

## **Blanchard vs. Fedoroff (April 2000)**

The document below is a debate between [Ray Blanchard](#) and [J. Paul Fedoroff](#), two Canadian “experts” associated with [CAMH](#), history’s most regressive clinic for transgender people.

It is presented as an example of institutionalized transphobia displayed by “supportive” professionals at the end of the 20<sup>th</sup> century.

The CAMH clinic turned away about 90% of adult transgender patients and had some of the most rigid requirements for treatment. Their children’s division engaged in aversion “therapy” that many considered child abuse. The children’s clinic practices were later outlawed.

In 2015, CAMH radically overhauled their trans health services and fired clinician Kenneth Zucker. Wait times and patient satisfaction immediately improved.

This clinic’s 50-year near-monopoly on nationally subsidized Canadian healthcare for trans and gender diverse people caused profound harm that will take decades to correct.

# PSYCHIATRY

## Rounds

DEPARTMENT OF PSYCHIATRY,  
UNIVERSITY OF TORONTO  
CENTRE FOR ADDICTION AND MENTAL HEALTH  
TORONTO, ONTARIO

APRIL 2000  
Volume 4, Issue 2

### The case for and against publicly funded transsexual surgery

RAY BLANCHARD, Ph.D. Head, Clinical Sexology Program, The Centre for Addiction and Mental Health and Department of Psychiatry, University of Toronto

J. PAUL FEDOROFF, MD, Co-Director, Clinical Ethics Committee, The Centre for Addiction and Mental Health, Assistant Professor of Psychiatry, University of Toronto.

#### Part I : The case against publicly funded transsexual surgery

By J. Paul Fedoroff, MD

*"All my life I wanted to look like Liz Taylor. Now I find that Liz Taylor is beginning to look like me."* – Divine

Transsexualism (TS), involving the case of a man "with the delusion of being a woman" was first reported in 1830.<sup>1</sup> The term transsexualism, as a formal disorder, appeared in DSM-III in 1980, and was removed from psychiatric nomenclature with the publication of the DSM IV in 1994.<sup>2</sup> TS therefore has the unique distinction of being one of the newest, but shortest lived, psychiatric disorders with the most radical of recommended treatments: amputation and surgical reconstruction of healthy genitals. TS is also unique for being the only psychiatric disorder in which the defining symptom is facilitated, rather than ameliorated, by the "treatment."

There is no consensus about what basic problem (if any) needs correction in TS. However, five major themes have emerged (Table 1). In my respectful opinion, none of these conceptualizations justify publicly funded surgery for psychiatric reasons. The five ways of understanding TS are as follows.

#### **TS is a delusional disorder**

Some patients with TS present with the chief complaint: "I am a man trapped in a woman's body." Since this assertion is a fixed, false belief, some experts have suggested that TS patients are delusional. If so, surgery is not justified because it simply reinforces the delusion (analogous to performing brain surgery on schizophrenics suffering from the delusion that the government has implanted transmitters in their heads).

#### **TS is an overvalued idea**

Some TS patients present with the chief complaint: "No one will love me until I have breasts." These patients often idealize stereotypic conceptions of the opposite sex leading some experts to conclude that TS patients suffer from an overvalued idea (defined as a thought shared by others in society, but held with such intensity of emotional commitment that behaviour is dominated in its service.<sup>3,4</sup> If TS is the result of an overvalued idea, then surgery is inappropriate since it aids and abets the basic pathology (analogous to performing liposuction on anorexics who think they are too heavy).



Centre  
for Addiction and  
Mental Health  
Centre de  
toxicomanie et  
de santé mentale



UNIVERSITY  
OF TORONTO

The Centre for Addiction and Mental Health was created by the merging of:  
Clarke Institute of Psychiatry  
Addiction Research Foundation  
Donwood Institute  
Queen Street Mental Health Centre

#### **Physician-in-Chief**

David S. Goldbloom, MD, FRCPC  
(Editor)

#### **Clinical Directors**

Howard Barbaree, PhD, C. Psych  
Joseph Beitchman, MD, FRCPC  
Jean Byers, MD, FRCPC  
Gloria Chaim, MSW  
Barbara Dorian, MD, FRCPC  
Luis Fornazzari, MD, FRCPC  
Dennis James, MSc  
Sidney Kennedy, MD, FRCPC  
David Marsh, MD  
Susan Morris, MSW  
Joel Sadavoy, MD, FRCPC  
Wayne Skinner, MSW  
Robert Zipursky, MD, FRCPC

#### **The Centre for Addiction and Mental Health**

250 College St.  
Toronto, Ontario M5T 1R8  
Website: [www.camh.net](http://www.camh.net)

The editorial content of *Psychiatry Rounds* is determined solely by the Centre for Addiction and Mental Health

### ***TS is a variant of normal.***

Some TS patients present saying simply: "I don't feel right living life as a woman," raising the possibility that TS can be understood as an extreme variant of gender identity. If so, then surgery is inappropriate since the condition to be treated is non-pathologic (analogous to administering testosterone to male homosexuals on the dually mistaken notion that homosexuality is a disease and that gay men are not "real men").

Recently, TS writers themselves have begun to argue that the unoperated TS phenotype is a legitimate state that does not require surgery any more than homosexuals need surgery to make their sexual orientation compatible with society's preconceptions.<sup>5</sup>

### ***TS is a lifestyle choice***

Some TS patients present with somewhat solipsistic ideological complaints about perceived sex roles. For example, female-to-male TS patients may present with the complaint: "I want people to call me 'Mr.'" If TS is a voluntary lifestyle choice, then publicly funded surgery is inappropriate since the condition is a chosen lifestyle (analogous to prescribing anabolic steroids to athletes who want to augment their muscle mass).

This situation is not unusual. Many women decide their lives would be better if their breasts were a different shape. Similarly, many men decide they will be "less dysphoric" if they weren't bald. Neither group requires a psychiatrist to refer them to a surgeon.

### ***TS is a physical disease***

Some TS patients say: "My penis is an abnormal growth," arguing they have a body-disfiguring disease. A more plausible variant of this perspective suggests that TS patients suffer from an as yet undiscovered physiologic abnormality affecting their brains. If TS is the result of a physical disease, then it should be treated by experts in the affected physiologic system (analogous to individuals with achondroplasia who might initially present with a complaint that their hands are bigger, but who are referred to surgeons as soon as their pituitary tumour is diagnosed).

### ***Typical arguments***

It is important to note that no matter which perspective proves to be the correct one, there is not one that supports sex reassignment surgery as a "cure" for TS. Given that none of the conceptualizations of TS described above are ethically consistent with publicly funded surgery, the question arises as to how anyone could argue for it? I will now deal with the typical arguments in order to show how they are fatally flawed.

#### ***1. People with TS ask for the surgery.***

This is true. However, many psychiatric patients ask for interventions that are not in their best interests. We

do not help anorexics lose weight just because they ask for it.

#### ***2. People with TS say they are pleased with the surgery.***

This is partially true. Most reviews of post-surgical TS patients report "good outcomes" in 70%-90% of respondents.<sup>6</sup> However, there have been no scientifically conclusive follow-up studies. As a case in point, in the most recently published follow-up study<sup>7</sup> involving a three-year follow-up of 47 male to female patients who underwent transsexual surgery, only 28 patients (60%) were contacted, and only 11 directly (23%). Three are known to have died: one in a motor vehicle accident (details not disclosed), one from AIDS, and one from suicide in jail. Of the survivors, "all 28 expressed that they felt better from surgery." However, of those who said that orgasm was "very important for sexual satisfaction" (n=14), only four (29%) reported inability to reach orgasm. Clearly, "satisfactory outcome" is in the eye of the beholder.

However, proponents of TS surgery have a much bigger problem to overcome than the current, inconclusive, methodologically flawed follow-up studies that have been published to date. The difficulty is that the subjects in TS surgery outcome studies are all people who have been carefully selected to be pleased with genital amputation and surgical reconstruction (according to standard criteria).<sup>8</sup> Given these selection criteria, the fact that 100% of all outcome studies do not report 100% satisfaction with an irreversible surgical procedure is worrisome. If we had treatment programs to help anorexics lose weight, or help agoraphobics stay at home, or help OCD patients wash their hands more, I predict they would all be highly rated by the survivors just as TS surgery is by its survivors.

#### ***3. The negative studies of TS outcome are methodologically flawed or politically motivated.***

This is true. All studies are subject to criticism. However, for every unsatisfactory "negative" study, an equally unsatisfactory "positive" study can be presented. This is the problem. At the same time that psychiatrists began arguing that TS surgery was a legitimate "cure," they were also arguing for clitoridectomies for females who masturbated.<sup>9</sup> However, the onus for proof of efficacy should be on the advocates of irreversible genital mutilation, not on the opponents. Many non-TS men who accepted penile implants as a cure for erectile dysfunction likely regret not waiting for the discovery of sildenafil (Viagra).

#### ***4. Nonsurgical treatments are unsatisfactory.***

This is true. Although spontaneous remissions of TS have been reported,<sup>2,10</sup> most people with this condition have a chronic course. Nevertheless, therapeutic nihilism is not an

**Table 1: Understanding transsexualism**

If	Then
TS is a psychotic illness (eg, Monosymptomatic hypochondriasis)	Surgery is inappropriate because it accepts the delusion as reality
TS is an overvalued idea (eg, Anorexia nervosa)	Surgery is inappropriate because it aids and abets the disorder
TS is a normal human variant (eg, Homosexuality)	Surgery is an individually elected choice
TS is a lifestyle choice (eg, Steroids for athletes)	Surgery is an individually elected choice
TS is a physical disease (eg, Achondroplasia)	The diagnosis should be made by experts in physical disease

indication for surgery. If TS is a psychiatric disorder, psychiatrists should endeavour to help patients with TS to live with their affliction (as we do with other chronic psychiatric disorders). If the current treatments are not always successful, we should say so. If our patients choose non-psychiatric remedies, we should advise them of the risks and offer to help them with the consequences of their decisions. However, psychiatrists should never advocate irreversible, unproven solutions to problems which are known to spontaneously remit<sup>10</sup> or which appear to improve prior to surgery.<sup>11</sup>

### 5. We can't wait until we find a cure.

This is false. Psychiatry has historically supported lobotomies for schizophrenics; hysterectomies for hysterics; and clitoridectomies for "nymphomaniacs." Given that we do not know the etiology<sup>12</sup> or prognosis of TS without surgery; given that TS patients show substantial improvement *before* surgery;<sup>13</sup> given that TS patients do not always report satisfaction;<sup>14</sup> and given that clinics which do *not* offer surgery for TS do not report worse outcomes, can we advocate surgery? Psychiatrists are first and foremost physicians. As such, we should heed the advice which has served our physician colleagues well: *Primum, Non Nocere* (First, do no harm).<sup>15</sup>

### 6. If we don't offer surgery, our patients will just go elsewhere.

This may be true. However, it is not a justification for an unvalidated surgical intervention. There may be surgeons who are willing to amputate penises and perform mastectomies on nondiseased organs without the recommendation of a legitimate gender identity clinic, but I doubt it. If these surgeons are in practice, they should

receive our condemnation. Most surgeons are dedicated to curing or ameliorating disease. They do not relish the thought of using their skills to amputate healthy organs.

### Conclusion

Currently, TS is the only psychiatric disorder for which genital surgery is the mainstay of treatment. It is the only psychiatric disorder in which no attempt is made to alter the presenting core symptom. To date, there is no definitive evidence that surgery is more helpful than anything else.

Psychiatric advocacy of TS surgery has the following effects:

- it legitimizes surgery as a solution for a (presumably) psychiatric condition
- it simultaneously pathologizes TS as a psychiatric condition and as a surgically treatable disorder
- it does not affect the core symptom (belief that one belongs to the opposite sex)
- it confirms the TS person's belief that they are abnormal, pathological, and untreatable
- most importantly, it diverts resources from finding a true cure for this disorder toward a band-aid, unproven, and potentially misguided solution.

Finally, no one who has sat across from a man who is tearfully begging to be castrated can fail to appreciate the extreme anguish that TS patients endure. However, we also sit across from patients with Munchausen's syndrome who plaintively beg for the same procedure. Both would be "happier" if referred for surgery, but I maintain that our response should be the same: to humanely and respectfully save our patients from the consequences of their disorder, even if it means admitting we don't have a cure...yet.

## Part II: The case for publicly funded transsexual surgery

By Ray Blanchard, Ph.D.

In his thoughtful presentation in Part I, Dr. Fedoroff has raised a number of issues about sex reassignment that merit serious consideration. I will attempt to respond to his specific points and to defend the standard view of mental health professionals involved in the clinical management of gender-dysphoric patients.

### Nosological position of transsexualism

#### *Transsexualism is a short-lived diagnosis*

Transsexualism (TS) is an ancient and wide-spread phenomenon. The hijras of India, for example, are a traditional community of men who dress and live as women and earn their living as entertainers, in particular, by singing and dancing at weddings, childbirth celebrations, and so on. Acceptance into the hijra community involves ritual castration and penectomy.<sup>16</sup>

TS was first recognized as a specific psychiatric disorder in the DSM-III. The diagnostic label, "transsexualism" was eliminated from the DSM-IV in favor of the broader term, "gender identity disorder," which applies to all persons who would previously have been diagnosed as transsexuals, as well as those with milder or remitting forms of gender dysphoria. This terminological change was a consequence of the effort to harmonize the diagnostic criteria for gender identity disorders in adults and in children (whom one would be reluctant to label as "transsexual"). Thus, TS has not been "removed" from the DSM, as is sometimes misunderstood; it has simply been renamed. The ICD-10, which also lists gender identity disorders as specific psychiatric disorders, retained the term "transsexualism."

#### *Transsexualism is a delusional disorder*

The phrase, "A woman trapped in a man's body" (*"Anima muliebris in corpore virili inclusa"*) was originally used to describe male homosexuality.<sup>17</sup> Transsexuals seized upon this phrase as the only language available for explaining their predicament to themselves and for communicating their feelings to others. The great majority of patients understand full well that this is a *façon de parler*, not a literal statement of fact, and are not delusional in any normal sense of the word.

#### *Transsexualism is an overvalued idea*

I have never heard a patient say "No one will love me until I have breasts," but if I did, I might have to concede he has the data on his side. Blanchard et al found that postoperative transsexuals with breast implants were more likely to be cohabiting with a male partner.<sup>18</sup> Leaving aside my specific response to Dr. Fedoroff's specific example, I do not think TS meets the criterion of an overvalued idea. What sets transsexuals

apart from the majority is not that the majority are less invested in the idea of changing sex, but that the majority do not entertain this notion at all.

#### *Transsexualism is a variant of normal gender identity or a lifestyle choice*

These arguments have been advanced in recent years by a few transsexual activists who wish to avoid the stigma of being diagnosed with a mental disorder. The notion that TS is merely an extreme variant of gender identity is specious. The number of adults who are unsure what sex they are, or should have been, or would like to be, is vanishingly small. Gender identity is not distributed along some bell-curve, with transsexuals representing one tail of the distribution, and persons completely contented with their sex representing an equally tiny proportion at the other end.

The notion that transsexualism is a life-style choice is equally absurd. The "choices" confronting transsexuals are whether to endure a lifetime of frustration and misery, kill themselves, or risk – and often lose – their families, friends, and jobs in hopes of finding a happier life as the opposite sex. That is hardly analogous to deciding whether to rent an apartment downtown or buy a house in the suburbs.

#### *Transsexualism is a physical disease*

A few studies on homosexual males<sup>19,20</sup> raise the possibility that transsexualism might, at the neuroanatomic level, literally represent a type of intersexuality. Such a conclusion would certainly change the complexion of the nosological debate. One might then ask who is more delusional – the transsexuals who claim they are "women trapped in men's bodies" or the person who continues to insist they are not. At present, however, the empirical data are lacking to decide this matter one way or the other.

#### *Transsexualism is what?*

If transsexualism is not a delusion, an overvalued idea, a normal variant, or a lifestyle choice, then what is it? A gender identity disorder, as Gertrude Stein might have said, is a gender identity disorder. It is not, nor does it have to be, a subtype, species, or exemplar of any other psychiatric disorder, psychological state, or sociological phenomenon. It is *sui generis* and was recognized as such by the framers of the DSM-III, who placed it in its own section: Gender Identity Disorder. What forms of treatment are or are not appropriate for other types of psychiatric disorders is simply not relevant.

### Surgical treatment of TS

The clinical management of TS has always been a purely empirical, trial-and-error undertaking. Sex reas-

signment surgery has continued to be one of its treatment modalities partly because nothing better has come along to replace it and partly because the bulk of available evidence indicates that it does enable patients to live more comfortably with their gender identity disorder.

It is important to understand that, at reputable gender identity clinics, sex reassignment is not the first treatment offered to patients, but rather, it is the last. At the CAMH Gender Identity Clinic, for example, patients are required to live full-time as the opposite sex for two years before they are even considered eligible for surgery; our requirements further specify that patients must work, attend school, or perform *bona fide* charity work in the cross-gender role during this trial period, and that they must provide us with documentation proving they have done so. This requirement alone screens out the 80% of new referrals whose gender dysphoria is clearly not strong enough to merit sex reassignment, and gives the other 20% plenty of time to decide whether life in the cross-gender role is, in fact, a substantial improvement over life in their original gender role. The positive outcomes described below partly reflect the fact that mental health professionals have traditionally been very conservative in approving patients for sex reassignment surgery.

#### **Therapeutic impact of sex reassignment surgery**

Several reviews of the treatment outcome literature have concluded that sex reassignment surgery alleviates emotional distress and improves psychosocial adjustment in transsexuals.<sup>21-24</sup> Individual studies have examined various areas of functioning. Sex reassignment surgery has been shown to be associated with improvements in psychiatric symptomatology, especially anxiety and depression,<sup>25-27</sup> with improvements in patients' love relationships and sex lives,<sup>25,28-30</sup> and in their social lives.<sup>27</sup> The effect of sex reassignment surgery on patients' economic circumstances is more complicated. Better economic adjustment appears to be associated with the male gender role, regardless of the transsexual's biological sex, and regardless of whether this is the role of choice. Therefore, the socioeconomic consequences of sex reassignment are more positive for female-to-male than for male-to-female transsexuals.<sup>18,25</sup>

#### **Consumer satisfaction**

One of the most striking and consistent findings in the surgical outcome literature is the overwhelming proportion of transsexuals who express satisfaction with their decision to undergo sex reassignment surgery. Blanchard et al,<sup>31</sup> for example, investigated 111 postoperative transsexuals who had been surgically reassigned for at least one year, representing a

follow-up rate of 84%. The mean follow-up interval was 4.4 years. Only 4 patients expressed regrets, leaving a satisfaction rate of 96%.

If patients' claims of greater happiness were accompanied by objective evidence to the contrary – frequent suicide attempts, psychiatric hospitalizations, general deterioration in social relationships – one would be justified in dismissing their self-reports as the result of denial or cognitive dissonance reduction. As I indicated in the previous section, however, the objective evidence, far from belying patients' reports of satisfaction with surgery, tends to confirm them. It therefore appears that patients' hopes of a happier life in the cross-gender role are, in fact, realized.

#### **Treat or wait?**

If a non-surgical cure for transsexual feelings was within sight – say 3-4 years away – attending clinicians should and would advise their transsexual patients to wait for that cure, rather than undergo irreversible and merely palliative treatment. The reality is that we are perhaps decades away from the most basic scientific understanding of normal gender identity development, let alone any prospect of treatments that would reverse cross-gender identity in transsexual adults. To recommend to patients presenting *today* that they accept no treatment short of a "cure" is to recommend that they relinquish their hopes for salvaging a blighted and tragic life – something few of us would willingly accept for ourselves or for our families.

#### **Rationale for public funding**

The reasons for treating psychiatric disorders are so obvious that they are rarely discussed: certainly there is the alleviation of human suffering, perhaps also enhancement of patients' ability to contribute to society, or a reduction of the burden they place on their families. The ability of reassignment surgery to accomplish these goals, especially the first, compares favorably with that of many other psychiatric treatments and is therefore equally deserving of public funding.

#### **Summary**

- Transsexualism is recognized as a psychiatric disorder by the American Psychiatric Association and by the World Health Organization.
- Sex reassignment surgery is the treatment of last resort for transsexuals who cannot achieve peace of mind in their original gender role.
- There is ample evidence that sex reassignment improves transsexuals' psychosocial adjustment, in particular, their mood and morale.
- The overwhelming majority of patients express satisfaction with their decision to undergo sex reassignment.



- The fact that sex reassignment surgery is a palliative treatment rather a cure is not a rationale for withholding it.
- As an effective treatment for a specific mental disorder, sex reassignment surgery is as deserving of public funding as any other psychiatric treatment.

#### References

1. William B, Arndt J. *Gender disorders and the paraphilias*. Madison: International Universities Press, Inc; 1991:113.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> Edit. Washington, D.C.: American Psychiatric Association; 1994:536.
3. Jaspers, K. *General psychopathology*. Toronto: Toronto University Press; 1923:107.
4. McHugh P, Slavney P. Bulimia nervosa: A behavior treated through stages of change. In: *The Perspectives of Psychiatry*. Baltimore: Johns Hopkins University Press; 1998:215.
5. Queen C, Schimel L, eds.. (1997). *Homosexuals. Challenging assumptions about gender and sexuality*. San Francisco: Cleis Press.
6. Gordon E. Transsexual healing: Medicaid funding of sex reassignment surgery. *Arch Sexual Behavior* 1991;20:61-74.
7. Rahman J, Lazer S, Benet A.E, Schaefer LC, Melman A. The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Arch Sexual Behavior* 1999;28:71-89.
8. Berger J, Green R, Laub D. *Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons*. Galveston, Texas: University of Texas Medical Branch, Janus Information Center, 1977.
9. Howe JW. *Excessive venery, masturbation and continence*. New York: Bermingham & Company; 1883:111.
10. Barlow DH, Abel CG, Blanchard EB. Gender identity change in a transsexual: an exorcism. *Arch Sexual Behavior* 1977;6:387-395.
11. Blanchard R, Steiner BW, Clemmensen LH. Gender dysphoria, gender reorientation, and the clinical management of transsexualism. *J Consult Clin Psych* 1985;53:295-304.
12. Blanchard R. Preface In: Blanchard R, Steiner B, eds. *Clinical Management of Gender Identity Disorders in Children and Adults*. Washington, 1990.
13. Blanchard R. Gender dysphoria and gender disorientation. In: B.W Steiner, ed. *Gender Dysphoria: Development, Research, Management*. New York: Plenum, 1985.
14. Blanchard R, Sheridan PM. Gender reorientation and psychosocial adjustment. In: Blanchard R, Steiner B, eds. *Clinical Management of Gender Identity Disorders in Children and Adults*. Washington: APA, 1990.
15. Galen (circa 168), allegedly quoting Hippocrates, *Epidemics*, Book 1, Chapter 2.
16. Nanda S. The hijras of India: A preliminary report. *Medicine and Law* 1984;3, 59-75.
17. Ulrichs K.H. *Memnon*. Schlez: Hübscher.; 1868.
18. Blanchard R, Steiner BW, Clemmensen LH. Gender dysphoria, gender reorientation, and the clinical management of transsexualism. *J Consult Clin Psychol* 1985; 53:295-304.
19. Allen LS, Gorski RA. Sexual orientation and the size of the anterior commissure in the human brain. *Proc Natl Acad Sci USA*, 1992;89:7199-7202.
20. LeVay S. A difference in hypothalamic structure between heterosexual and homosexual men. *Science* 1991;253:1034-1037.
21. Abramowitz SI. Psychosocial outcomes of sex reassignment surgery. *J Consult Clin Psychology* 1986;54:183-189.
22. Blanchard R, Sheridan PM. (Gender reorientation and psychosocial adjustment. In: R. Blanchard, BW Steiner (eds.) *Clinical management of gender identity disorders in children and adults*. Washington, DC: American Psychiatric Press; 1990:159-189.
23. Lundström B. *Gender dysphoria: A social-psychiatric follow-up study of 31 cases not accepted for sex reassignment*. A Report from the Department of Psychiatry and Neurochemistry, St. Jörgen's Hospital, University of Göteborg. Hisings Backa, Sweden: University of Göteborg; 1981.
24. Paily IB. Outcome of sex reassignment surgery for transsexuals. *Australian and New Zealand J Psychiatry* 1981;15:45-51.
25. Blanchard R. Gender dysphoria and gender reorientation. In: BW Steiner (ed.), *Gender dysphoria: Development, research, management*. New York: Plenum Press, 1985:365-392.
26. Mate-Kole C, Freschi M, Robin A. Aspects of psychiatric symptoms at different stages in the treatment of transsexualism. *Brit J Psychiatry* 1988;152: 550-553.

27. Mate-Kole C, Freschi M, Robin A. A controlled study of psychological and social change after surgical gender reassignment in selected male transsexuals. *Br J Psychiatry* 1990;157:261-264.
28. Fahrner E.-M, Kockott G, Duran G. Die psychosoziale Integration operierter Transsexueller [The psychosocial integration of postoperative transsexuals]. *Nervenarzt* 1987;58:340-348.
29. Kockott G, Fahrner E.-M. Transsexuals who have not undergone surgery: A follow-up study. *Arch Sexual Behavior* 1987;16:511-522.
30. Kockott G, Fahrner E.-M. Male-to-female and female-to-male transsexuals: A comparison. *Arch Sexual Behavior* 1988;17:539-546.
31. Blanchard R, Steiner BW, Clemmensen LH, Dickey R. Prediction of regrets in postoperative transsexuals. *Can J Psychiatry* 1989;34:43-45.

#### Abstract of Interest

##### The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients.

RAHMAN J, LAZER S, BENET AE, SCHAEFER LC, MELMAN A.

From 1980 to July 1997, sixty-one male-to-female gender transformation surgeries were performed at our university center by one author (A.M.). Data were collected from patients who had surgery up to 1994 (n = 47) to obtain a minimum follow-up of 3 years; 28 patients were contacted. A mail questionnaire was supplemented by personal interviews with 11 patients and telephone interviews with remaining patients to obtain and clarify additional information. Physical and functional results of surgery were judged to be good, with few patients requiring additional corrective surgery. General satisfaction was expressed over the quality of cosmetic (normal appearing genitalia) and functional (ability to perceive orgasm) results. Follow-up showed satisfied (sic) who believed they had normal appearing genitalia and the ability to experience orgasm. Most patients were able to return to their jobs and live a more satisfactory social and personal life. One significant outcome was the importance of proper preparation of patients for surgery and especially the need for additional postoperative psychotherapy. None of the patients regretted having had surgery. However, some were, to a degree, disappointed because of difficulties experienced postoperatively in adjusting satisfactorily as women both in their relationships with men and living their lives generally as women. Findings of this study make a strong case for making a change in the Harry Benjamin Standards of Care to include a period of postoperative psychotherapy.

*Arch Sexual Behavior* 1999; 28:71-89.

#### Upcoming Scientific Meetings

May 13-18, 2000

##### American Psychiatric Association Annual Meeting

Chicago, Illinois

CONTACT: Tel. 202-682-6286

Fax. 202-789-8882

Email: emercer@psych.org

June 14-18, 2000

##### Beyond 2000: Healthy Tomorrows for Children and Youth

Ottawa, ON

CONTACT: Kim Tytler

Canadian Institute of Child Health

Tel: 613-224-4144 (ext. 222)

Fall 2000

##### Introductory and Advanced

##### Dialectical Behavior Therapy (DBT) Workshops

Centre for Addiction and Mental Health

CONTACT: Kathryn Parker

Tel. 416-535-8501 ext: 6791

Email: kathrynparker@camh.net

Provided as a service to medicine through an educational grant from

**Merck Frosst Canada & Co.**