Sex reassignment therapy

Sex reassignment therapy (SRT) is an umbrella term for all medical procedures regarding sex reassignment of both transgender and intersexual people. Sometimes SRT is also called **gender reassignment**, although it is a misnomer as SRT alters physical sexual characteristics to more accurately reflect the individual's psychological/social gender identity, rather than vice versa as is implied by the term "gender reassignment."[1] Most trans people simply call this process **transition**.[1]

Sex reassignment therapy can consist of hormone replacement therapy (HRT) to modify secondary sex characteristics, sex reassignment surgery to alter primary sex characteristics, and permanent hair removal for trans women.

In addition to undergoing medical procedures, transsexual people who go through sex reassignment therapy usually change their social gender roles, legal names and legal sex designation. The entire process of change from one gender presentation to another is known as transition.

Psychological treatment

The need for treatment is emphasized by the higher rate of mental health problems, including depression, anxiety, and various addictions, as well as a higher suicide rate among untreated transsexual people than in the general population.[2] Many of these problems, in the majority of cases, disappear or decrease significantly after a change of gender role and/or physical characteristics.[3]

Many transgender and transsexual activists, as well as many caregivers, state that health and health-related problems are not usually related to the gender identity issues themselves, but to problems that arise from dealing with a gender identity that does not match an assigned gender role and the related social conflicts. Many feel that the health-related problems from the gender identity conflict are much more likely to be diagnosed in transsexual people than in the general population. Transsexual people are usually required to visit a mental health professional to obtain approval for hormones and sex reassignment surgery, thus exposing the transsexual community to a higher level of evaluation for mental health issues than the general populace.

Therapists' records reveal that many transsexual people do not believe they need psychological treatment as mandated by the Harry Benjamin Standards of Care, but rather they will acquiesce to legal and medical expectations in order to gain rights which are granted through the medical/psychological hierarchy. (Brown 103) Legal needs such as a change of sex on legal documents, and medical needs, such as sex reassignment surgery, are usually impossible to obtain without a doctor and/or therapist's approval. Due to this, many transsexual people feel coerced into affirming pre-ordained symptoms of self-loathing, impotence, and sexual-preference, in order to overcome simple legal and medical hurdles. (Brown 107) Transsexual people who do not submit to this medical hierarchy typically face the option of remaining invisible, with limited legal options and, possibly, with identification documents incongruent with gender presentation.

Diagnosing transsexualism

The current diagnosis for transsexual people who present themselves for psychological treatment is "gender identity disorder." As the Diagnostic and Statistical Manual of Mental Disorders (DSM) has changed its terminology, the diagnosis of "transsexualism" has become unused in recent years. The "gender identity disorder" diagnostic label is often necessary to obtain sex reassignment therapy; however, some people diagnosed with gender identity disorder have no desire for sex reassignment therapy, particularly not genital reassignment surgery, and/or are not appropriate candidates for such treatment. While some feel that formal diagnosis helps to destigmatize transsexualism, others feel that it only adds stigma, essentially feeling that such a diagnosis is equivalent to saying something really is wrong with them. (Brown 105)

Some individuals who desire sex reassignment therapy do not have gender identity disorder, as the term is usually defined, and desire to transition for other reasons. Individuals who choose to pursue sex reassignment therapy may include homosexual people who are unable to accept their homosexuality, or who were, up until the 1970s, *encouraged* by caretakers to change their gender role; some cross-dressers who feel more comfortable dressed as members of the opposite gender, although it is important to realize that many transsexual women go through a period where they self-identify as cross-dressers; and people with certain psychiatric disorders, such as schizophrenia, borderline personality disorder, dissociative identity disorder, and Munchausen syndrome. (Brown 106–107) Most professionals believe that sex reassignment therapy is not appropriate for such individuals. (Brown 107) If sex reassignment surgery is performed in such cases, the result is usually expected to be very negative for the individual, since SRS, unlike for patients with gender identity disorder, typically does not alleviate issues for them, but rather leaves them with an intolerable body.[4]

However, some transsexual people may suffer from co-morbid psychiatric conditions unrelated to their gender dysphoria. The DSM-IV itself states that in rare instances, gender identity disorder may co-exist with schizophrenia, and that psychiatric disorders are generally not considered contraindications to sex reassignment therapy unless they are the primary cause of the patient's gender dysphoria. (Brown 108) Despite this permissiveness, the process of psychological treatment is usually much more complicated for transsexual people with co-morbid psychiatric conditions.

Some transsexual people have pressured the American Psychiatric Association to remove Gender Identity Disorder from the DSM. Many of these people feel that at least some mental health professionals are being insensitive by labeling transsexualism as "a disease" rather than as an inborn trait. Furthermore, many people have expressed concerns that in viewing transsexualism as "a disease" some psychologists and psychiatrists have sought to develop specific models of transsexualism such as Ray Blanchard's model, which may exclude many transsexual people.

Andrea James, in an article rejecting terminology and disease-models of transsexuality, has proposed the terms "*interest in feminization*" and "*interest in masculinization*" to refer to a desire for sex reassignment therapy, regardless of whether or not the person with the desire is transsexual.[5] Although James has admitted that there are numerous difficulties and issues related to this terminology and she hasn't advanced this terminology to a finalized state, she does consider it a start towards finding terminology that avoids the traditional descriptions that label transsexuality as a "disease" or a "deviant" condition.[5] Critics of James' proposed terminology insist that she has swung the pendulum too far in the other direction, now equating transsexuality to a "life-style choice" which can offend those transsexuals who feel that their condition has a biological origin. James agrees that transsexuality is not a choice, but she strongly rejects any assertion that it should be classified as a disease rather than as part of typical human variance.[5]

Other people, under the position that transsexuality is a physical condition and not a psychological issue, assert that sex reassignment therapy should be given if requested, and may even align with those who feel that all body modification should be offered on demand. (Brown 103)

Additionally, the rules or requirements for diagnosis of transexuality and sex reassignment therapy are almost always determined by non-transsexual medical personnel who have the power to allow or deny a transsexual person's will to transition, based on their own perceptions of how a transsexual person should act and/or appear. These perceptions are sometimes prejudiced or based largely on cultural stereotypes; for example, medical personnel may reject a transsexual man as a candidate based on the length of his hair, judging it to be "too long" even though many non-transsexual men like to wear long hair.

Hormone replacement therapy

For transsexual men and women, hormone replacement therapy (HRT) causes the development of many of the secondary sexual characteristics of their desired sex. However, many of the existing primary and secondary sexual characteristics cannot be reversed by HRT. For example, HRT can induce breast growth for transsexual women but cannot reduce breasts for transsexual men. HRT can prompt facial hair growth for transsexual men, but cannot regress facial hair for transsexual women. HRT may, however, reverse some characteristics, such as distribution of body fat and muscle, as well as menstruation in transsexual men. Generally, those traits that are easily reversible will revert upon cessation of hormonal treatment, unless chemical or surgical castration has occurred, though for many transsexual people, surgery is required to obtain satisfactory physical characteristics.

As with all medical activities, health risks are associated with hormone replacement therapy, especially when high hormone doses are taken as is common for pre-operative transsexual patients. It is always advised that all changes in therapeutic hormonal treatment should be supervised by a physician because starting, stopping or even changing dosage rates and levels can have physical and psychological health risks.

Although some transsexual women use herbal phytoestrogens as alternatives to pharmaceutical estrogens, little research has been performed with regards to the safety or effectiveness of such products. Anecdotal evidence suggests that the results of herbal treatments are minimal and very subtle, if at all noticeable, when compared to conventional hormone therapy.

Chest reconstruction surgery

For most trans men chest reconstruction is required to present as male. Binding of the chest tissue can cause a variety of health issues including reduced lung capacity and even broken ribs if improper techniques or materials are used. A Mastectomy is performed, often including a nipple graft for those with a B or larger cup size.

For trans women, breast augmentation is done in a similar manner to those done for cisgendered women. As with cisgender women, there is a limit on the size of implant that may be used, depending on the amount of pre-existing breast tissue.

Sex reassignment surgery

Sex reassignment surgery (SRS) refers to the surgical and medical procedures undertaken to align intersex and transsexual individuals' physical appearance and genital anatomy with their gender identity. SRS may encompass any surgical procedures which will reshape a male body into a body with a female appearance or vice versa, or more specifically refer to the procedures used to make male genitals into female genitals and vice versa.

Sex reassignment surgery is the most common term for what may be more accurately described as "genital reassignment surgery" or "genital reconstruction surgery." Other proposed terms for SRS include "gender confirmation surgery," "gender realignment surgery," and "transsexual surgery." The aforementioned terms may also specifically refer to genital surgeries like vaginoplasty and phalloplasty, even though more specific terms exist to refer exclusively to genital surgery, the most common of which is genital reassignment surgery (GRS). Another recently coined term in the medical community is Genital Correction Surgery (GCS), which emphasizes that the sex reassignment surgery is merely correcting the genitals to match the inner sense of an individual's gender.

SRS tends to be expensive and is not always covered by public or private health insurance. In many areas with comprehensive nationalized health care, such as some Canadian provinces and most European countries, SRS is covered under these plans. However, requirements for obtaining SRS and other transsexual services under these plans are sometimes more stringent than the requirements laid out in the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, and in Europe, many local Standards of Care exist. In other countries, such as the United States, no national health plan exists and the majority of private insurance companies do not cover SRS. The government of Iran, however, pays for such surgery because it is believed to be

valid under Shi'ite Belief.[6]

There are significant medical risks associated with SRS that should be considered before undergoing the surgery.

Prior to surgery, transsexual men and women are often referred to as *pre-operative* (*pre-op*); those who have already had the surgery may be referred to as *post-operative* (*post-op*) or simply identified as members of the sex to which they have transitioned. Not all transsexual people undergo sexual reassignment surgery (either because of the high cost of such surgery, medical reasons, or other reasons), although they live constantly in their preferred gender role; these people are often called *non-operative* (*non-op*).

A more modern idea suggests that the focus on surgery status is misplaced, and therefore, an increasing number of people are refusing to define themselves in terms of operative status, often defining themselves based on their social presentation instead. Many transsexual people believe that SRS is only a small part of a complete transition.

A 1998 clinical review[7] found that MTF sex reassignment surgery had positive effects on psychiatric morbidity, and that surgery may have reduced healthcare costs; However, the authors noted evidence was limited because few controlled clinical trials existed.

Requirements

The requirements for hormone replacement therapy vary greatly; often, at least a certain period of psychological counseling is required, as is a period of living in the desired gender role, if possible, to ensure that they can psychologically function in that life-role.

Generally speaking, physicians who perform sex-reassignment surgery require the patient to live as the members of their target gender in all possible ways for at least a year ("cross-live"), prior to the start of surgery, in order to assure that they can psychologically function in that life-role. This period is sometimes called the Real Life Test (RLT); it is part of a battery of requirements. Other frequent requirements are regular psychological counseling and letters of recommendation for this surgery.

Most US professionals who provide services to transsexual women and men follow the controversial Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People put forth by the World Professional Association for Transgender Health. Outside the USA, many other SOCs, protocols, and guidelines exist, although the Harry Benjamin SOCs are certainly the best known. A significant and growing political movement exists, pushing to redefine the SOC, asserting that they do not acknowledge the rights of self-determination and control over one's body, and that they expect (and even in many ways require) a monolithic transsexual experience. In opposition to this movement is a group of transsexual persons and caregivers who assert that the SOC are in place to protect others from "making a mistake" and causing irreversible changes to their bodies that will later be regretted – though few post-operative transsexuals believe that sexual reassignment surgery was a mistake for them.[8]

The requirements for hormone replacement therapy vary greatly. Often, a minimum time period of psychological counseling, or a time period spent living in the desired gender role is required. This time period of "cross-living" is usually known as the Real-Life-Test (RLT) or Real-Life-Experience (RLE). This is not always possible; transsexual men frequently cannot "pass" this period without hormones. Transsexual women may also require hormones to pass as women in society. Most trans women also require facial hair removal, voice training or voice surgery, and sometimes, facial feminization surgery, to be passable as females; these treatments are usually provided upon request with no requirements for psychotherapy or "cross-living". The most recent revision of the HBIGDA Standards of Care recognizes this limitation for some transgender people. Therefore, the SOC state that patients may be approved for hormone treatment after either a period of successful cross-living *or* a period of diagnostic psychotherapy – generally at least three months. Some doctors are willing to prescribe hormones to any patient who requests them; however, most physicians are reluctant to do so, especially for trans men. In trans men, some hormonally-induced changes may become virtually irreversible within weeks, whereas trans women usually have to take hormones for

many months before any irreversible changes will result. Some transsexual men and women are able to avoid the medical community's requirements for hormone therapy altogether by either obtaining hormones from black market sources, such as internet pharmacies which ship from overseas, or more rarely, by synthesizing hormones themselves.

Some surgeons who perform sex reassignment surgeries may require their patients to live as members of their target gender in as many ways as possible for a specified period of time, prior to any surgery. However, some surgeons recognize that this so-called real-life test for trans men, without breast removal and/or chest reconstruction, may be difficult. Therefore, many surgeons are willing to perform some or all elements of sex reassignment surgery without a real-life test. This is especially common amongst surgeons who practice in Asia. However, almost all surgeons practicing in North America and Europe who perform genital reassignment surgery require letters of approval from two psychotherapists; most Standards of Care recommend, and most therapists require, a one-year real-life test prior to genital reassignment surgery, though some therapists are willing to waive this requirement for certain patients. A recent study done on trans women has shown that a real-life test of less than one year, or no real-life test at all, does not increase the likelihood that a patient will regret genital reassignment surgery.[9] Many transsexual people opt for a real-life experience longer than is officially required, to remove any doubts they may have of whether they should undergo surgery or for financial reasons.

The requirements for chest reconstruction surgery are different for transmen and transwomen. The Standards of Care require trans men to undergo either 3 months of Real-life-test or psychological evaluation before surgery whereas transwomen are required to undergo 18 months of hormone therapy. The requirement for trans men is due to the difficulty in presenting as male with female breasts, especially those of a C cup or larger. For very large breasts it can be impossible for the trans man to present as male before surgery. For trans women, the extra time is required to allow for complete breast development from hormone therapy. Having breast augmentation before that point can result in uneven breasts due to hormonal development, or removal of the implant if hormonal breast development is significant and results in larger breasts than desired.

Controversy

In 1967, John Money, a prominent sexologist at Johns Hopkins Hospital, recommended that David Reimer, a boy who had lost his penis during a botched circumcision, be sexually reassigned and raised as a girl. Despite being raised as a girl from the age of 18 months, Reimer was never happy as a girl, and when he learned of his sex reassignment, he immediately reverted to living as a male. Money never reported on the negative outcome of Reimer's case, but in 1997, Reimer went public with the story himself. His case, as well as several cases of intersexed infants with conditions such as cloacal exstrophy who have been reassigned and raised as females, suggest that gender identity is innate and immutable. Milton Diamond, the winner of the Norwegian Diversity Prize for his research efforts on behalf of transsexual and transgender people worldwide, had tracked down Reimer, discovered the failure of his sex reassignment, and exposed his case.

In 1979, when Paul McHugh became chairperson of the psychiatric department at Johns Hopkins, he ordered the department to conduct follow-up evaluations on as many of their former transsexual patients as possible. When the follow-ups were performed, they found that most of the patients stated that they were happy as members of their target sex, but that their overall level of psychological functioning had not improved. McHugh reasoned that to perform physical gender reassignment was to "cooperate with a mental illness rather than try to cure it." At that time, Johns Hopkins closed its gender clinic and has not performed any sex reassignment surgeries since then. [10]

A similar conclusion came from James Beatrice in 1985.[11] He used the Tennessee Self-Concept Scale and found no significant difference in self-acceptance among pre- and post-operative male-to-female transsexuals, transvestites and a control group. Based on further analysis with the Minnesota Multiphasic Personality Inventory he concluded "The results suggest that these transsexuals may be at risk for further deterioration of their psychological status if sexually reassigned."

Analyses of recent studies[12][13] have stressed problems with randomization, control groups, and self-report in follow-up assessments. A 1997 and 2004 review of follow-up studies by the University of Birmingham[12] concluded "The degree of uncertainty about any of the effects of gender reassignment is such that it is impossible to make a judgement about whether the procedure is clinically effective." A 2010 meta-analysis of follow-up studies[13] reported "Very low quality evidence suggests that sex reassignment that includes hormonal interventions in individuals with GID likely improves gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life. MF transsexuals may have worse outcomes than FM individuals."

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