



## TCARE: Transgender Care Advocacy Research & Education

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*[TransActive Note: This document contains excerpts from an original paper by Sarah A. Marshall. We have taken the liberty of substituting the term "Gender Realignment Surgery" in place of "Gender Reassignment Surgery" and "GRS" for "SRS" as we believe these are more descriptive of the actual process. TransActive does not advocate any type of transgender-related hormone therapy or gender realignment surgery on pre-pubescent children, nor is there any indication that any surgeon or medical practitioner in the United States endorses, recommends or performs such procedures.]*

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### Gender Realignment Surgery: An Effective and Valuable Medical Procedure

In the United States, health care providers are usually able to offer their patients the most appropriate treatment. Any decision to proceed with that treatment is then made in confidence between the doctor and patient. Indeed, health care privacy is so important in this country that the most restrictive guidelines ever were implemented under HIPAA in 2003. In stark contrast to these trends, however, many persons outside the health disciplines [*politicians, religious figures, political activists, etc.*] have felt inclined to weigh in on the matter of gender realignment surgery (GRS) in recent years.

Gender Realignment Surgery actually consists of multiple procedures intended to adapt the primary sex organs of one sex to an appearance and functionality more consistent with the other sex. For example, for genetic males, it is possible to transform a phallus into a vagina so successfully that distinguishing a sex reassigned person's vagina from that of a natal female is very difficult (Conway, 2006). Although such a procedure may seem drastic, it has potential to help transsexuals, who identify as members of the sex opposite their birth sex. GRS is also required to update legal documents, which can be critical for avoiding discrimination in situations where IDs are required. Given that an estimated 1:250 Americans may qualify as transsexual (Conway, 2002), the possible benefits are enormous.

Determining the efficacy of GRS is therefore essential.

### **Common Objections: “It Costs Too Much”**

Although objections to GRS are raised repeatedly, they typically rely on scant evidence. One common complaint is that funding GRS would bankrupt the US health care system.

Female affirming GRS now costs approximately \$20,000 in the United States (James, 2008); however, the cumulative cost is not high compared to other procedures, considering relatively few persons request the operation, and only one procedure is usually needed. In San Francisco, which has one of the nation’s largest populations of transsexuals, a \$1.70 surcharge was added to the health insurance plans of city employees to cover the cost of GRS. This bold step resulted in a surplus of \$5.6 million after four years, and the surcharge was dropped altogether (Buchanan, 2007).

### **Common Objections: “It’s Experimental”**

Another common objection to GRS is its alleged experimental nature. In fact, gender realignment in its modern form has been performed since at least the 1930s (Ebershoff, 2000).

Today, dozens of surgeons around the world, including several in this country, perform GRS in modern, sterile hospitals (Conway, 2006).

Eric Gordon (1991, p. 72) aptly suggests GRS is in a “refining” stage: “If the medical community continues to offer the treatment, it can no longer be considered experimental.”

Serious medical complications are rare, and occur primarily as a result of poor post-operative care (Conway, 2006).

As Christine Jorgensen’s GRS surgeon Christian Hamburger noted [*in the 1950’s*], “You Americans are so childish about sex! ...Operate on the brain, perform a lobotomy, create a whole new personality—but operate on a testicle and everybody explodes!” (Jorgensen, 1967, as cited in Califia, 2003, p. 21).

Even though the exact etiology of transsexualism remains to be unraveled, there is no reason its symptoms should not be treated.

### **Common Objections: “It Doesn’t Work!”**

Opponents of GRS have also suggested it simply does not work. GRS should not be performed if more effective, less invasive alternatives exist. Fortunately, many studies have been conducted in the last several decades to address this very question.

One study by Mate-Kole, Freschi and Robin (1988) sought to compare male-to-female transsexuals at different stages in their transition:

- those awaiting assessment for surgery
- those scheduled for surgery, and
- those who are post-operative.

Subjects completed the Crown-Crisp Experimental Index in six areas:

- free floating anxiety
- phobic anxiety
- obsessiveness
- somatic anxiety
- depression
- hysteria;

Scores ranged from 1.7 to 8, and lower scores indicated lower morbidity. **Mate-Kole et al. (1988) found that for all six indicators, post-operative transsexuals scored significantly lower than the other two groups at a  $p$  value  $< .05$ .**

For example:

- post-operative transsexuals' somatic anxiety was measured at 1.7, whereas the assessment group and waiting group scored 7 and 4, respectively.
- free floating anxiety was recorded as 3 for the post-operative group, but 8 and 5.5 for the other two groups, respectively.

Although this trend did not hold true for phobic anxiety, it appears that psychological functioning improves once surgery is in sight and then even more after surgery is completed.

Another study followed 158 transsexuals who completed GRS prospectively (Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005). This approach is ideal since researchers can see how patients changed from the time they approached the clinic to one year after surgery.

The authors of the study sought to investigate:

- change in gender dysphoria
- physical appearance
- body dissatisfaction, and
- psychological functioning.

These measures were obtained using different questionnaires, such as the Dutch Short MMPI, except for physical appearance, which was assessed by three independent observers. This time, the results also strongly suggested GRS carries important benefits for transsexuals.

Gender dysphoria, which was measured on a scale ranging from 12-60, declined from 54.3 pre-test to 14.8 post-surgery ( $p < .001$ ).

- Physical appearance also improved by 10.9 points on a 70 point scale ( $p < .001$ ).
- Body dissatisfaction declined ( $p < .001$ ) for secondary, and neutral body characteristics, and even more so for the primary sex attributes. Perhaps more importantly, negativism, shyness, psycho-neuroticism, anxiety, depression, inadequacy, and sensitivity improved ( $p < .001$ ).
- Somatization, psychopathology, and extraversion all improved ( $p < .006$ ). Every measure of psychological functioning improved significantly ( $p < .05$ ), except for hostility, which was already very low when first measured (Smith et al. 2005).

**These findings are consistent with an earlier study from the Netherlands in which 90.9% of 55 male to female transsexuals had no doubt that surgery was appropriate and the other study participants had only moderate doubts (Kuiper & Cohen-Kettenis, 1988).**

### **Common Objections: “Transgender People Regret Having Surgery”**

Anne Lawrence (2003) chose to investigate transsexuals’ subjective appraisals of GRS. She distributed questionnaires to patients of a prominent American GRS surgeon, Toby Meltzer, and received 232 replies from his 1994-2000 patients. Even Lawrence, a controversial figure who has earned the ire of many transsexuals, reported that:

- “more than 96% of participants gave a positive rating to their overall happiness with their GRS result and 97% reported that GRS had improved the quality of their lives” (p. 309). Surprisingly, only two patients expressed even occasional regret.

Not surprisingly, many researchers have looked for cases in which a gender realigned person expresses regret over their change, hoping to cast doubt on the reliability of this procedure. Landen, Walinder, Hambert, and Lundstrom (1998) examined all Swedes who received GRS in that country from 1972-1998 for cases of regret.

- Of 218 subjects, only 3.8% expressed regret.

### **Risk Factors For GRS Regret**

Two risk factors for regret were identified:

- poor family support
- presence of a psychotic disorder

That someone is more likely to express regret when he or she lacks family support is hardly surprising. Furthermore, individuals with conflicting psychotic disorders should probably not be granted surgery. This paper did indicate “the need for substantial efforts to support the families and close friends of candidates for gender realignment” (p. 284).

Regretful cases are rare; when they occur, it is usually because these patients should not have been approved for GRS in the first place. Regret may also occur when someone experienced surgical complications or poor surgical results, not because GRS was inappropriate.

### **Gender Realignment Treatment & Transgender Youth**

One question that remains is whether psychotherapy is an equally effective alternative to GRS. Smith, van Goozen, and Cohen-Kettenis (2001) compared 20 adolescents who were approved for GRS with 14 adolescents who were not approved for GRS because they did not meet the clinic’s criteria. Although it is unclear, presumably the non-GRS group received other kinds of psychotherapy to address its members’ gender issues. **The GRS group of adolescents improved on all measures (gender dysphoria, body dissatisfaction, and psychological function assessed by the Dutch Short MMPI and the SCL-90) after surgery except for one aspect of the SCL-90. The GRS group also fared better than the non-surgical group on every measure.** Depression decreased for the treated group from 9.8 at the time they approached the clinic to 3.7 after surgery ( $p < .01$ ). **The non-treated group, however, only declined from 15.6 to 14.7, or less than 1 point (Smith et al, 2001).**

An important consideration raised by this discussion is the *[hormonal/surgical]* treatment of transsexual youth.

**Treating gender dysphoria at a young age may provide important benefits not available to older transsexuals.**

- Adolescents depend on cultural concepts of gender to learn how men and women are expected to act in their country. Appropriately treated young transsexuals undergo socialization as a member of their true sex *[gender]*, making them better adjusted after surgery.
- Notably, if hormonal treatment is undertaken before the onset of puberty, irreversible changes such as lowering of the voice, development of facial hair, and enlarged bone structure can be avoided, which will increase quality of life in terms of personal satisfaction and [the ability to be accepted without question as a member of their true gender.]

Moreover, sex hormone antagonists may be prescribed that effectively block puberty in transsexual youth (de Vries, Cohen-Kettenis, & Delemarre-Van de Waal, 2006). Thus, puberty can be delayed until the patient is old enough to make a reliable judgment regarding cross-sex hormones.

GRS is not recommended for everyone. Nor should a surgeon remove the appendix from a healthy patient. However, for true transsexuals, reasonable diagnostic criteria exist that make it highly likely GRS will be an appropriate, beneficial treatment. The controversy over GRS in the past several decades appears to reflect cultural and religious factors, not medical or psychological ones.

Ideology should not be allowed to intrude on excellent health care. Doctors and mental health professionals are better suited to determine appropriate medical care for [transgender individuals] than politicians. Liberals and Conservatives should defend the right to doctor-patient confidentiality and respect the best judgment of qualified health professionals. Although medical ethics can be complex, in this case, GRS appears to provide substantial benefits to the patient not available elsewhere. The evidence leads to one incontrovertible conclusion: gender realignment surgery is a necessary and valid medical procedure that health providers should make more accessible and affordable.

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