for example in the National Suicide Prevention Strategy (2012), that male gender is a risk factor. With men at greatest risk we have a duty to address this startling health inequality (Equality Act, 2010).

From the early 2000s there has been a growing movement of people campaigning and raising awareness of the high rates of suicide in men. As a measure of the progress that has been made, the issue of male suicide was recently debated in the House of Commons (19 November 2015). This represents some real shift in attitudes amongst our policy makers and society as a whole.

Examples of emerging services, projects and initiatives for males

As stated above, a range of services and initiatives is emerging in the UK that can be said to be developing the beginnings of a male-friendly anti-suicide culture, at least in the voluntary sector.

Campaign against living miserably (CALM)

CALM is the brain child of Jane Powell, being originally commissioned to provide help for young men in Merseyside in 2000 and becoming a national charity in 2006. CALM has a user-driven ethos. Campaigns have targeted males specifically (but not exclusively) and challenged societal assumptions about male distress and raising awareness of suicide as a male gender issue.

CALM has been effective by setting up ‘CALMzones’ involving local communities and agencies in a co-ordinated effort. CALM
Reducing male suicide

operates through a confidential helpline, a text/e-mail service, a website, magazine and social media. CALM uses high-profile campaigns that engage directly with the world that most young men inhabit by using role models such as rappers, musicians, comedians, sports stars and other highly admired celebrity figures. CALM also uses a ‘street-wise’ language and a style of communication that appeals more to young men in particular. One of the most effective ways CALM has been able to connect with their audience is through their use of stories of men been through personal difficulties and who have come through them. Hearing stories of recovery and hope from people just like you, who have experienced problems, can be incredibly powerful, particularly for males who do not usually get to share stories of this kind.

Over the first decade (1999–2010) since the first CALMzone was established in Merseyside, suicide rates in that area fell by a massive 55 per cent, from well above the national average to significantly below it. These figures speak volumes about the value of honouring male pain in male-friendly ways and the effectiveness of doing so. These figures show that men can seek and use help if we change the way we listen rather than expecting men to change the way they talk.

Samaritans
Samaritans is a well-known charity established in 1953 and perhaps the first of its kind. The founder, Chad Varah, was a priest who recognised the simple and fundamental principle that despair can be reduced if it can be shared with a fellow human being who is genuinely listening and trying to make a connection. As well as providing a 24 hour telephone confidential helpline and drop-in face-to-face support, the Samaritans also run an e-mail and texting service. The Samaritans also offer outreach services at rock festivals and other outdoor events and have developed joint projects and relationships with, amongst others, network rail, the London Underground, CRUSE bereavement care, schools, prisons, mental health services and homeless organisations.

The figures consistently show that the Samaritans attract as many male callers as females. Unlike CALM, the Samaritans is not targeted specifically at men. Their success in appealing to male callers appears to reflect the fact that callers have the option of complete anonymity, which may be less shaming and stigmatising for men. More recently, however, the Samaritans has undertaken more gender-aware campaigning (e.g. ‘Men on the Ropes’, 2010), recognising that males are at greater risk of suicide. A research report (Wylie et al., 2012) was also commissioned to explore the psychosocial reasons behind male suicide. The Samaritans are also now beginning to adapt their training to address the gendered needs of male clients. In a project called ‘Man Talk’ (2014), devised by a small team (including MS), the Central London branch of the Samaritans devoted a whole year of training events to exploring ways of understanding, reaching and listening to men. In particular, volunteers were encouraged not to label male banter as irrelevant and emotionally evasive, but to see it as a vital path to establishing trust and a human connection. By the end of the year, the statistics showed that the average length of conversations with male callers had increased significantly, along with volunteer satisfaction in taking calls from men. These ideas are now gradually being disseminated more widely across the organisation in branches, at conferences and at training events.

Movember Foundation
The Movember Foundation was started by two friends in Australia in 2003 and has been growing ever since. The Foundation was set up to raise awareness and funding to champion research, education and services that promote good male health and combat male health problems and inequalities. Movember started with a focus mainly on physical health, particularly male cancers, but more recently has been highlighting the mental health problems and inequalities facing the male gender, most nota-
bly suicide. They are currently in the process of allocating funding to grass roots projects that reach out to men in psychological need.

**Men’s Health Forum**
The Men’s Health Forum (MHF) was founded in 1994 by the Royal College of Nursing, with the aim of tackling health issues affecting men and boys. It became an independent charity in 2001 and has become a trusted and authoritative voice on male health issues, retaining a strategic partnership with the Department of Health. MHF started with a focus on physical health, but more recently has widened its remit to include mental health. In 2006 MHF hosted an important national conference ‘Mind Your Head’, at Wembley on men’s mental health, and has subsequently produced several important reports on this subject authored by David Wilkins and colleagues (Men’s Health Forum, 2010, 2011, 2013).

**Eaton Foundation**
The Eaton Foundation was set up in August 2013 by Alex Eaton in memory of his father Neil. The Eaton Foundation is the UK’s first centre for male mental health and wellbeing, which speaks for itself about our blindness hitherto towards the psychology of the human male. The Foundation provides a whole person approach to male wellbeing that takes in mental health, addiction, debt, homelessness, education and employment issues. Services are provided to adult males in the East Staffordshire area. Training is also provided on men’s issues to professionals wanting to develop more expertise in reaching men.

**MIND**
MIND is another well-known mental health charity founded in 1946. MIND has shown the same pattern as other organisations in beginning to turn its attention to male mental health in the first decade of the 21st Century. In 2009, MIND delivered a campaign on male mental health, together with an accompanying report called *Getting It Off Your Chest* and co-authored with MHF a practical guide for developing male-friendly services called *Delivering Male* in 2010.

**Men’s Minds Matter**
Men’s Minds Matter (MMM) was initially set up by one of us (LS) in 2011 to help raise awareness of the issue of male suicide via its website, blog and social media. The website continues to offer information on the key issues and provides information on self-help material and how to seek support in a crisis.

More recently, the project has taken a shift towards delivering interventions locally to Southwark residents as part of its suicide prevention strategy. At the beginning of the year MMM launched its first men’s group for men in psychosocial crises.

**Reducing suicide means acknowledging males collectively as a high-risk group**
Services for men still to this day remain orientated largely around certain traditional problem behaviours or around specific minority groups. We can see this in our criminal justice system, drug and alcohol services, homeless services, and in services for young people and those for gay men.

The drawback of this approach is that it is fragmented and fails to recognise the bigger picture of the mental life of the male gender as a whole. The statistics consistently show that men of all ages and all backgrounds are more at risk of suicide than their female counterparts. There is something about being male that increases risk.

The statistics already show two clear things about males time and time again: That they are: (i) more likely to take risks; and (ii) less likely to seek help of any kind (Sullivan, 2011; Sullivan, Camic & Brown, 2015). This helps to explain why men continue to underuse generic mental health services that are available to both men and women. This male pattern of risk-taking and going without help should surely be an urgent public health issue, spurring our society to support men in their communities and develop services that engage specifically with male minds.

Simply urging men to seek help (‘Open up, guys!’) is unlikely to succeed, although it is still commonly attempted in mental health charity campaigns. A better approach is to recognise and honour the male gender by adapting ser-
services to what we already know about male psychology. As things stand, most services are still offered within a feminised culture (see Morison et al., 2014), where the client is expected quickly to ‘open up’ about personal feelings in an intimate face-to-face encounter.

The vital contribution of psychology: explaining the gender difference in suicidal behaviour

Despite the beginnings of societal attitude change towards male distress and the development of some male-specific services, there is still a lack of research or any strong theoretical basis for understanding male suicide and designing services that will reach men. This is where psychology should be taking a lead, respecting gender as a diversity issue and asking key questions, in particular:

(i) Why do males take more risks and seek less help generally? Does this correlate with increased rates of suicide?
(ii) How do males differ psychologically from females in their ways of dealing with distress?
(iii) What are the implications of male psychology for designing and adapting our services so that they are better tailored to attracting men, helping them and preventing suicide?

Our own research group (e.g. Seager et al., 2014) has begun to look at these questions and found preliminary evidence to support our hypothesis that gender difference, perhaps unsurprisingly, has a strong biological and evolutionary basis, generating, on average, different motivational drives, pressures and expectations for males and females. These drives appear to be universal to our species and can be described in terms of a script or set of rules. For men, the rules amount to a pressure to be ‘strong’, to be ‘winners’ and to be ‘in control’, and this can create unbearable shame and dishonour for men who feel they do not meet this standard (Pleck, 1995).

Conclusions and recommendations

The issue is perhaps simple. The male has evolved as a risk-taker and a protector of the social group. This seems, on the face of it, to explain why men to this day in all cultures seek help less than women, ‘soldier on’ with their pain, and ultimately reach the point of suicide more often. Societies too across the globe reflect these same universal expectations, turning a blind eye to male vulnerability and tolerating a higher level of injury in the male. Similarly, there are universal rules for females about glamour and motherhood. Perhaps it is time to respect these gendered phenomena as genuine differences within the human condition rather than as mere ‘social stereotypes’. Recognising that some aspects of gender difference are archetypal within our species does not prevent us from expressing these ancient rules in new ways socially and culturally. For example, we can start telling men that seeking help is a sign of strength, just as we are starting to tell women that beauty can take many forms and need not be restricted to one single ideal body shape.

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Book Review

Treatment of Generalized Anxiety Disorder: Therapist Guides and Patient Manual

Gavin Andrews, Alison E.J. Mahoney, Megan J. Hobbs, & Margo R. Genderson

Oxford University Press, 2016

This book begins by providing the reader with a succinct history and aetiology of generalised anxiety disorder (GAD), focusing on the updates from the Diagnostic and Statistical Manual of Mental Disorders (5th edition) (DSM-5) texts. Since the term was first used, the classification of GAD has undergone numerous revisions. The requirements of an individual to meet threshold criteria, which are embedded in the categorical tradition of the DSM, are contributing factors to the difficulties in the classification and diagnosis of GAD. Furthermore, professionals have also struggled to obtain empirical evidence to differentiate GAD as a specific anxiety disorder; these issues are explored further in the first chapter.

The authors give a concise overview of assessment measures used to identify anxiety, which provides the reader with information and advice. However, there is a strong focus on the benefits of each measure, such as the levels of validity and internal consistency. In my opinion, this section would have benefited from greater critique when comparing measures with relation to the empirical research that is discussed.

The section ‘Treatment effectiveness’ provides cogent, objective summaries of the contemporary models used in the treatment of GAD from a cognitive-behavioural perspective. There is also a review of recent literature around the effectiveness of iCBT (internet-based cognitive behavioural therapy) programmes, and the reader is provided with examples of how each model can be applied to specific interventions. There are excellent examples of psychological formulations that utilise original case studies, and the authors offer directions for future research. These are valuable for individuals interested in the assessment and treatment of anxiety disorders.

The ‘User Treatment Manual’ provides activities that can be used during assessment, formulation and intervention when working with individuals with GAD. There are a number of practical resources in the appendices which could easily be adapted when working with different clinical populations.

This book can be used as a practical guide specifically for clinicians working with individuals with GAD. Existing research is adequately explained and the authors use a balance of qualitative and quantitative evidence to demonstrate their points. As such, this text will be a valuable resource for either qualified professionals or individuals completing studies. The book facilitated a space for reflection on my own practice working with individuals with GAD in learning disability services. It benefits clients by outlining a structured and accessible treatment manual that offers the clinician a variety of models by which to plan the most appropriate interventions.

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FOR MANY OF US, September is a month irrevocably associated, historically or presently, with the start of a new term at school, college or university. We may be refreshed after a summer holiday, or at least a summer break, and the chance to enjoy some sunshine abroad or at home (however briefly!). We may be full of renewed enthusiasm, eager to grasp the opportunities the new term brings. Or we may be reluctant, dispirited and anxious about the challenges ahead, or about returning to face unresolved problems and concerns. My conversations with DCP members in the last few weeks reflect a mixture of both. My hope for our profession is that we can all affirm or rekindle the former – the enthusiasm and energy that we brought to learning about psychology; to developing and using our theoretical and practical knowledge and skills as clinical psychologists for the benefit of, and in partnership with, the people we are here to serve.

In order to do this we need to get better at taking up leadership roles (not only within psychology) and other opportunities to increase our influence. We need to invest time and effort into sharing our positive experiences and ‘success stories’, as well as into supporting each other through difficult times, without getting trapped into ‘ain’t it awful’ narratives. Whilst the latter can be cathartic and enhance camaraderie, they are also unproductive at best, and at worst can become self-fulfilling prophecies.

A great example of a ‘success story’ is the DCP Faculty for Children, Young Peoples and their Families (CYPF) publication *What Good Looks Like in Psychological Services for Children, Young People and their Families*. This has been distributed widely to clinical commissioning groups and other bodies. CYPF are now working on further publications on integrated psychological services with the two commissioners who originally suggested producing the ‘what good looks like’ document. The original document is free to download (www.bps.org.uk/networks-and-communities/member-microsite/dcp-faculty-children-young-people-and-their-families) and free hard copies can be ordered from Helen Barnett at the Society’s Leicester offices. CYPF are also producing shorter and more accessible printed leaflets based on each chapter of the document. Can we build on this approach across the lifespan?

Another very encouraging development is the new Collaborative Learning Network (or ‘CLaN’) for staff wellbeing, which was launched on 21 June 2016 at the Society’s London office. This is the next step for the Wellbeing project and Charter, led by Amra Rao and colleagues from the DCP Leadership and Management Faculty, Society Vice President Jamie Hacker Hughes and Jeremy Clark, Chair of the New Savoy Partnership, which I described in my July column.

There were also several news items about this work in the June edition of *The Psychologist* and the July issue of CPF. We were delighted to wel-
come a wide range of people to the network launch, including representatives of other professional bodies and colleagues from a range of professional backgrounds. Nine pathfinder sites have been identified, and representatives gave us a brief description of their work and aspirations aimed at improving staff wellbeing. These ranged from initiatives aimed at specific groups (e.g. an e-learning project to support clinical psychologists with mental health problems to feel able to disclose and seek help) to systemic approaches across organisations to improve staff wellbeing proactively. The network will spread and share their initiatives, and we hope this will enable us to improve the wellbeing and support available to clinical psychologists and all clinical staff with whom we work.

It’s also time to start looking ahead to 2017 and the opportunities and challenges ahead. Planning for the January 2017 DCP Conference ‘The Future is Now’ is in full swing, and there is still time to submit posters (until 21 September). We will have a great programme of key note speakers, papers and symposia on academic and professional issues and social events. There will also be a public facing conference ‘fringe’ of arts based activities: arts, music, crafts, poetry, and films, all with a mental health focus. Many of the performers will themselves have lived experience of mental health services. The clinical psychology fringe festival aims to raise the profile of clinical psychology within the public sphere. It will show that clinical psychology is stepping out of what can be seen as its ‘ivory tower’ to share the human experience of the arts in mental health. The conference is on 18–20 January at the Hilton, Liverpool city centre, and the fringe festival will take place on the evenings of 19–20 January and Saturday 21 January. (See www.bps.org.uk/dcp2017 for more information and registration.)

Our DCP Experts by Experience network and strategy development are key initiatives, supported at Executive Committee level by Sheelagh Rodgers (DCP Membership Services Unit Director), Jo Hemmingfield (DCP EbE England Lead and Executive Committee EbE representative) and myself. We are very grateful to everyone who has taken a lead in or supported these developments, particularly
Tracey Smith, Rachel Purtell, Annie Mitchell and Society Vice-President Jamie Hacker Hughes. Our next network event will be on 30 September, and we will be giving a progress report to the wider membership at the DCP annual conference.

I am hoping to visit as many DCP branches, nations, faculties and other groups as possible during my period as UK Chair. I have had the opportunity to spend a day with two of our DCP England branches recently: Jenny Taylor (a former DCP Chair) and I delivered a workshop on ‘Mentorship and leadership development’ in Newbury by invitation of the South Central Branch, and I gave a talk at the North East Branch relaunch in Newcastle (home territory!), along with Jamie Hacker Hughes and Lucy Johnstone. It was great to see the enthusiasm of members in both these areas for reinvigorating local branches after periods of inactivity, and I was delighted to see Barry Ingham (who has taken the role of interim chair and played a significant role in re-establishing the Branch) become the new North East Branch Chair. I have some other invitations already in the diary, but if you would like me to join you at any future events please get in touch!

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