

**Title:** Who watches the watchmen? A critical perspective on the theorization of trans people and clinicians

Richards, C., Barker, M., Lenihan, A. & Iantaffi, A. (2014). Who watches the watchmen? A critical perspective on the theorization of trans people and clinicians. *Feminism and Psychology*, 24 (2), pp.248-258.

**Link to repository:**

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**Additional information:**

Article as accepted for publication in *Feminism and Psychology* published by SAGE Publications available at <http://dx.doi.org/10.1177/0959353514526220>.

**Publisher:** SAGE Publications

**Version note:**

The version presented here may differ from the published version or from the version of record. If you wish to cite the following item, it is advised to consult the publisher version. Access to the publisher version can be found via the repository URL listed above.

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**Observation and commentary**

**Who watches the watchmen? A critical perspective on the theorization of trans people and clinicians**

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**Keywords**

Trans, theory, clinicians, research, trans healthcare.

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## **Introduction**

Much has been written recently about trans people and the clinicians who work with them; particularly in relation to those who seek some sort of physiological intervention and the clinicians who are involved in determining the efficacy and safety of these requests. We wanted to take the opportunity of a special issue of *Feminism & Psychology* on the topic of trans to comment on some of the common problems, which we, as academic-clinicians of a diverse range of gender identities and presentations, see in academic writing in this area. We also sought to suggest some possible ways forward in relation to future research and writing on such topics by authors regardless of orientation and whatever their own identities and practices relating to trans.

We are focusing, here, upon the pragmatic implications of work in this area for the lives of trans people themselves, rather than upon making any form of theoretical intervention. Therefore we are not writing this paper from a specific theoretical perspective, nor addressing one particular theoretical position (e.g. psychoanalytic, medical, constructionist). In addition we are not situating this paper within a specific ‘debate’ or context as such beyond considering the necessity for ethical practice within the academy. Instead our aim is to consider problematic issues in some of the theorising of trans experience and people, and clinicians, in general, and to explore some of the practical implications such work can have on individuals and communities.

All four of us work as academics and as practitioners, addressing trans and related topics in both our research and our therapeutic practice. Two of us (Penny and Christina) are clinicians within the largest and oldest gender identity clinic in the world (Green, 2008), whilst the other two (Alex and Meg) have worked therapeutically with gender issues as well as studying these, and related, communities. Between us we have also worked on developing British Psychological Society guidelines for practice with sexual and gender minorities (Shaw et al, 2012), and on books and papers dealing with the same issues (e.g. Lenihan & Hegarty, 2007; Iantaffi, 2010; Richards & Barker, 2013) and on drawing up suggestions for psychology research relating to trans people (Hegarty, Lenihan, Barker & Moon, 2004). Together we sit at the nexus of a variety of personal and professional identities concerning trans. Therefore we feel well placed to comment upon some of the more concerning aspects of the extant literature pertaining to it.

We have made the deliberate decision in this short *point of view* piece not to 'name names' in terms of the problematic research and writing that has been produced in the past. Rather we will simply highlight common trends which occur in such writing and give some hypothetical examples. We have made this decision for three reasons. First, a brief commentary does not allow room for a detailed critique of past work. Secondly, focusing on specific individuals is probably unhelpful: it may mean that others assume that they are immune to these problems, and we are interested in moving this area on rather than remaining stuck in discussions about the specifics of a particular piece of research or article. Thirdly, some of the material we are drawing on we have seen published, and some we have seen as part of the peer review process (and therefore it is

not possible to reference it). It is important to speak to both research which gets through the peer review filter and that which does not. Non-published research nonetheless still gets conducted, and may make it into the grey literature, as well as potentially finding its way back to the communities involved.

Of course we recognise that failing to ‘name names’ means that we are not supporting our claims with direct citations. We hope that the reader will reflect upon the literature in this area that they have read, including this special issue, in order to evaluate, alongside us, whether such problems remain prevalent and/or whether the field is beginning to see some improvement in these matters.

### **Treating people as people**

Our overriding concern is that research and writing should treat both trans people and clinicians *as* people, rather than reducing them to a single identity. This means recognising them as full human beings, rather than objectifying them as ‘just’ trans, or ‘just’ a clinician. For example, we have read many papers in which it is assumed that trans people will not be clinicians and vice versa. It is important to acknowledge the multiplicity of identities most people inhabit and to recognise that being “trans” or a “clinician” are not mutually exclusive categories. Separating trans people and clinicians into two camps of ‘us and them’ is damaging to both groups (Fiske & Taylor, 1991; Sherif, 1956), as well as being factually incorrect. This is of particular concern to us as

we see trans people who have been misled about this dichotomy who have delayed accessing services (with the attendant physical and mental health costs) for this reason.

It may be assumed that critical and qualitative work is more likely to recognise people fully than pathologising, reductionist, quantitative research and mainstream psychological theories, which this special issue call for submissions referred to. Critical and qualitative work, after all, emphasises the voices, experiences and meanings of the participants themselves (Silverman, 2004), and many of those involved are politically engaged.

However, in our readings and reviews of trans research we have seen that qualitative researchers and critical theorists can be just as capable of fixing a participant as one aspect of their being, of presenting one experience as universal, and of constructing a polarised argument based upon a limited reading of accounts. For example, we have seen studies on trans men submitted to women's studies journals (and vice versa) which fails to respect the participants' identities. Also, the presentation of participant experience in a wholly celebratory or critical light is common (see below).

**Comment [u1]:** Kept this as the point is in relation to quantitative analysis.

It is important to recognise the diversity of trans people and clinicians. Much of the research on trans focuses, for understandable practical reasons, on people who answer requests for participants and/or who attend support groups or Gender Identity Clinics (GICs), or take part in internet trans chatrooms, clubs, etc. However, people in these categories may be at a particular stage in their life, and cannot be representative of all trans people throughout the life span. Most trans people are instead getting on with life, earning a living perhaps being chartered accountants and the like, taking the children to

school and/or being carers; quietly going about their everyday business. Similarly, not all clinicians work in GICs, subscribe to the same definition of trans, or act from a psychoanalytic or psychiatric perspective. However, much research in this area speaks of ‘the medical discourse’ or ‘clinicians’ as if there was a unified understanding and all individuals are the same. There is a vast, and silent, majority of both trans people and clinicians who are rarely represented in research. Generalisations from such small and biased samples should be avoided.

Furthermore, studies wherein the researchers have actually spoken to clinicians in this field are rare, and those in countries other than the US (e.g., the United Kingdom) are almost non-existent. There are many papers which report and generalise from second and third hand information about what takes place in clinical contexts, but which are not based upon source information from those contexts. This research loses the wealth of individual and organisational perspectives within trans-specific healthcare.

### **Trans people**

There has been a marked tendency for writers in recent years to co-opt trans experience to fit some either celebratory, or critical, theory which they put forward. This is particularly tempting to those writers new to the field, who have yet to gain the experience of the more mundane reality that trans people are neither the pathologised or idealised 'other' they may first assume, but are in fact just members of the general public whose 'transness' may well not be pertinent to their selected issue. For example, queer

and gender theorists have often used all trans experience to demonstrate the construct of gender fluidity, and as an example of PoMo (postmodern) sexuality. However, many trans people's experiences do not fit these celebratory discourses given that they see themselves as a man or a woman, fitting within a mainstream dichotomous understanding of gender, and do not claim genderqueer or gender-fluid identities and desires.

There has been an equally problematic trend in research to demonstrate the heteronormativity of trans accounts, arguing that trans people are stuck within dichotomous, often stereotypical, understandings of gender and sexuality. Over and above the simplicity of such polarised positions (*either celebratory or critical*), such work fails to capture the diversity of experiences under the broad umbrella of trans, and is restricted to the specific context in which the data are collected. This may well impact upon what is recollected and what is shared (see Barker, Richards & Bowes-Catton, 2012).

When researchers present only one unified understanding of a group, community or identity (even if it is a celebratory one) they constrain and limit those within it. Feminist writers on disability, for example, have long argued against a monolithic construction of disability as a purely social handicap (Lloyd, 1992; Morris, 1992), as well as against the dichotomous construct of disabled people, particularly women, as either 'brave heroes/angels' or 'dangerous villains' (Safran, 1998). Rather, they have asked for researchers and theorists to engage with more complex accounts of the lives of people with disabilities (Vernon, 1999; Iantaffi, 2009). As Heckert (2011) argues, claiming the



authority to speak for another person does violence to them in limiting their capacity to speak for themselves and to tell their own stories. Therefore it is vital that qualitative researchers and critical theorists really think about the impact of their words when drawing on people's accounts. As May (1994) asserts: 'Practices of telling people who they are and what they want erect a barrier between them and who (or what) they can create themselves to be' (p.131).

Furthermore, assertions as to what people 'should' be doing based upon theory may well be inappropriate; as political and theoretical ideals are often trumped by the day to day demands of real life, such as paying the bills, getting ready in the morning, health concerns, making the school run, and so on. It seems both strange and unethical to ask oppressed people within a society to shoulder the burden of a universal theoretical or political stance. When theorising, or writing, about trans people then (whether they are clinicians or not), it is important to recognise that the people being theorised about are not some conceptual entity to be deconstructed or used to buttress a theory. They are instead real human beings, with full existences most of which have nothing to do with their being trans.

Let us consider gender fluidity as a case in point. As mentioned above, some theorists have attacked trans people for being too dichotomously gendered, or have asserted that gender stereotypical behaviours of trans people are in some way false. It is reasonable to assume that some trans people are performing gendered stereotypical behaviours in a way that is 'authentic' for them. For example a trans woman may indeed like pink, or a trans

man enjoy sports (and why not?). Serano (2007) suggests that such people are often pilloried as having a false consciousness, and for failing to recognise the constructed nature of gender. This argument is first of all specious as a preference for pink or sports are not necessarily a by-product of cultural norms. Some trans people, however, may indeed be adhering to cultural norms for a gender they were not assigned at birth, against their own explicit internal wishes, either by choice or by having internalised cultural norms, just as cisgender people do.

We are aware that all gender presentations (as distinct from identities) are culturally constructed. Non-bifurcated legwear within large areas of contemporary western culture are clearly cultural artefacts; with no evolved preference for or against them. If a person wears such legwear when it is defined as a skirt, then they are wearing a 'female' item of clothing because they have been told this is so (unless they are in Scotland, and it is a kilt, for example). This cultural reading of the gendered nature of clothing (and one's self-association with it) is taught, usually in childhood. A preference for skirts is not an innate quality. While a person's femininity may be present at birth, the association of femininity with skirts comes later, and is constructed, whether one is cisgender or trans. It seems unreasonable then to attack trans people who wish to convey their gender identity through the medium of a skirt. Performing gender is simply what we, cisgender or trans, do.

There is also a pragmatic issue. While we may wish to live in a gender fluid utopia, few of us actually do. Those people who are at the nexus of intersecting marginalisations;

through race, disability and being trans, for example, may be least well placed to challenge prevailing norms while still maintaining the ability to put food on their table. Challenging established gender norms is often enabled by a certain degree of privilege within mainstream society, whether this is white, class, education privilege, or an intersection of all of those. It is unreasonable to expect a working-class trans woman, who is trying to ensure that her children have enough to eat, to question the gender binary uniform policy at her place of work. If she wants not to risk her job, she may just choose to wear the designated uniform. The same is true for the trans teenage boy, who is just keen to get through the school day without having his 'head kicked in', and who might want to fit in with their peers like most teenagers do. Why should the onus of questioning the school's uniform or sports policy necessarily be on them?

It seems to us that a great many seemingly white, cisgender, heterosexual, non-disabled academics in positions of power use theory to question or invalidate the personal lives of real people who are least well placed to address these issues and to keep themselves and their loved ones safe. We wonder why these academics have not interrogated and theorized themselves first, or indeed instead - including the nexus of power and gender - whose benefits they appear to enjoy rather than calling upon trans people to do so. This obliviousness to the utilitarian concerns of ordinary trans people is also apparent amongst some queer academics, whose jobs and lives allow a degree of flexibility undreamed of for someone living in contexts where non-adherence to the prevailing norm can lead to violence and even death, or can potentially expose their children to bullying or being ostracised. Both of these appropriations of people's lives for theoretical ends, with no

regard for the impact these could have on them and others with whom their lives are interconnected, are, at best, thoughtless and unethical, and, at worst, abuses of privilege and power. We are unclear why these academics do not, to use an aphorism, pick on someone their own size. For example, why not address the distinct boys and girls aisles in mainstream stores, like Toys Я Us, instead of real people who are simply trying to get by?

### **Clinicians**

One group who could be seen as a size closer to academic scholars are the clinicians, and other professionals, who work within trans-specific healthcare. This group is often referred to, in trans research and writing, by using terms like 'the medical approach to/discourse of' trans, or 'the psy professions'. Presenting such people in this unified manner creates, once again, a straw figure, whereby any reported experiences of trans healthcare, or views of one professional, is presented as a monolithic, universal perspective of the whole profession. One discourse becomes *the* discourse.

Just as trans people are many and varied, so are clinicians, and the discourses which they draw on. We are personally aware of clinicians within trans care in the United Kingdom, and beyond, who are trans themselves, cisgender, bisexual, heterosexual, gay, lesbian, kinky, non-kinky, monogamous, non-monogamous; indeed much of the gamut of sexual and gender identities. Suggesting that clinicians working with trans people are all heterosexual cisgender men (as is often implied) is factually incorrect. As an aside, let us

also lay a couple of these old chestnuts to rest. In order to gain access to physiological interventions trans women do not have to wear skirts (although they can if they want), and people do not have to be heterosexual. We see these things written in contemporary documents and wonder why otherwise skilled academics do not present a more accurate reflection of the current status of professional practice. It is, of course, entirely reasonable to report that these things were a participant's experience, and we acknowledge that, sadly, negative, oppressive encounters with mental health professionals have sometimes happened, but to generalize this as a universal experience for trans people seeking medical intervention is incorrect. To further report that experience as being a matter of universal, health policy is not only incorrect, but it is damaging, not only to clinicians but to trans people as well.

As clinicians, as well as researchers, that damage concerns us. Clients who are very young, or who have a learning disability, or mental health problems, frequently present to clinics extremely distressed about things that they have heard, such as the examples above, which are simply not true. Such people often report that they were thinking of settling for sub-standard services, or risky self-managed treatment, rather than approaching reputable clinics. Worryingly, especially given the rates of mental distress and suicide amongst trans people who are not provided with services, there are others who are completely put off by the myths circulating about trans-specific healthcare, leading to desired and necessary treatment being delayed for years. If people write factually incorrect things in respected publications, simply because they support their

theory of gender and/or the medical professions, they need to be aware of the very real implications for real people.

Academics should further consider these real implications, and the tough decisions clinicians have to make. In countries with national health services, such as the United Kingdom, clinicians in the statutory sector are required to provide safe treatments that have proven efficacy. In interventions that have the capacity to cause great harm, the burden of proof of efficacy is even higher. Academics who are not themselves clinicians should bear this in mind when they suggest that clinicians are needless ‘gatekeepers’. Unless authors have themselves put their signature on papers in support of, or authorizing physiological interventions, and are willing to justify their actions legally and professionally, they have precisely no responsibility for the outcome – an outcome that will radically alter someone’s life. Furthermore, those academics need to consider that all medical interventions usually call for informed consent. Whether a mental health professional is required to provide a letter of support, or to facilitate the decision-making process at the request of a trans client, a truly informed consent, with the attendant difficulties associated with that, is generally the desired outcome for all parties.

Some people may argue that the right for self-determination is worth promoting the elimination of any ‘gate-keeping’. This is clearly a complex issue, however the current situation requires that a clinician, beside the person seeking treatment, makes these difficult decisions. Even when no mental health professionals or GICs are involved in the care of trans people, as it may happen in the US, under what has been described as the

informed consent model, a physician and/or surgeon still need to authorize interventions such as hormone treatment or surgery. Academics may only be aware, for example, of a relatively privileged group of trans people who are part of a particular online or community group which they have accessed. Unlike clinicians, they may not have talked with, for example, people in great distress who have accessed hormones or surgeries privately and who now regret it, or those within forensic contexts or who have serious mental health issues who are looking to access services, and the complex issues involved in these situations.

Clinicians, regardless of their gender identities, sit in uncomfortable places. In our experience, they rarely relish the exercise of power, or the role of ‘gate-keeper’, but they do acknowledge the responsibility of ensuring that people recognise the decisions they are making and so are truly able to give *informed* consent. Professional judgement and experience cannot be ignored in endorsing medical interventions when it is sought, either by client themselves and/or by statutory health systems. Academics need to recognize the complexity of ethical, professional standards, and the requirements of statutory health services or health insurance companies, when clinicians are involved in the care of trans people. The nexus of professional roles, national health systems, economics, environmental, social and personal circumstances cannot be reduced to simplistic accounts of ‘gatekeeping’ or of ‘trans people vs medical professionals’. Academics who have not signed a form, committing themselves, their career, and their livelihood, to their decision as well as taking on the legal responsibilities, should think before attacking in print those of us who have.

## **Conclusions**

Good practice guidelines for writing about trans specifically (Hale, 2009), and marginalised groups more broadly (Barker *et al.*, 2012) should certainly be given careful consideration by those working in this area, before they embark upon their work. This is particularly vital given the legacy of personal and political agendas fuelling problematic, and potentially damaging, writing and research, with little consideration of the lives of those who are most affected. Specifically, it is important that writers and researchers, including graduate students undertaking dissertation projects, reflexively consider their agendas before embarking on their work. We cannot help but be emotionally invested in work around trans issues and identities, whether we are trans ourselves (and perhaps hoping to report other stories like our own, or to achieve certain political aims), or wonder if we might be (and are, perhaps, writing about it in order to explore it more or to avoid engaging in it more personally), or know that we are not (and are invested in being seen as an ally, or find trans threatening to our personal view/performance of gender). We need to make sure that we recognise the humanity of *all* those we are writing about, rather than losing our sense of multiplicity and complexity when we come to speak of professionals and clinicians.

It is also vital that we look at what has gone before, to avoid over-researching a certain group, or repeating problems of the past. Given the vast amount of often problematic literature in the area of trans already, we need to ask ourselves whether the world needs yet another study on trans, and who exactly it is benefiting. If we are keen to look at



discourses of gender, might there be other places where these are being played out, and resisted, which are equally interesting, less researched, and less politically and personally precarious, than this one? If we must research trans then we ask scholars to question what has not been done before (Riggle et al, 2011). How can we approach those we are writing about with humility and a willingness to learn? How can we ensure that we capture the complexity and multiplicity of experiences? And how can we ensure that we have enough knowledge, expertise and insight before we attempt to publish?

We ask that researchers and authors remember that clinicians and trans people are just that: people. They are not places to hang an argument. If academics want to theorize, then they are asked not to use trans people's bodies and lives, or those of clinicians (trans or cisgender), but to start with themselves, and to privilege reflexivity in their accounts and theories. Too much writing about trans people and clinicians also seems to fail the basic test of good manners, including being respectful, and can be unnecessarily unkind.

Writers should be accountable, and consider the real-life ramifications of the arguments they are making for the flesh and blood people they are talking about. Those trans people who just want to make sure their gas bill is paid should be left alone to live their lives as they see fit.

### **Acknowledgements**

Christina and Penny would like to thank their colleagues at the Charing Cross Gender Identity Clinic and all of the authors want to thank the clients and patients they have worked with over the years.

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