This is a pre-publication version of the following article:
Barry, JA (2017). Is your therapy gender aware or gender blind? *British Society of Clinical & Academic Hypnosis Newsletter, 8*, 10, 6-8.

Is your therapy gender aware or gender blind?

We all want to do the best for our clients and most people believe in gender equality, but what if I told you that the motivation to see men and women as the same might be limiting your ability as a therapist?

In medicine, recognising sex differences is an important fact of patient care, and of course obstetrics and gynaecology would not exist without this recognition. Even outside sexual medicine, it can be important to recognise sex differences e.g. the symptoms of heart attack are sometimes different in women and men (Lichtman et al, 2015).

In academia today there is a fashionable reluctance to recognize sex differences, exemplified by Hyde's (2005) 'gender similarities hypothesis'. Gender is seen as a product of culture, and the evidence for the contribution of biology to gender (e.g. Hines, 2004) is ignored. So although the average person will acknowledge – or indeed value – everyday gender differences e.g. boys as young as 9 months tend to prefer playing with cars than dolls (Todd et al, 2016), some academics find generalisations about such behavior threatening to their idea of gender equality.

But I am not trying to win a nature-nurture debate – I think the weight of evidence (e.g. Hines, 2004) demonstrates that gender differences result from a combination of nature and nurture. The point is that taking a 'gender blind' approach is a highly questionable way to maximize the health and wellbeing of men and women.

I began investigating gender differences after pondering why men commit suicide at 3.5 times the rate that women do (ONS, 2015), yet seek psychological help far less than women do (Kung et al, 2003). It almost seems that some men would rather kill themselves than talk to a therapist. But rather than blaming men for not being man enough to talk about their feelings – that is hardly a client-centred approach - I think we need to find out how therapy can be made more appealing to men. In taking the latter approach, myself and colleagues interviewed 20 life coaches (Russ et al, 2015), 6 hypnotherapists (Lemkey et al, 2016), and 20 psychologists (Holloway et al, in peer review). We found:

- Almost all of the therapists we spoke to identified sex differences in some aspect of therapy
- Regarding therapy, in general women want to talk about their feelings and men want a quick solution to their problem.
- Most therapists – though none of the hypnotherapists – showed signs of struggling with cognitive dissonance when asked to talk about gender differences in the needs of their clients.

This third point highlights what is an important psychological barrier against making best use of the insights of the first two points. Although hypnotherapists – at least in the small sample we spoke to – can take some pride in not suffering from gender blindness in their therapy, other psychological therapists need to catch up. To this end my colleagues and I put on free lectures, free films, and an international conference aimed at raising awareness of these issues. More importantly, there is a vote amongst members of the British Psychological Society (BPS) in April (details in footnote) when we will decide whether we want to have a specific section of the BPS dedicated to addressing issues such as male suicide, help seeking, male-friendly therapy, and other issues.

In my experience, more and more psychologists are catching up with what many of us already know: men and women are largely similar, but it's the differences that often make all the difference. This means that therapists who use a gender-sensitive approach to therapy are likely to be delivering a better service.

Members of the BPS can vote for the formation of the Male Psychology Section in early April. The April edition of The Psychologist periodical *will include a ballot paper which you can mark X and return to the BPS in the prepaid envelope. Note that any previous online votes for the Section don't count – you will need to return the postal ballot paper in order for the new Section to be created.*

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Biography

Dr John Barry practiced clinical hypnosis in London from 1999 to 2010. After completing his PhD (Psychology) in 2011 at City University London, he joined University College London's Institute for Women's Health at the UCL Medical School, based at the Royal

Free London Hospital, London, England. While there, he pioneered the use of guided imagery to change hormone levels in women suffering from polycystic ovary syndrome. Since 2010 he has published some 50 papers in various peer reviewed journals, including international-standard journals in gynaecology, cardiology and ophthalmology. Prompted by the considerable suicide rates among men and the establishment's inertia in dealing with men's mental health problems, John initiated a research program in 2011 to investigate the mental health needs of men and boys.

John specialises in gender and mental health, research methods (surveys and questionnaire development, meta-analysis, meta-regression), and currently practices clinical hypnosis on a part-time basis.

Contact details

Dr John A Barry University College London (UCL), Dept of Psychology, London, UK Email: john.barry@ucl.ac.uk

Websites: iris.ucl.ac.uk/iris/browse/profle?upi=JBARR47

http://www.malepsychology.org.uk/