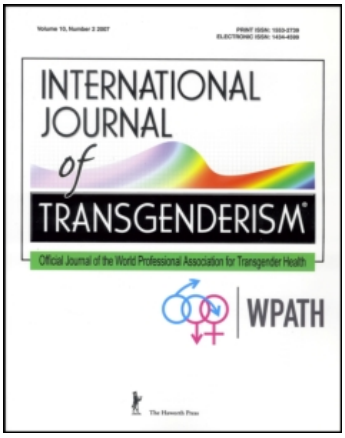

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Psychotherapy in the World Professional Association for Transgender Health's *Standards of Care*: Background and Recommendations

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Psychotherapy in the World Professional Association for Transgender Health's *Standards of Care*: Background and Recommendations

Lin Fraser

ABSTRACT. This invited article on psychotherapy in the *Standards of Care* (*SOC*) of the World Professional Association for Transgender Health (WPATH) provides background and makes recommendations for the psychotherapy section of the next revision of the *SOC*. The article describes (1) the history of psychotherapy within the *Standards*; (2) the major changes affecting psychotherapy since the 2001 *SOC*; (3) new directions proposed by the association leadership; and (4) a summary of the recent psychotherapy literature, including current gaps in the literature. These directions and missing elements provide the context and rationale for the suggested revisions. Included in the recommendations are minor changes to the 2001 *SOC* and suggestions for additional sections. These recommendations consider the spectrum of transgender identities, the impact of culture in psychotherapy, the importance of working collaboratively with communities, the use of trans-positive psychotherapy models from the recent literature, and the unique benefits, challenges, and rewards within this specialization. The recommendations also include potential future directions using recent advances in technology to provide international training and distance counseling.

KEYWORDS. Transgender, transgender psychotherapy, psychotherapy, standards of care

The assignment for this invited article on psychotherapy in the *Standards of Care* (*SOC*) of the World Professional Association for Transgender Health (WPATH) was "to review the evidence (and provide us with references), to point out where research is lacking and needed, and to make possible recommendations (significant and cosmetic) to the *SOC* based upon new evidence" (E. Coleman, personal communication, October, 2, 2006). This article provides the requested background material and then makes recommendations for the psychotherapy section of the next revision of the *SOC* (or *Standards*). First, it describes the history of psychotherapy within the *Standards*. Then, it describes the major changes affecting psychotherapy since the previous *SOC* (Meyer et al., 2001). These include the directions suggested by WPATH (or the Association) leadership and the recent psychotherapy literature. It also describes current gaps in the literature. These directions and missing elements provide the context and rationale for the suggested revisions.

The article concludes with recommendations for minor changes to the current *Standards* and suggestions for new sections to be added to

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the psychotherapy section of the *SOC*. These suggested additions consider the spectrum of transgender identities, the international scope of WPATH and the impact of culture in psychotherapy, the importance of working collaboratively with communities, the use of trans-positive psychotherapy models from the recent literature, and the unique benefits, challenges, and rewards within this specialization, for both the client and the clinician. The recommendations also include potential future directions using recent advances in technology to provide international training and distance counseling.

HISTORY OF PSYCHOTHERAPY AND SOC

The attendees of the Sixth International Gender Dysphoria Symposium, San Diego, California, approved the original *SOC* in February 1979. The original document was written by the late Dr. Paul Walker with input from other professionals who comprised the first *SOC* committee. Dr. Walker was the first President of the Harry Benjamin International Gender Dysphoria Association (HBIGDA)—the association later renamed the World Professional Association of Transgender Health (WPATH)—and a licensed psychologist who had studied under Dr. John Money, also a psychologist, of Johns Hopkins, an early surgery center. Along with his committee, Dr. Walker wrote the original document "to provide guidelines to consumers and to set minimal requirements for the indication of hormonal and surgical sex reassignment . . . " (Pfäfflin 2007, p. 171). From the beginning, clinical behavioral scientists (mental health professionals) played a primary role. The original *SOC*, and all subsequent revisions, was intended to be flexible and responsive to the needs of the community and to changing cultural conditions. In addition, the Standards were to be based on the best clinical and scientific evidence of the time, mindful of being inclusive and international.

The first four versions (1979, 1980, 1981, 1990) described the parameters of a clinical behavioral scientist and required psychotherapy before referrals could be made for hormones and surgery. The emphasis was on eligibility and requirements for medical intervention. Nothing was said about what psychotherapy was for, except to evaluate and make referrals.

A shift occurred in the fifth version (1998) that included a removal of the psychotherapy requirement and added a special section on psychotherapy, as a step two in the processes of managing patients with gender identity disorder and follow-up to initial diagnosis and treatment planning. This section included a description of optimal therapeutic outcomes: the "goal of the work is to create a long term stable lifestyle with realistic chances for success in relationships, education, work, and gender identity and role." (Levine et al., 1998, p. 2). It included a recognition of the patient's autonomy, multiple options for gender adaptation, and the mention that with psychotherapy "some patients rethink their ambition to live in the opposite sex role" (Levine et al., 1998, p. 2). It also included the importance of the therapeutic alliance regarding eligibility and readiness and the potential stalemates without it: that therapy is not undertaken to cure the gender identity disorder and that "psychotherapy, although strongly recommended for most patients, is not an absolute requirement for all adults with gender identity disorders"(Levine et al., 1998, p. 2).

The psychotherapy section in Version 6 (2001; the current *SOC*) is essentially unchanged from Version 5 with an occasional minor edit, clarification, or deletion. Versions 5 and 6 have sections on a basic observation about the benefit of psychotherapy, the recognition that it is not a requirement, a brief mention of goals, a discussion and description of the therapeutic relationship—that the clinician should ideally work "with the whole of the person's complexity" (Meyer et al., 2001, p. 12) and that the "goals of therapy are to help the person live more comfortably within a gender identity and to deal effectively with nongender issues"(Meyer et al., 2001, p. 12). The goals recognize that a person can never completely eradicate vestiges of their original sex assignment. Sections follow on the processes of psychotherapy and a description of what happens during therapy, stating the importance of collaboration as well as recognizing multiple options and outcomes. Both versions include a section on potential adaptations that

do not always include the full triadic sequence or that wouldn't necessarily include transition.

The current *Standards of Care* still have value, because they are flexible, address multiple outcomes, and support individualized treatment. Nevertheless, the next *Standards* needs to address the new directions the Association has taken in the intervening years, international and cultural diversity, new paradigms in some parts of the world, and the more recent psychotherapy literature. This article proposes additional paragraphs addressing these matters as well as offering supplementary information about the unique rewards and challenges facing the psychotherapist in this multifaceted field.

CHANGES SINCE THE 2001 SOC

Before suggestions can be made for a revision of the psychotherapy section of the new standards, it is important to put these proposals into context.

Two interdependent areas that have come to the forefront since the last *SOC* have an impact on the psychotherapy section of the next version. First, is the direction proposed by the leadership and the organization. Former president Eli Coleman's 10 Steps To Promote Transgender Health, proposed at the 2003 Ghent Symposium (Ettner, 2007), the new mission and vision statements, and the new name of the organization developed at the 2006 board retreat (Whittle, personal communication, 2008), are examples of WPATH's direction. The second area influencing the suggestions for the psychotherapy revision is the updated information described in the recent psychotherapy literature. Both these areas overlap and reflect changes in world views regarding transgender people. These will be described in turn.

Directions Proposed by the Leadership of the Association

Eli Coleman's 10 Steps to Promote Transgender Health

In his presidential address to the (then HBIGDA) membership in 2003, Dr. Coleman outlined 10 steps to promote transgender health. A more thorough explanation of these steps can be found in his afterword of the recent *Principles of Transgender Medicine and Surgery* (2007). He notes, "Dramatic advances in medical, surgical and psychological treatments have occurred in the past several decades . . . . there has been a significant paradigm shift in how we have treated transgendered persons . . . . As we move forward, we must think about the best ways to promote transgender health" (Coleman, 2007, p. 311). The following 10 steps are Dr. Coleman's prescription forward (pp. 312–313):

1. Promote sexual health including elimination of the barriers to sexual health.
2. Learn from other cultures.
3. Let old paradigms die and new ones emerge.
4. Provide access to optimal care.
5. Provide training to allied health professionals.
6. Provide sound and ethical research.
7. End discrimination and stigma.
8. Change laws and public policies.
9. Change religious views.
10. Promote social tolerance for diversity.

New Vision and Mission Statements

New vision and mission statements were adopted at the January 2006 board retreat held in New York City. These include:

> The vision of HBIGDA is to expand its worldwide authority by promoting education, advocacy, training, research, quality health care and best practice standards for service providers and policy makers regarding gender variant individuals. (WPATH board minutes, 2006)
>
> As an international multidisciplinary professional Association, the mission of HBIGDA is to promote evidence-based care, education, research, advocacy, public policy and respect in transgender health. (WPATH, board minutes, 2006)

To complement these new directions, a new name seemed appropriate.

New Name and Acronym

At the September 2007 Chicago Symposium, then President Dr. Stan Monstrey presented to the membership the thinking behind these changes. Some specific reasons (amongst others) given for the change to WPATH were:

> **World**. A better representation of the full global inclusivity of the association, a worldview rather than appearing to be a North American association with international links
> **Professional**. A better representation of our membership and to confirm that full membership is for professionally trained people, who work with Trans-patients or clients.
> **Transgender**. A better recognition of the therapeutic, nonsurgical work performed by the members, that the association was not just about those transpeople who sought gender reassignment surgeries.
> **Health**. A better recognition of the skills of our association's members, and working towards following the World Health Organization (WHO) definition of health:
>
> Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (Preamble, Constitution of the World Health Organization, 1948, as cited in Whittle, 2008)

The new name, WPATH, as described above, is self-explanatory, reflecting the global direction of a professional association addressing the overall health of multiple transgender identities. It moves away from an identity, at least in perception, of being an American or a European and American organization serving people identified as being dysphoric and in need of primarily medical interventions. The new title suggests an association with more depth and breadth than did the former title, including multiple cultural and gender identities, and it recognizes its professional (not lay) membership.

These directions will be folded into the proposals for changes to the psychotherapy section of the *SOC* that will be developed later in this article.

Shifting Paradigms, Major Trends, and Recent Literature

The recent literature, including Dr. Coleman's steps, the new vision and mission statements and name, supports these directions. Although a truly international literature remains to be written or perhaps translated for the largely Western membership, shifting paradigms, major trends, and specific recent literature about psychotherapy are consistent with the WPATH acronym and Coleman's ten steps.

Shifting Paradigms

Since Version 6, and as Dr. Coleman outlines in his steps, new paradigms have emerged about the nature of transgender identity and experience.

Dr. Coleman's Step 3 states, "Let old paradigms die and new ones emerge."

> We have moved away from archaic notions of what we once thought were best practices. With the advent of scientific advances and new understanding, we are embracing a new paradigm, which recognizes the gender-identity spectrum and the affirmation of [an] individuals' right to express [the] preferred gender. We now provide individualized treatment options. Choices for the management of cross-gender feelings are no longer limited to adjustment in either the male or female gender role, but include the possibility of affirming a unique transgender identity. (Coleman, 2007, p. 312)

Providers and transpeople alike now recognize a spectrum of transgender experience and potentially multiple gender identities that, in some cases, may be fluid over time (Fraser, 2007). This is a major change from the conventional wisdom that gender is stable and immutable and that there are two sexes and two

genders, male and female, termed the binary system of gender (Auge et al., 2001). In the past, transpeople tended to describe their experience as fitting into that paradigm, with a mismatch between sex and gender. For example, the criteria listed for Gender Identity Disorder in DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) are descriptive of many people who experience dissonance between their sex as assigned at birth and their gender identity, which is developed in early childhood and understood to be firmly established by age 4. (Schor, 1999). Hence, the triadic sequence of therapies, hormonal, surgical, and cross living—as described in the previous *SOC*'s—interventions designed to match the body to a fixed gender identity. However, as outlined by Dr. Coleman, a paradigm shift has occurred. A gender spectrum exists and many transpeople do not fit into this binary system of gender.

Denny (2004) has described the earlier paradigm as the Transsexual Model and the newer one the Transgender Model. She also describes their implications for the *SOC* and psychotherapy. In her 2004 seminal paper "Changing Models of Transsexualism," she describes how the shift to the newer paradigm originated from transgender people themselves and provided an alternative to the older one that had held sway since the 60s:

The initial model held that transsexuals were "trapped in the wrong body," experiencing a psychic pain that could be alleviated only by body transformation. The new model views gender as a continuum rather than a male/female dichotomy (Bornstein, 1994: Rothblatt, 1994) and calls for individualized gender trajectories, which may or may not include hormonal therapy and sex reassignment surgery (Denny, 2004, p. 26).

Other clinicians, writers, and researchers (Boyd, 2007; Ettner, 2007; Fraser, 2007; Green, 2004; Henkin, 1997, 2001; Karasic & Drescher, 2005; Lev, 2004, 2005, 2009/this issue; Nestle, Howell, & Wilchins, 2002; Pfafflin, 2007; Rosario, 2004; Rosenberg, 2007; Roughgarden, 2004; Serano, 2007; Whittle & Stryker, 2006), describe and recognize this spectrum of transgender experience. Bockting (2007) has produced a documentary *Transgender Coming Out: The Powerful Stories of Men Who Became Women, Women Who Became Men, and People All Along the Gender Spectrum Who Simply Became Themselves,* chronicling individual voices illustrating gender diversity.

These new paradigms, as Denny (2004) and Coleman (2007) elaborate, have implications for the revised *SOC*, supporting an even more individualized treatment regime. Furthermore, many people may not request nor will they require the full triadic sequence. The existence of the transgender spectrum requires a flexible psychotherapeutic approach tailored to the needs of the individual (Lev, 2009/this issue).

Major Trends in the Literature

Consistent with and underscoring the applicability of the described directions of the association are the trends in the recent psychological literature. First, three major books, written or edited by WPATH members (Ettner, Monstrey, & Eyler, 2007; Lev, 2004; Bockting, 2007) develop new guidelines for transgender care that have implications for the *SOC*. A second trend involves more collaboration between psychotherapists and the community consistent with the direction of international health care of the World Health Organization (WHO, 2008). Third, recent literature includes trans-positive psychological explanations and understandings of transgender identity development and experience based on the realities of trans-lives. These descriptions use established developmental models and systems of psychotherapy, sociology, and identity theory in new ways (Bockting & Coleman, 2007; Devor, 2004; Fraser, 2007; Lev, 2004). The literature is also beginning to address the importance of stigma as an important component of transgender experience (Bockting, Coleman, & Benner, 2007; Lev, 2004). Finally, although not new, the importance and unique contribution of psychotherapy, with a special emphasis on the therapeutic relationship, is another component of the recent literature (Ettner 2007; Pfäfflin, 2007; Lev, 2004).

Specific Recent Works as Examples of Trends

Guidelines for transgender care. Three books merit discussion as an overview of recent

additions to the psychotherapy literature. These books provide guidelines for transgender care. The first, *Principles of Transgender Medicine and Surgery* (Ettner et al., 2007) is a comprehensive compendium of transgender care—medical, surgical, and psychological—and is a collaboration of American and European authors. A second book, the meticulously researched *Transgender Emergence* (2004) by American social worker and family therapist Arlene Lev, describes Therapeutic Guidelines for Working with Gender-Variant People and Their Families; and a third, the Canadian *Guidelines for Transgender Care* (Bockting & Goldberg, 2006) provides comprehensive information for a range of providers, including psychotherapists. This latter special issue of the *International Journal of Transgenderism* was developed via a collaboration between providers and the transgender community in Vancouver, Canada.

What these guidelines have in common is an appreciation of the complexity of the whole person, a flexible, individualized approach consistent with the current *SOC* but with less emphasis on the triadic model and an appreciation of shifting paradigms. These guidelines also include the centrality of the listening and compassion component of psychotherapy and recognition of the challenges inherent in this evolving and multifaceted field.

For example, in the introduction to *Principles of Transgender Medicine and Surgery* (Ettner et al., 2007), Ettner explains,

> The authors you are about to read eschew pathologizing positions. Each has emerged as an expert based on years of listening and bearing witness to narratives of those who long for identity alignment. Ironically, it is the regression to this fundamental mode of communication—listening—and the most advanced mode of consciousness—compassion—that trump technology in advancing this burgeoning field. (p. xxiv)

Pfäfflin (2007) concurs and adds,

No matter how rapidly medical science evolves, it will always confront new phenomena for which there are no practical solutions at hand. Transvestism, transsexualism, and transgenderism were, and still are, social phenomena that challenge long-standing medical knowledge. . . . no guideline, standards or practical handbook, not even this one, can offer an ideal and all-encompassing paradigm (pp. 169–170).

Collaboration with community. Consistent with listening in an individual setting, a second trend involves partnering with the community to set up mental health standards, guidelines, and training protocols. More voices of gender-variant people are being heard in the development of principles and standards of care. Consistent with this collaborative approach is a move to include families in the treatment process, when clinically appropriate.

For example, collaborative approaches have been developed in both Canada and in the United Kingdom. The *Trans Care Project* of Vancouver was created to develop advanced practice and training protocols. The guidelines incorporated the views from gender-variant people from the community as well as experienced professionals in the field (Bockting, Knudson, & Goldberg (2006).

Another collaborative project, *Good Practice Guidelines for the Assessment and Treatment of Gender Dysphoria* (in progress) will be coming out of the United Kingdom. The Royal College of Psychiatrists in London in collaboration with "representatives from a number of sources including the medical Royal Colleges, professional societies and Associations and representatives from user groups and other interested parties" (Wylie, 2006, p. 1) is developing the document. Although different in format and less comprehensive in terms of psychotherapeutic guidelines than the Canadian guidelines, the Royal College guidelines extol "the need for greater patient led ownership of the transition pathway" (Wylie, 2006, p. 1) They also include an appendix describing the importance of family support (Wylie, 2006, p. 34) recognizing that transpeople do not live in a vacuum and that family involvement can be an important part of identity integration and good mental health.

Using established models in new ways. The recent literature also includes new psychological explanations and understandings of transgender

identity development and experience. These applications utilize established theoretical models (coming out, narrative, psychodynamic, minority stress) in new ways to describe and help understand the transgender phenomenon. All eschew pathology and seek to explain normative transgender experience and development.

Identity/emergence/coming out models. Bockting & Coleman (2007) and Devor (2004) built their stage models of the transgender coming-out process and transsexual identity formation on, respectively, Coleman's (1982) and Cass's (1979) models of homosexual identity formation. In building their transgender models, the researchers relied heavily on established developmental theorists and then added their own expertise about transidentity development to complete their explanations. Both models have implications for psychotherapy in that they demonstrate a blueprint for transgender-identity integration.

For example, Bockting and Coleman, in their article "Developmental Stages of the Transgender Coming-Out Process: Toward an Integrated Identity" state:

> We adapted Coleman's (1981/82) model of developing a homosexual identity to the development of a transgender identity. Our model identifies five developmental stages: (1) precoming out, (2) coming out, (3) exploration, (4) intimacy, and (5) identity integration. It is based upon Erikson's ideas of social development (Erikson, 1956). It posits that identity development is greatly influenced by social interaction (Erikson, 1956; Plummer, 1975), and is shaped according to the nature of interpersonal relationships (Sullivan 1953). It is not only consistent with the models previously described, but also reflects our particular insights and clinical experience, and accounts for a wide range of transgender identities. (Bockting & Coleman, 2007, pp. 186–187)

Devor's 14-stage model of transsexual-identity formation, beginning with abiding anxiety and confusion and ending with integration and pride, like that of Bockting and Coleman, underscores the importance of social interaction for identity formation. Devor acknowledges the central role of witnessing and mirroring (constructs from depth psychology) for identity formation and the importance of transition for the transperson to experience this validating social feedback. His adaptation of these psychodynamic constructs to transgender-identity development has parallels to Fraser's (2003) psychotherapeutic treatment model—to be described in more detail later— where it is the therapist's task to witness and mirror the newly emergent self.

Narrative. Lev (2004) describes the clinical use of narrative psychotherapy, an established system of psychotherapy, as a witness to the birth of the self. In her award-winning book *Transgender Emergence,* Lev described psychotherapy using established narrative theory:

> Using a narrative model is not about creating histories or inventing life stories. It is about allowing client's struggling with gender-identity issues to tell their stories in their own words. It is an evocative process in which the therapist is the midwife, assisting in the birthing, offering encouragement and support but essentially witnessing the client's own birthing process. The goal is to assist the client in finding significance and purpose in the life he or she has lived, developing organization and structure in which to make sense of it, and to determine direction and goals for his or her future. (p. 223)

Psychodynamic. Consistent with Lev, but using contemporary psychodynamic rather than narrative theory as the underlying clinical orientation, Fraser (2003) presents a nonpathologizing view of transgender-identity development. Unlike past psychodynamic theory on transsexuality that presumed the transgender identity was an undifferentiated, split-off or false self or a defense, (Bak 1968; Freud 1940/1964; Greenson 1968; Ovesey & Person 1973; Stoller, 1985) Fraser argues that the transgender identity can be part of the authentic self. She furthers the notion that distortions and problems ensue from inadvertent faulty mirroring, agreeing with sociologist Devor's (2004) comments about

witnessing and mirroring in his 14-stage model. Using established gender-identity development (Chodorow, 1978, 1994; Pollack, 1995) and attachment theory, (Ainsworth 1979; Ainsworth, Blehar, & Waters, 1978; Bowlby, 1969, 1973; Bretherton, 1992) she proposes that transgender people may develop psychological concerns over time as a result of never being "seen" in their authentic gender which is hidden (or stigmatized) without the witnessing or mirroring required for healthy ego development. (Winnicott, 1971; Kohut, 1971, 1977; Lacan 1949/2002).

Both models emphasize the value of the therapeutic relationship, with its intersubjective connection and feeling of safety. Both models are based on theories of development and report that problems emerge, not due to any inherent pathology of the transperson, but due to problems in the environment, either through inadvertent faulty mirroring (Fraser, 2007, p. 6) or trauma (Lev, 2004, p. 195) Recognition exists in both, consistent with the aforementioned quotes from Ettner (2007) and Pfafflin (2007) that psychotherapy is first a relationship through which healing can occur and that telling and hearing one's own story in one's own voice is important.

Stigma. Using the hypotheses of minority stress and resilience (Bockting et al., 2007) offered preliminary support for a relationship between social stigma and symptoms of depression among transgender people. Resilience was correlated with family support and identity pride. Their conclusions are consistent with advocacy and education recommended by the WPATH leadership in the new vision and mission statements.

Importance of psychotherapy. The final trend in the recent literature underscores the importance of psychotherapy in the face of the aforementioned shifting paradigms, challenges in identity development, and social stigma. For example, the conclusion of the Vancouver manual (Bockting & Goldberg, 2006) offers a tidy summation about the benefits of psychotherapy.

> Mental health clinicians can have a significant positive influence in helping transgender people and loved ones build resilience to heal from and cope with societal stigma, promoting healthy psychosocial development and facilitating timely treatment of mental health concerns (p. 40).

Another example of the importance of psychotherapy is Bockting's prepublication comment about *Transgender Emergence* (Lev, 2004), in which he describes that a central and overlooked focus of her book is "the tremendous healing potential of psychotherapy."

Finally, Rachlin (2002), Biondi (2007), and Bockting, Robinson, Bennes, and Scheltema (2004) report data-based research on the efficacy and importance of clinicians knowledgeable about transgender issues.

Gaps in Literature

The primary gap in the literature arises due to an absence of working coming from areas outside of Europe and the United States.

We need a more inclusive literature, one that describes non-Western ways of constructing gender. Bockting and Coleman (2007) note that their developmental model of the coming-out process is "limited by the fact that it was constructed within the context of the dominant Northern American/Western European culture, without accounting for processes that exist in other cultures" (p. 187). Winter (2007, 2009) addresses this gap for the *SOC* and describes similarities and differences with respect to gender-identity variance outside the developed West.

Moreover, the gap in the literature that has implications for psychotherapy includes not only a dearth of information about worldwide transgender experience but also about mental health in general. For example, to develop a more international *SOC*, we need to know more about the role (or lack thereof) of psychotherapy outside of the Western purview.

Although outside the scope of this article, information is available from the World Health Organization about international mental health needs and services, some of which might be extrapolated to a more global *SOC*. Other comments regarding the paucity of international education and training are addressed in the potential future directions section of this article.

Finally, clinical literature of longer case studies including therapists' thought processes, and

not just vignettes, is missing. These are needed to provide clinicians with a more subjective-based window into the heart of clinical practice. Few case studies in the more subjective-analytic tradition using contemporary nonpathologizing models exist in the current literature. Single case reviews illustrating couples and family therapy are especially needed.

RECOMMENDATIONS

General Principles to Retain from the 2001 SOC, Given the Direction of WPATH and Recent Literature

The remainder of this article will cover general and specific suggestions regarding the psychotherapy section of the *SOC*. The following are examples of standards affecting psychotherapy from the current (2001) *SOC* that are consistent with recent trends and should be maintained in the next revision. More specific suggestions will appear in the next section. The following are either explicit or implicit general principles from the 2001 Standards that do not need revision:

- The overarching treatment goal. The general goal of psychotherapeutic . . . therapy for persons with gender-identity disorder is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment (Meyer et al., 2001, p. 1).
- The SOC are clinical guidelines and may be flexible contingent on adherence to professional ethics and the best interest of the client.
- The SOC recognize cultural differences in gender-identity variance throughout the world.
- The SOC recognize the centrality of careful listening and the importance of the therapeutic alliance in the therapeutic relationship.
- Psychotherapy is not a prerequisite for triadic sequence

Finally, as a general suggestion, the format is fine but the Standards need to utilize more-sensitive language and acknowledge more explicitly the gender spectrum.

Specific Text to Retain or Revise from 2001 SOC

The following text includes specific comments and recommendations for continued inclusion or revision of sections of the 2001 *SOC*. Only standards and portions of the *SOC* relevant to psychotherapy are included, but their format and order follow the current Standards. The recommended revisions are consistent with recent trends and literature. A "Retain" comment (below the quoted and italicized Standard under discussion) suggests continued inclusion. The recommended revisions are self-explanatory.

I. Introductory Concepts

The Overarching Treatment Goal. *The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.*
Recommendation: Retain.

The Standards of Care Are Clinical Guidelines. *The SOC are intended to provide flexible directions for the treatment of persons with gender identity disorders.*
Recommendation: Retain. Flexibility is especially important given cultural variation.

II. Epidemiological Consideration

Cultural Differences in Gender Identity Variance Throughout the World. *Even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of these conditions. Moreover, access to treatment, cost of treatment, and the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather*

than compassion; there are striking examples in certain cultures of cross-gendered behaviors (e.g., in spiritual leaders) that are not stigmatized
Recommendation: Retain. An additional paragraph about cultural variation and psychotherapy should be included in the psychotherapy section (see VI).

III. Diagnostic Nomenclature
Between the publication of DSM-III and DSM-IV, the term "transgender" began to be used in various ways. Some employed it to refer to those with unusual gender identities in a value-free manner—that is, without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender identity issues. Transgender is not a formal diagnosis, but many professionals and members of the public found it easier to use informally than GIDNOS, which is a formal diagnosis.
Recommendation: Retain and update. The term "transgender" is included in the name of our association, and although the term is still not used as a formal diagnosis it is commonly used in psychotherapy as an umbrella term. As noted by our leadership, the term is more inclusive of the people served and underscores the importance of language (Matte, Devor, & Vladicka, 2009).

Are Gender Identity Disorders Mental Disorders? *The designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients' civil rights.*
Recommendation: Retain and update. The direction of the *SOC* should be toward a nonpathologizing nomenclature.

VI. Psychotherapy with Adults

A Basic Observation. *Many adults with gender identity disorder find comfortable, effective ways of living that do not involve all the components of the triadic treatment sequence. While some individuals manage to do this on their own, psychotherapy can be very helpful in bringing about the discovery and maturational processes that enable self-comfort.*
Recommendation: Retain and add that psychotherapy can be useful whether the person is contemplating the triadic sequence or not.

Psychotherapy Is Not an Absolute Requirement for Triadic Therapy.
Recommendation: Retain (assuming the triadic sequence continues to be described in the *SOC*).

Goals of Psychotherapy. *Psychotherapy often provides education about a range of options not previously seriously considered by the patient. It emphasizes the need to set realistic life goals for work and relationships, and it seeks to define and alleviate the patient's conflicts that may have undermined a stable lifestyle.*
Recommendation: Retain.

The Therapeutic Relationship. *The establishment of a reliable trusting relationship with the patient is the first step toward successful work as a mental health professional. This is usually accomplished by competent nonjudgmental exploration of the gender issues with the patient during the initial diagnostic evaluation. Other issues may be better dealt with later, after the person feels that the clinician is interested in and understands their gender identity concerns. Ideally, the clinician's work is with the whole of the person's complexity. The goals of therapy are to help the person to live more comfortably within a gender identity and to deal effectively with nongender issues. The clinician often attempts to facilitate the capacity to work and to establish or maintain supportive relationships. Even when these initial goals are attained, mental health professionals should discuss the likelihood that no educational, psychotherapeutic, medical, or surgical therapy can permanently eradicate all vestiges of the person's original sex assignment and previous gendered experience.*
Recommendation: Retain but with a minor change about the priority of gender

exploration during initial diagnostic evaluation. The *SOC* need to recognize that the transgender person may be consulting the transgender expert for other issues. The clinician needs to be able to respond in terms of client priority, sometimes before, and sometimes in conjunction with trans-issues.

Moreover, the above Standard implies the older binary model of only two gender identities, male and female, and suggests that the person may want to eradicate the original assigned identity. The Revised Standards should include an exploration of a transgender identity that could and might fully integrate the socialized identity, the preferred presentation or any other option along the gender spectrum.

Processes of Psychotherapy. *Psychotherapy is a series of interactive communications between a therapist who is knowledgeable about how people suffer emotionally and how this may be alleviated, and a patient who is experiencing distress. Typically, psychotherapy consists of regularly held 50-minutes [sic] sessions. The psychotherapy sessions initiate a developmental process. They enable the patient's history to be appreciated, current dilemmas to be understood, and unrealistic ideas and maladaptive behaviors to be identified. Psychotherapy is not intended to cure the gender identity disorder. Its usual goal is a long-term stable life style with realistic chances for success in relationships, education, work, and gender identity expression. Gender distress often intensifies relationship, work, and educational dilemmas. The therapist should make clear that it is the patient's right to choose among many options. The patient can experiment over time with alternative approaches. Ideally, psychotherapy is a collaborative effort. . . . Collaboration can prevent a stalemate between a therapist who seems needlessly withholding of a recommendation, and a patient who seems too profoundly distrusting to freely share thoughts, feelings, events, and relationships. Patients may benefit from psychotherapy at every stage of gender evolution. This includes the postsurgical period, when the anatomic obstacles to gender comfort have been removed, but the person may continue to feel a lack of genuine comfort and skill in living in the new gender role.*

Recommendation: Retain, but include a transgender identity as part of gender evolution. Do not assume a postsurgery or triadic sequence.

Options for Gender Adaptation. *The activities and processes that are listed below have, in various combinations, helped people to find more personal comfort. These adaptations may evolve spontaneously and during psychotherapy. Finding new gender adaptations does not mean that the person may not in the future elect to pursue hormone therapy, the real-life experience, or genital surgery.*

Recommendation: Remove this section and include a different section on multiple options for gender adaptations to account for the paradigm shift since 2001. This might include the option of a transgender identity, recognition of the validity of sexual orientation and gender identity fluidity among some transgender people, and the recognition that, for some, identity is a process and may never stabilize. With fluidity and more individual choice, a case can be made that psychotherapy may be even more useful to help people sort out their multiple options.

General Principles/Sections to Add to SOC, Given Direction of WPATH and Recent Literature: An Outline of New Recommendations for the SOC

Given the direction of the leadership and the current literature and gaps in the literature, general suggestions include additional brief paragraphs on the following topics that might serve as an introduction to the section on psychotherapy.

A Section About New Paradigms, Transgender Diversity, and the Transgender Spectrum

This could possibly be Dr. Coleman's statement about the new paradigm. It would include a statement that WPATH recognizes that many transgender people are comfortable in the binary system of gender while others fit a unique transgender identity. WPATH supports individual choice.

A Section on Culture and Its Ramifications for Psychotherapy

This would be written by an expert on international psychotherapy that would include but not be limited to the following points:

- A recognition and appreciation of cultural diversity and its impact on psychotherapy and the mental health professional. For example, some cultures may be considered individualistic while others are considered collectivistic (Triandis, 2001), and these differences have implications for systems of psychotherapy and clinical orientation. The SOC have grown out of a Western tradition with its emphasis on the centrality of the individual.
- A recognition of cultural differences relating to gender and transgender experience and its impact on the psychotherapist, client, and psychotherapeutic process.
- A recognition of the enormously different environments in which clinicians work across the world.
- A statement about ethics such as the following:

> Psychotherapy is a deeply interpersonal and subjective relationship and, by extension, that relationship may be culturally and therapist specific. Nevertheless, no matter where or under what circumstances it occurs, therapy needs to be grounded in an established clinical orientation, recognized in a given culture as established practice along sound ethical principles and adapted to the reality of transgender people's lives. WPATH recognizes that this may vary somewhat from culture to culture. Therapists needs to be certified or licensed to practice in their given country according to professional regulations.

A Section on Collaborative Approaches

This section would emphasize WPATH's relationship to the larger world health community. For example, as an international organization, WPATH recognizes and supports the direction of the World Health Organization (WHO, 2008) in which mental health is linked to human rights issues. WPATH thus supports sexual, gender, and transgender mental health. WPATH also supports collaboration with community-based guidelines such as the Vancouver and British guidelines to develop best practices of psychotherapy. These practices may be individual, conjoint, family, or group.

A Section on the Use of Trans-Positive Models Consistent with Research and Clinical Experience

WPATH recognizes that conventional models of gender-identity theory and systems of psychotherapy are not necessarily consistent with the reality of transgender people's lives. As described in the recent literature, established theory may be reframed in trans-positive ways that are consistent with clinical practice. WPATH supports the development of new models or systems of psychotherapy in this evolving field.

A Section on the Benefits of Psychotherapy (Independent of Assessment and Evaluation) for the Client and on the Unique Challenges and Rewards for the Psychotherapist

The following is a more subjective exposition about psychotherapy, (thoughts from the writer's more than 30 years clinical experience) written for the person contemplating psychotherapy and for the therapist working with or contemplating working with transgender people.

For the person contemplating psychotherapy. Psychotherapy is not a prerequisite for referrals for medical interventions and, in many ways, is independent of the assessment and evaluation

requirements of the SOC. Psychotherapy involves a deeply interpersonal and subjective relationship between two people—the client and the therapist—focused on the expressed needs and goals of the client during a usually transitional (in the broadest sense of the word) period of the client's life. This involves a process of (Pfäfflin, 2007) listening closely: acknowledging the distress, fears, and hopes of the client, and together exploring the direction to take. This may, under some circumstances, include assessment and referral but does not do so in any substantive way.

The transgender person seeks therapy for the same reason as does anyone else—to sort out difficulties within a compassionate, safe, nonjudgmental, and neutral environment. Yet, the transgender path involves a unique journey, one with quite specific potential obstacles. The transgender specialist knows a good deal about this particular path and can help the client negotiate the difficulties along the way.

Specific challenges include finding and hearing one's authentic voice and learning to express an identity and negotiate relationships independent of external pressures, both from the wider community and even from within the transgender community. With more available choices and individual variation along the transgender path, the importance of the safety within the therapy relationship to sort out myriad options cannot be overestimated.

A major aspect of healthy identity development involves being seen and mirrored authentically, and for the transgender person, this may occur for the first time in psychotherapy. An identity does not develop in a vacuum, yet for many transgender people, their sense of self in a gendered way has developed in secret inside their own mind and hasn't had the opportunity to be in a relationship. As alluded to in earlier sections (see Bockting & Coleman, 2007; Ettner, 2007; Fraser, 2003; Lev, 2000; Pfäfflin, 2007), the therapy environment provides a space to develop the client's authentic narrative—a space to be seen, heard, and mirrored, without stigma, with compassion and to even retrieve, in Ettner's words, the lost soul. As Pfäfflin (2007) mentions, it also provides the space for the instillation of hope, one of the foremost tasks of psychotherapy.

Depending upon the situation and the needs of the client, a good therapist is a mirror, a guide, an ally, an advocate, and one who provides a steadying hand and stable consistent image that can be internalized during the therapy and beyond. The benefits can last indefinitely.

For the clinician. This evolving field offers unique challenges, and when working in the spirit of the standards and under the canons of ethical practice, it offers extraordinary rewards. It is pioneering, interdisciplinary, challenging, creative, and operates on the frontiers of the human endeavor. Gender is central to human identity. Working with people who are examining their gender identities offers the therapist the opportunity to bear witness to some of the most profound and ultimately satisfying transformations extant in the mystery.

As Ettner (2007) has suggested, "provider[s] working with transclients need to forswear nearly every timeworn sacred canon of allopathic Western medicine" (p. xxiii), since there is no observable disease, diagnostic test, or organ deficiency. She suggests the metaphor of "soul retrieval," where the clinician, during the therapy, helps retrieve and return the lost essence of the person. Consistent with this spirit, is Lev's (2004) earlier description of the therapist as midwife or Pfäfflin's (2007) advice on the importance of individualized treatment, listening, challenging established models, recognizing the basic human need of wanting to be understood.The therapist is called to examine his or her own preconceived ideas about sex and gender to be able to do this deeply personal work. In terms of general knowledge, the therapist must have both general and specific knowledge, the general including knowledge of general psychotherapy and assessment as well as knowledge of co-morbidity issues.

Specifically, the therapist needs to understand general sexual identity development and transgender identity development and, moreover, be able to challenge conventional theory. The work demands a comfort with the frontiers of gender theory as well as a certain creativity and imagination. What is seen in the consulting room is

rarely consistent with established nonspecialist literature. The work challenges the clinician to develop new models or frame conventional models in trans-positive ways to mirror and bear witness to the real human beings seen in practice.

An open-minded, flexible therapeutic approach is implicit and explicit in the Standards. Much is unknown, gender identity is at bottomline a mystery, etiology of transgender identity is unknown (Pfäfflin, 2007), gender and transgender have multiple meanings contingent on culture and individual circumstance. Gender operates on a spectrum and transgender clients can have multiple outcomes. The importance of an open minded therapist stance cannot be overestimated.

Moreover, the field requires more than a little interdisciplinary knowledge of other fields, not just psychotherapy. Gender is a multidisciplinary construct central to biology, medicine, law, sociology, political science, and anthropology, among others. The therapist works with multiple disciplines and providers—with surgeons, endocrinologists, family practice physicians, lawyers, speech therapists, and electrologists, among others—following best practices of overall care. Moreover, the therapist is also called upon to do human rights work, advocacy, training, teaching, and consultation—all consistent with the vision of the Association. The work takes one across national and international borders. It is creative, pioneering, and multidisciplinary.

Whether going outward to do social justice, teaching, or advocacy, or inward to do theory-building or writing, the clinician ultimately goes back to the heart of psychotherapy, bearing witness in the encounter with another human being in the liminal space of the consulting room.

It is this relationship that is the center of clinical work. Ultimately, it is this transformative relationship at the heart of therapy that provides the greatest rewards for both the client and the clinician. For therapists interested in pioneering and creative endeavors and wanting to work with remarkable people, the field offers extraordinary challenges and rewards. For transgender people, psychotherapy with a knowledgeable, compassionate clinician offers the potential for a more individuated and meaningful life.

A Section on the Potential Use of Technology for Training and Therapy

Consistent with WPATH's vision and mission statements and Dr. Coleman's prescriptions regarding access, education, and training, future directions might include e-training and e-therapy. With the arrival of more sophisticated and secure technologies, worldwide training and psychotherapy might be done by way of the Internet.

Specialized training. WPATH cannot ignore the importance of specialized training (Lev, 2009/this issue). Although this task is both major and ongoing, WPATH needs to consider taking the leadership of this important project, one that would develop standards and content to train or supervise clinicians as gender specialists. WPATH clinicians could do the training or be supervisors to local, culturally competent, affordable clinicians. It is outside the scope of this article to develop standards for training, but the following is a brief outline of subjects to be addressed:

- Define clinical competence and provider qualifications.
- Develop WPATH training manuals utilizing known information.
- Develop supervision requirements, potentially by WPATH members (either locally or online).
- Use training manuals already in place, such as the excellent Vancouver model described in this article, tweaked to be culturally competent for local use.
- Work with local mental health communities to establish cultural competence and affordability.
- Expand or extrapolate from the Vancouver model of working with local communities to develop guidelines with more clinician/community partnerships.
- Use the power of the Internet for developing training manuals and offering supervision to local clinicians.
- Gather more information about MHF (Mental Health Facilitator). This is an interesting model being developed by the International Division of the National Board

for Certified Counselors (in the United States) where the trainee isn't a clinician but is an educator, medical person, or helping professional who gets specific training in mental health facilitation. The model takes advantage of skills and competencies of culturally knowledgeable local people who then provide mental health services. WPATH clinicians could add specialized training in transgender care (see http://www.nbccinternational.org/mhf).

E-therapy. Moreover, along with e-training, the *SOC* needs to address the potential use of the Internet to provide services of e-therapy to increase global access for the mental health needs of transpeople. Information on this topic is outside the scope of this article but will be addressed in the article on e-therapy (Fraser, in press). A summary of the e-therapy recommendations might be included as one of the recommended additional paragraphs in the psychotherapy section of the *SOC*.

CONCLUSION

Given the new directions taken by WPATH's leadership and the current literature and gaps in the literature, the following provide a summation of recommendations for the psychotherapy section of the next revision of the *SOC*:

1. Minor changes to the current *SOC* to reflect recent trends and
2. Additional paragraphs to cover the following topics:
   - New paradigms, transgender diversity, and the transgender spectrum,
   - Culture and its ramifications for psychotherapy,
   - Collaborative approaches,
   - Use of trans-positive models consistent with research and clinical experience,
   - Benefits of psychotherapy independent of assessment,
   - Unique challenges and rewards for the therapist, and
   - Potential use of technology for therapy and training.

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