Thoughts on the Standards of Care

by Reid Vanderburgh, MA

I have often been asked (by trans and non-trans people alike) my opinion of the Harry Benjamin Standards of Care (SOC) for appropriately and effectively working with trans people. I have mixed feelings about the SOC, in any of its various iterations. While I realize the SOC was initially developed to help shepherd trans people safely through this profoundly life-transforming process, to provide as much support as possible, I have always had rather vague misgivings about its structure and presentation.

To take the pro-SOC position first… I feel it's virtually impossible to grow up trans in this culture without incurring emotional and/or psychological damage along the way. Both as a therapist and a transman who grew up in this culture, I have some knowledge of what kinds of damage to look for in clients, how the damage occurs, and how to help clients transcend its effects. I view that as a primary part of my job when working with trans clients. My other main goal with trans clients is to facilitate a process of deep self-knowledge, from which the client will be best prepared to make good decisions about how they want to live their lives. From this point of view, it seems quite natural to require clients to undertake a course of therapy prior to beginning a physical transition.

Further, I believe there are rare instances (let me repeat: *rare*) when a client may have seized on gender dissonance as the reason for their extreme discomfort living in their bodies, when in fact there may be other causes for the discomfort, such as the residual effects of extreme child sexual abuse. It seems to me that in addition to the risk of developing Dissociative Identity Disorder, such people are at risk for latching onto Gender Identity Disorder in their extreme need to become anyone other than who they are, because as children, their very lives were in jeopardy as long as they remained who they were. The key question here is whether the client is trying to transition in order to become more fully who they are, or are they trying to become someone else. A competent therapist should be able to distinguish between these two very different motivations.

Now for my anti-SOC position… Despite my belief that therapy can be extremely beneficial to trans people, I do have reservations about the SOC, the most obvious being that few therapists understand gender identity well enough to be considered competent in this arena. Trans people know this quite well, having encountered more than their fair share of therapists who just didn't "get it." (Two of the three therapists I saw early in my transition process just didn't get it.) Given this situation, it seems most unfair (and borderline unethical) to require therapy when the practitioners often understand far less about the condition than their trans clients. In essence, this situation results in the client paying to educate their therapist. The SOC contains the mandate that the therapist be competent in the area of gender identity, however, clients are often forced to see therapists who don't meet this criteria, simply because of geographical limitations and the scarcity of therapists competent to work with trans issues.

In addition to this fairly obvious reservation, I have always had a deeper uneasiness about the actual structure of the SOC and have only recently been able to pin down the source of my uneasiness. In my own experience, I needed very little time in therapy before realizing who I was

and what I needed to do in order to finally become a self-actualized, fulfilled adult. Despite the fact that I'd repressed my gender dissonance throughout my adult life, once my blinders were stripped off, I needed very little time with a therapist in order to make competent decisions about my life.

Granted, part of the reason I needed so little time is that I had a competent therapist who did understand gender identity, so I reserve these comments to apply only to those situations where a client is working with a therapist who "gets it." Now, the amount of time needed in therapy varies a great deal from client to client, but it has been my experience that if a client is given tools of self-knowledge, those tools can be applied by the client to any life situation with or without the intervention or assistance of a therapist. Is it *helpful* to have an ally or witness to this process? Absolutely. But is it *necessary*? Not really, for those with sufficient ego strength and self-knowledge to be able to make their own life decisions.

I was given an exercise by my gender identity therapist that enabled me to get to know all my various sub-personalities, have a dialog with them whenever I would reach a crossroads in life, and thus make good decisions for myself throughout my life. As with any good therapist, mine had given me a tool that enabled me to be my own therapist in the future, when it came to making life decisions that were in my best interest.

Trans clients will tell their therapist that they always felt "different," and often that they knew the difference they felt had to do with an inappropriate gender identity assignment given them at birth. What I found myself, and have observed in other trans people, is that the real need for therapy, the real value, came *after* my physical transition. I found myself in uncharted territory, for which my early training and socialization had ill-prepared me. While I had always felt different, I had no idea what to do, what would happen, if that difference were suddenly alleviated. We are not accustomed in this culture to viewing gender as malleable, and thus have no idea what the boundaries are. When it comes to gender roles, what is reality and what is social construction? Trans people must answer these questions in every life context, as gender permeates all our interactions as social creatures. We learn a new gender role, but this time, as adults with full consciousness that this is what we're doing. The first time around, as small children, we weren't aware that we were *learning*. We were just *being*.

In considering transition as a long-term process, I am reminded of one of the differences between Freud's stages of development and those of Erikson. Freud's stages stopped at the end of adolescence, as if adults don't develop once they are done with puberty. Erikson recognized that people *never* stop developing, and that there are different stages of adulthood as there are different stages of childhood. The current SOC view transition as ending with the final surgical procedure, and don't address the tremendous pressures exerted on the individual as every relationship in their lives goes through a maëlstrom of change: Coming out to people, dealing with other people's varying reactions over time, dealing with frustrations and disappointments, dealing with living a new gender role, dealing with feelings of "now what?" The list goes on and on.

None of these issues can be dealt with prior to the beginning of physical transition, just as a child cannot deal with any of the life stage issues that adults over 40 face. The SOC only addresses the psychosocial pressures a pre-transition person faces, and does not address the fact that the post-

transition pressures are *at least* as great. In my experience, personally and professionally, the *post*-transition individual may be in greater need of the therapist ally/witness than the *pre*-transition individual.

Despite the recent revisions in the SOC, making it easier for a person to tailor their transition to suit their own personalities and life desires, I have not seen any move toward developing an SOC that views transition as a long-term adjustment process. I would like to see more emphasis on making clear to the client that issues are going to come up *post*-transition that cannot be foreseen or dealt with *pre*-transition, and that competent post-transition therapy (at least once in awhile) might be a good idea.

Unfortunately, no one has yet developed a transition model parallel to Erikson's, outlining the stages of development one might expect *post*-transition. Until such a model is in place, "competent therapy" is going to mean simply recognizing that there are going to be post-transition issues to deal with, and "rolling with the punches" as the unforeseen happens to our clients. What I tell clients is, "Expect change, but don't expect to know in advance what the changes will be or where they'll come from or where they'll lead."

My reservations about the SOC, then, have less to do with their existence than with their scope, which seems to focus on the issues that come up for a client pre-transition rather than recognizing that issues are going to come up at various stages of life both pre- and post-transition.

Developed in the early 1990s, the Health Law Standard (HLS) takes an entirely different approach from the medical-model paradigm of the original SOC. Rather, HLS takes an informed consent approach, and is written in the form of a contract between client, doctor, and legal spouse. Clients sign the HLS, indicating they understand and take full responsibility for all risks inherent in the transition process. Once they have signed the HLS, they may access hormones and any surgical procedures related to transition, bypassing the therapeutic process altogether if they so choose.

Recent iterations of the SOC have shifted away from the medical model. The HLS completes this process. While I appreciate the paradigm change, I feel that many people who transition could benefit greatly from working with an experienced gender identity specialist. I would like to see more value placed on the therapeutic relationship. As with the SOC, the HLS focuses on the pre-transition process, making clear that the burden of decision and ultimate responsibility rests with the client and no one else. While true, this still does not address the fact that the post-transition adjustment and resocialization process often causes as much psychoemotional distress as the original need to transition. What I have found among my own clients is that this distress has caused more than one to wonder if they were "doing transition right," or to question whether they'd made the right decision. They had not talked of these feelings with friends (particularly friends who had already transitioned), fearful of being judged or criticized. Only through my work with many trans people have I been able to conceptualize this as a common feeling among those in the early-to-middle stages of transition.

I am troubled by the following paragraph in the HLS, and disagree with the last statement:
"The Health Law Standards of Care were developed in the wake of widespread dissatisfaction by many in the transgender community with the Harry Benjamin Standards of Care. Also relevant is the pending de-listing of transsexualism per se as a mental disorder from the DSM-IV. Many, if not most, of the

patients doctors see for gender medical services (hormones; surgery) do not require any psychological services."

While I don't view being trans as a psychological pathology, it is misleading to make claims about the numbers of people who may or may not "need psychological services." Nor would it be helpful to those who do benefit from therapy, or who might find it helpful, to read this kind of blanket statement.

I understand the dissatisfaction many trans people have felt, seeing the current SOC as nothing more than a series of road blocks set up by well-meaning but less-than-helpful gatekeepers. I felt similarly about the first two therapists I saw early in my own transition process. Nevertheless, I feel a *competent* gender identity specialist can be of enormous benefit to many trans people, and can make their transition path easier than it would otherwise be.
I would like to stress again the word "competent," meaning: A therapist who understands transition as a process of identity emergence, not as a medical intervention to "cure" a psychological disorder. If there are no local therapists who fit this description, a transitioning individual is better off with a good social support network than seeing a therapist who "doesn't get it." In this situation, I would agree with the use of the HLS. However, that is not the same thing as saying all (or even most) of the trans people in this situation would not benefit greatly from a good therapeutic relationship. The best possible scenario is to have both – social support, *and* a good therapist.

At some point, gender identity disorder (GID) will be removed from the DSM, a move that is long overdue. At that point, I foresee a convergence between the SOC and the HLS, some new agreement or protocol that brings the two together. If one reads the HLS and recent version of the SOC, it is clear that the tone of the two are similar. Neither *require* therapy in order to proceed with transition; the SOC simply suggest therapy as a good idea – a suggestion I agree with.

I would hope that removal of GID from the DSM will soften the resistance so many trans people feel toward seeking out therapy when their transition process throws them a curveball. If GID is not in the DSM, it is far less likely that newly-trained therapists will try to make trans identity the presenting issue. The removal of homosexuality from the DSM in the early 1970s resulted in precisely this sort of shift, away from pathologizing sexual orientation and toward a model of helping people accept themselves, deal with homophobic attitudes within their families, etc. While there are still conservative (usually fundamentalist) therapists who attempt to "cure" homosexuality, this is not the mainstream standard within the profession, nor is it considered an ethical treatment. Within my profession, sexual orientation is now viewed as a fixed identity, not as an issue of behavior. I believe that over time, the same will be true when discussing gender identity.