Reflections on the Legal Battles Over Prisoners with Gender Dysphoria

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Momentum has shifted in the legal battles over the provision of sex reassignment surgery (SRS) for male prisoners. In 2015, two court decisions granted the operation and were not appealed by the California Department of Corrections and Rehabilitation. The author, who has participated in some of these battles as an expert, analyzes the strengths and limitations of the medical illness, developmental, and minority rights paradigms for Gender Dysphoria that are used to reach psychiatric opinions about medical necessity. Courts are influenced by the recommendation of the World Professional Association for Transgender Health (WPATH) that inmates should be treated as are individuals in the community. This is a compassionate assertion, but one not fully informed by practical experience with SRS among prisoners. Most inmates requesting SRS through litigation are serving very long or life sentences. Their backgrounds are quite unlike most transgendered individuals encountered in the community. If long-term prisoners are provided with SRS, the study of their adaptations may enable future decisions to be based on adaptation data rather than the competing opinions of experts. Gathering such data may be challenged as an experiment, however, and viewed as unethical.

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On June 26, 2015, the U.S. Supreme Court affirmed the right of gay and lesbian couples to marry.[1] This five-to-four ruling was the culmination of 50 years of organized efforts by sexual minority communities. Although most of the attention during these decades focused on homosexual persons, a quieter social change was occurring in the increasingly visible transsexual (trans) community. Public and professional views of transsexuality evolved from the 1960s perception that this phenomenon was a bizarre rare psychopathology to the current common perception that transsexuality is a discrete understandable variation of the human family and is not rare.[2] The media have reported on gender transitions since Christine Jorgenson's in 1952. Their attention and Internet access are important forces that contribute to the dramatic increase in requests by children, adolescents, and adults for gender transition throughout the world.[3–5]

These social trends have affected federal and state prisons. As a result of early lawsuits[6] and the increasing number of inmates who identify as transgendered,[7] corrections facilities are now developing policies to deal with inmates who request, often threateningly, treatment of their conditions through name and pronoun changes and access to feminine attire, estrogenic compounds, facial hair removal, and sex reassignment surgery (SRS). The major question has been whether long-term male inmates with Gender Dysphoria (see Table 1 for diagnostic criteria; Gender Dysphoria is capitalized to distinguish the diagnosis from the symptom) should have access to all the treatments that are available in the community. The request for SRS is fraught with legal, safety, clinical, political, and policy concerns. These interacting layered concerns become polarized during trials. Lawyers call their experts to testify about what is or is not a medically necessary treatment for a particular prisoner. In two separate trials in 2015, a California judge ordered SRS. Instead of appealing, the state prepared an orderly mechanism by which inmates could obtain SRS.[8]

I have been involved in the research of and care for transsexuals and their families since 1974. In the past decade, I have provided evaluations of inmates and testified in these contentious matters. I now think that when experts duel in the courtroom, each side simplifies the complexity of the debate in their desire to win. My purpose in this article is to clarify the assumptions that underlie various assertions of med-

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Table 1 DSM-5 Criteria for Gender Dysphoria in Adolescence and Adults

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Ref. 9, pp 452–3)

ical necessity and make explicit the key uncertainties that experts should have when they function in this arena. It is a sobering process to articulate psychiatric knowledge and its limitations within an adversarial process.

Testimony Rests Upon Hidden Paradigms

Mental health professionals (MHPs) in the courtroom are qualified as experts on the basis of their clinical experiences with patients with Gender Dysphoria in the community. Their experiences with these patients, some of whom have undergone SRS, are usually stated to be in the many hundreds. In the community, professionals respond to these patients with a range of interventions, from immediate support for transition services to a more cautious approach to the timing of and requirements for medical and surgical interventions. This variation, too, depends on the assumptions that professionals make about those with Gender Dysphoria. Determining the medical necessity of SRS in the community is not a simple matter for the patient or the MHP. The weightiness and irreversibility of this decision are the reasons the standards of care of the World Professional Association for Transgender Health (WPATH) have always stressed the importance of using a team of MHPs to make the decision or to require the judgment of two independent MHPs. In court settings, however, experts typically function as independent decision makers in offering their opinions. Those on each side of the issue borrow assumptions from three perspectives.

The Medical Illness Paradigm

The medical illness paradigm assumes that the diagnosis, *per se*, should determine the treatment. Once the diagnosis is determined, the treatment naturally follows. In this model, Gender Dysphoria is assumed to be comparable with illnesses such as prostate cancer. Physicians treat medical illnesses based on the patient's unique abnormal physical state. They decide what is best for the patient after considering the danger of untreated disease, the effectiveness of the treatment, its short-term and long-term side effects, economic cost, and resources available. When a disease has a well-established best treatment, the physician routinely initiates it with the patient's consent. When different treatment approaches have equal known outcomes, the patient is asked to play a greater role in treatment selection. Ideally, in all situations, the patient and physician cooperate to determine the best treatment. In prostate cancer, the physician chooses among watchful waiting, prostatectomy, external radiation, radium implants, and hormone palliation. When this paradigm is applied to male-to-female Gender Dysphoria, the argument is often made that facial hair removal, female hormones, genital surgery, rhinoplasty, augmentation mammoplasty, cricoid cartilage shaving, and liposuction are medically necessary, because each procedure may lessen subjective suffering that is inherent when there is an incongruity between the individual's male features and her consolidating feminine gender identity. This incongruity, known as gender dysphoria, is the hallmark symptom of the DSM-5 diagnosis of Gender Dysphoria.[9] Clinicians using this paradigm may consider any or all of these treatments to be as necessary as is prostatectomy to cure cancer. They often consider the new feminine identity immutable. They also view SRS to be a cure for gender dysphoria.

Gender Dysphoria is presented in courtrooms as a serious medical condition. The word medical is emphasized as though the hormonal and surgical treatments correct some underlying well-understood biologic pathophysiology. The alternative view that Gender Dysphoria is a psychiatric condition like depression that can be treated with medication is not stressed. Gender Dysphoria is, after all, the only psychiatric condition that is surgically treated. The med-

ical paradigm seems very important to the determination of medical necessity.

In the community, patient preference is the primary determinant of SRS and cosmetic procedures. Mental health professionals (MHPs) do not suggest SRS to patients as physicians may for prostate cancer. We only cooperate with the patient's request. Now that Gender Dysphoria and SRS are no longer esoteric phenomena, the transsexual narrative of the hidden woman within the man is often uncritically accepted in many circles as a fact of nature, leading some clinicians to deemphasize the individual's developmental history and to institute hormonal treatment quickly because of the diagnosis. The recent growth of attention to Gender Dysphoria is an excellent example of how societal forces create concepts of illness and acceptable forms of treatment.[10]

Not all males with Gender Dysphoria desire SRS. A physician's judgment that SRS is medically necessary begins with the patient's desire for it, not the diagnosis, *per se*. SRS decidedly lessens the distress over having male genitalia. Dysphoria over feeling insufficiently feminine and not being sufficiently womanly persists. Most litigating inmates, however, believe that their problem will be solved when SRS makes them "a complete woman." In the community, the principal reason for surgeries after SRS is the need to look more authentic (i.e., to lessen their continuing gender dysphoria).

The Developmental Paradigm

The developmental paradigm assumes that the diagnosis of Gender Dysphoria does not suggest that hormones and surgery must be provided as a medical necessity. This paradigm recognizes Gender Dysphoria to be an adaptation to an evolving problem that was first manifested as a failure to establish a comfortable conventional sense of self in early childhood. This failure may have occurred for biological reasons, such as among children with autism[11] or ambiguous genitalia,[12,13] or for reasons of misfortune, such as may occur in a home of domestic violence, psychological abuse, and neglect, as is common among transgendered inmates.

The developmental paradigm assumes that the source and the evolution of this uncomfortable and behaviorally problematic sense of self are explained by the interaction of changing biological, social, psychological and cultural forces. Since efforts to identify the inciting process that almost all individuals with Gender Dysphoria share have thus far proven elusive, rather than presuming a biologic etiology, the developmental paradigm is focused on the processes of development in childhood, adolescence, and adulthood, including those that occur in prison.

In the paradigm, the term pathogenesis is used to evoke the identity pathways to Gender Dysphoria.[14] This terminology allows for the speculation among some inmates about their evolving awareness of their past destructiveness to others; their wish to find their morally good, peaceful self; and the need to find a purpose for their lives and to have an explanation for their past problematic behaviors. During adolescence, these forces create other unstable sexual identities involving elements of gender, orientation, paraphilia, and dysfunction in partner sexual intimacies. Fluidity of the person's gender sense, as well as other aspects of identity, is noted before and after SRS; inmates change their ethnicity, sexual orientation,[15] religion, and last name, for example. This paradigm assumes that adaptations and capacities are changeable.

The declaration of the self as a transgendered person is only the latest attempt to solve the basic problem of the deeply uncomfortable self. After these declarations, inmates view their life histories as containing elements that provide conviction that they have always been that way. They now see that they have had a feminine self, struggling for expression over their false but culturally approved of masculine self.

Gender Dysphoria is a psychiatric rather than a medical diagnosis. Its origins, like other DSM-5 conditions, are complex and multifactorial and often are accompanied by other psychiatric diagnoses, so-called comorbidities. Treatment within this paradigm is based on a compassionate understanding of the individual's history, comorbidities, and motivations for the transition. The therapeutic challenge is to consider what can be done to ameliorate the patient's suffering in the cultural setting of the patient's life. Clinicians who endorse this model acknowledge the pain of gender dysphoria and urge hope, patience, and continued clarification of the forces that shape the inmate's distress, current needs, and behavior. They work with the environment to make life easier for the patient. Within prisons, this involves addressing the inmate by her preferred name, staff education, and providing female canteen items. Hormones may be recommended. This para-

digm assumes that Gender Dysphoria is more than a diagnosis; it is a pathway to a solution to an underlying problem. The wish for SRS, which waxes and wanes in some individuals, can go away. Gender Dysphoria may arise *de novo* in prisons, just as it can develop for the first time well into adulthood in the community. Ongoing psychotherapeutic investigation can, in some circumstances, help the person to face his egregious childhood physical and sexual abuse, neglect, and abandonment and the ravages of adolescent substance abuse and criminality to lessen his need to start his life over as a woman, a quest that may never be achieved. In other cases, the developmental perspective, after psychotherapeutic investigation, allows a clinician to recognize the reasonableness of SRS for this individual. A thoughtful process based in the provider–patient relationship, however, intervenes between diagnosis and treatment.

The Minority Rights Paradigm

The minority rights paradigm assumes that the treatment of Gender Dysphoria should primarily be determined by the patient's wishes, because individuals have the right to express their gender as they see fit. Comorbidity and patient capacities matter little. The basis for this view is that, for most of the 20th century, psychiatry viewed homosexual persons as having a mental illness. This attitude changed in 1976 when, upon scientific inquiry, evidence for this assumption was found to be lacking. Homosexuality was then viewed as a developmental variation of orientation rather than an abnormality. The minority rights paradigm perceives trans inmates as similarly misunderstood, marginalized, diagnosed, stigmatized, and cruelly ignored or inappropriately delayed in their medically necessary endocrine and surgical therapies. As a result, inmates are in need of a vigorous legal defense of their basic rights to self-expression and medical and surgical treatment to support that self-expression. All that is required is that a qualified MHP who endorses the Standards of Care (SOC) of WPATH verify the diagnosis, the persistence of the wish for surgery after one year of hormone treatment, and the absence of florid psychosis.[16] This paradigm assumes that SRS is a cure that, if withheld, constitutes a gross violation of the Eighth Amendment.

The dramatic national gains in minority rights during 2014 and 2015 have invariably influenced clinicians and jurists. Advocates view anyone who hesitates to support transition and SRS as a dinosaur committed to an outgrown inherently discriminatory understanding of trans persons. Civil rights considerations trump all other clinical considerations in this paradigm. Prisoners' right to SRS overrides the fact that in the community they might not qualify because of their problematic behaviors and comorbidities. The argument is that they are now mentally and behaviorally well because of maturation and institutional control. If they want it, they should have it.

Limitations of the Paradigms

The medical illness paradigm assumes the biological origins of Gender Dysphoria. As of yet, there is no definitive scientific evidence to support this assumption. fMRI studies suggested that the brains of transsexual persons are different from those of other males, but such studies have many confounders.[17]

Gender Dysphoria may initially be manifested from childhood to older age. It is known to resolve spontaneously in response to life processes. Most boys diagnosed with Gender Dysphoria of Childhood, for instance, grow up to become homosexual adolescents.[18] Despite this, many trans individuals and their therapists come to believe that they were born this way and that the new gender identity is immutable. I have seen several Massachusetts inmates and trans individuals in the community abandon their female identity after several years. Judges are challenged to separate what a particular clinician expert believes, from what a group of clinicians believe (per an interpretation of WPATH's Standards of Care), from what science has established from reports of those who have observed patients for years. In the hierarchy of trustworthy data, which is the basis of evidence-based medicine, the lowest level of trustworthiness is experience with single cases or a series of cases. Expert opinion may be based on this level of data when other sources are unavailable. Data sources with greater validity and confidence include, in ascending order: case–control series, cohort studies, randomized clinical trials, systematic reviews, and meta-analyses.[19] Other specialists have pointed out that the knowledge basis of the treatment of Gender Dysphoria has a low scientific quality.[20,21] The knowledge basis of the treatment of Gender Dysphoria is experience with cases. The ideas expressed in this article represent no more than this level of expert opinion. Certainty is not justifiable at this point.

The application of the medical illness paradigm should be considered in the light of the understanding that biological diseases occur within a social context that shapes outcome because of economic, cultural and familial influences.[22] Ideally, treatments for biological diseases are aimed at the underlying chemical and cellular mechanisms. When pathogeneses of diseases are not understood, treatments are merely directed to the symptoms. SRS for Gender Dysphoria is symptom based. It does not correct a biological abnormality.

The practical value of calling Gender Dysphoria a medical illness is to obtain insurance coverage. WPATH explains the comorbid psychiatric problems in these patients as a consequence of familial and minority societal stress, which is an oversimplification of the human tendency to have significant chronic psychological dilemmas. WPATH dissociates the idea of Gender Dysphoria from the idea of mental illness, despite the frequent symptomatic and functional impairments of those with this disorder. Many individuals applying for SRS throughout the world have definable mental illnesses. SRS does not cure the diverse functional impairments of these individuals; a socially phobic distrustful person before surgery is likely to remain reclusive and wary of others after SRS.

The developmental paradigm often is in conflict with the patients' wishes. Inmates and many community patients may not want to consider the impact of their past adversities on their limited coping capacities, their convictions about their personal distress, and what they believe is necessary to relieve it. Many inmates will not establish a therapeutic alliance unless the therapist supports the permanence of the current gender identity and the unquestionable need for hormones and surgery. These inmates often have a pervasive distrust of others and cannot conceive that they might be wrong about what would benefit them. This paradigm is also difficult to apply in prisons, because mental health services are crisis oriented and because inmates are frightened to return to their traumas for fear of being as deeply upset as they were before incarceration. WPATH no longer considers preoperative psychotherapy to be a requirement, nor does it emphasize the developmental pathway to the realization of one's transsexual nature. It is important to WPATH that the person has Gender Dysphoria; the pathway to the development of this state is not.

The final caution about the developmental paradigm is that understanding a developmental process does not mean that the patient's ambitions can be changed. Change depends in part on patient capacity to use a therapeutic relationship to grow. There is no evidence beyond anecdotal reports that psychotherapy can enable a return to a male identification, although I and other clinicians have witnessed reinvestment in maleness after relationship changes and other personal experiences. In the community, psychotherapy is a useful tool to ameliorate comorbidity and to process the many interpersonal, vocational, and sexual consequences of transition.

The minority rights paradigm, a legal political perspective, borrows the medical model to get patients their desired hormones and surgery but then denies that Gender Dysphoria is any form of illness. WPATH is the authority for this perspective. The Standards of Care portray its guidelines as scientific. It calls upon clinicians to advocate for the transgendered. Combining science and advocacy produces problems. Science provides a dispassionate view of what seem to be the facts. Advocacy aims at attaining a specific goal, and it musters the facts that support that goal. Science recognizes its own limitations; advocacy is disinterested in emphasizing the limitations of its position. The fact that the suicide rate 10 years after SRS was high is irrelevant to the minority rights paradigm.[23] The Standards of Care, for example, asserts that gender identity and orientation are two ever-distinct aspects of sexual identity and that there is no inherent problem with Gender Dysphoria. These are political, not scientific positions. Psychiatry has long fought against the stigmatization of mental illness, without denying that its diagnoses are illnesses. The Standards of Care construe all gender variations as normal outcomes of development. It views no trans person's adaptation as a symptom of mental pathology. Any concurrent mental symptoms, such as anxiety states, suicidal preoccupations, suicide attempts, or substance abuse and unempathic aggression toward others, are viewed as consequences of social rejection. It appears that once a person declares himself transgendered, she is assumed to have been victimized. Many undoubtedly are, both in the community and in prison. Clinicians should also be attentive to the patients' limitations that all human seem to have. Trans-identified persons have agency; they are not simply victims.

Gender Dysphoria in Prison Populations and in the Community

There is a special psychology, I suspect, among those who serve a life sentence. They have the need to create a life purpose and hope for themselves. Through their legal quest for hormones or SRS, they can create a self-sustaining goal to pursue and a belief that their struggle will assist others in the future. They may be proud about the lawsuit. This pride tends to enhance the sense of entitlement to demand special treatment. Some derive pleasure from knowing it causes more work for their keepers. Nonetheless, periodic emotional decompensations are common among these inmates. Ascertaining their diagnosis of Gender Dysphoria is easy compared with the accurate categorization and description of the inmates' past and current mental health, character traits, functional capacities, and motivations for gender change. The scholastic and vocational histories of most of the men I have seen or learned about are, in short, terrible. Much of this derives from their early life gender struggles, but it could not possibly be the entire explanation. Clinicians need to conceptualize inmates' personality traits rather than ignore them. Psychiatry has long been aware that difficulties in identity, self-direction, empathy, and intimacy are core aspects of personality disorders.[24]

Plaintiff experts emphasize the diagnosis, the patient's needless suffering, and the well-established ameliorative impact of surgery. Several points are not mentioned: the possible role played by a prisoner's prospect of a future of unending incarceration; the possibility of inmates misrepresenting their developmental histories, despite extensive experience with fabrication in the community,[25] in research,[26] and in medicine in general; the sexual developmental history and the patient's sexual life in prison; and the reality that SRS for a prisoner is an experiment, given the lack of research data about outcomes in this population. It is difficult to grasp that a person would sacrifice genitalia to give a new organizing purpose to life. Occasionally, however, that seems to be the case.

The Standards of Care assert that institutionalized individuals should have the same right to treatment for Gender Dysphoria that community-dwelling individuals possess.

> The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons . . . [Ref. 16, p 2].

This assertion is based on compassionate values rather than scientific study or clinical experience. This statement is presented in courtrooms to mean that inmates should have the right to SRS. The policy is at best kindhearted and at worst dangerous.

When the first prison allows SRS, each recipient will represent a psychiatric experiment with a sample of one. It would be scientifically preferable to select prisoners for SRS by an agreed upon methodology, perhaps randomized to SRS and no SRS, to insure that each operated upon person's life course is carefully documented. Unlike the follow-up problems after SRS in the community, prisoners are not going anywhere. After only five years or so, with the data in hand, clinicians will be better informed and can base their decisions on clinical experience rather than court decisions.

The problem is that experiments with prisoner subjects are highly constrained. WPATH's assertion about "institutionalized individuals" disregards the frequently encountered comorbid character pathology of many inmates with a life sentence. Character pathology may sound insulting, but it has long been part of the objective assessment process in psychiatry. Every judge faced with a decision about SRS should consider the experiment that is being disguised as a patient right.

Prisoners, of course, do not have to interact with family, friends, and coworkers and manage independent living. They often have no friend or family visitors. The Standards of Care assert that the person should have a real life experience living in society as a woman for at least one year before SRS. The positive follow-up data of operated on male-to-female patients, which is more concerning as the years go by, cannot be generalized to inmates. The argument is that living as a trans inmate is an arduous real-life experience. No one seems to suggest a one-year stay in a women's facility as a real-life test before SRS is considered.[27] Such a test might allow some trans women to realize their dislike for women, their dissimilarities from women, and the painful loss of their motivation to be sexually desired by men and enable a return of sexual desire for women.[28] On the other hand, inmates with no hope of parole can have a real-life experience only while in prison. After SRS some trans women may further consolidate their feminine identities and learn to fit in with the diverse

women's population. As a result of a consultation request, I know of one inmate in the United States who autocastrated one testis and had the other one removed. When transferred from a Texas prison to a California women's facility, she became a persistent behavioral problem with agitation and aggression that stemmed from her complaint that she did not know what her gender was. In Belgium, where euthanasia is legal, a 45-year-old postoperative patient elected to die because of the failure of his SRS; he said that every time he looked in the mirror he felt like a monster.[29]

Considerations Concerning Medical Necessity

The Insurance Industry's Concept

Defining medical necessity is a practical matter for medical insurance companies. They distinguish between treatments that they will and will not pay for. They articulate levels of influence on medical necessity: a licensed qualified health professional who evaluates and treats the patient; an insurance company that decides whether the intervention is to be covered; state and federal legislation that mandates specific coverage; and courts that rule on disputes between these parties.

The attitude of government and insurance providers is evolving. An increasing number of plans and states are extending coverage to carefully diagnosed and prepared patients with Gender Dysphoria. SRS is being covered because of the belief that it can meaningfully help the patient psychologically, if not cure the problem. This coverage represents one of the many recent gains in minority rights. Although a patient's belief alone is insufficient to justify medical necessity, patient's belief is one of the factors that create the impression that SRS is successful in the first few years.

Easing Ethics-Related Qualms of Physicians

The original use of "medically necessary" among gender specialists appeared in the1970s within the Harry Benjamin International Gender Dysphoria Association (the initial name of the organization that is now WPATH), to assuage the concerns of endocrinologists and surgeons who recognized that their interventions went against the principle of nonmaleficence (do no harm). The employment of this term enabled surgeons to remove healthy tissues to improve the subjective quality of a person's life. If the term "psychologically beneficial" were substituted for medically necessary, there might be considerably less confusion.

Four Criteria of Medical Necessity

To qualify for medical necessity, a physician recommends a data-supported reasonable procedure that can accomplish one of these four goals.

Prevent Death

Individuals with Gender Dysphoria are well known to commit suicide before and after SRS. SRS is not conceived as lifesaving but as life enhancing.[30] When patients declare that they will attempt suicide without SRS, their desperation and manipulation are separately addressed. When experts declare a prisoner likely to attempt suicide without SRS, they overlook their profession's poor track record at prediction and what else can be done to deal with the patient's depression.

Prevent Complications

Disappointment, despair, depression, and suicidal ideation are likely to follow the rejection of a request for SRS as an inmate comes to grips with the obstacles in her chosen path. Some have argued that SRS will prevent genital self-mutilation. Mutilation is far more often considered than attempted and more often attempted than completed. It is frequently a response to the inmate's sense that her identity is being ignored. As a result of increasing experience with trans inmates, such desperation is, we hope, less frequently ignored. Inmates considering this act often say that they will begin the process in the hope that the doctors will finish it. Corrections staff cannot provide SRS under these conditions.

Relieve Pain

Gender dysphoria is a form of psychological pain. As represented in court, gender dysphoria is a steady state of distress, often described as suffering. SRS relieves the dysphoria caused by the presence of male genitalia and pleases because of the female genital appearance. The patient feels more like a natal woman. It is difficult to quantify or compare this type of pain. Most preoperative trans females have learned to ignore their penis most of the time, even though its functions remind them of their maleness. In legal proceedings the pain is represented as intense, unrelenting, and interfering with the ability to

function well. All psychiatric conditions have their own form of psychological pain. I do not know how to compare gender dysphoria objectively with the diverse psychiatric diagnoses that MHPs also try to ameliorate. What is unique about male gender dysphoria is the clinical experience that any form of increased feminization can at least temporarily ameliorate it.

Improve Capacity to Function

Many experts do not find medical necessity and readiness for SRS to be difficult judgments. The Standards of Care, however, leave much room for case-by-case judgments and state that they are intended to be flexible guidelines (Ref. 16, p 2). In prisons, ascertaining medical necessity and readiness are complicated processes. The clinician is asked to articulate why he feels his patient is ready and whether the patient has worked through ambivalence about SRS. "I have no ambivalence" is a sign that the inmate is either not being honest or is dangerously without insight. It is difficult to feel from an ethical standpoint that one has provided informed consent when an inmate is certain that nothing will go wrong and that the surgery will make him complete as a woman. Postoperative transsexuals report the arduousness of translating their concept of the self as a woman into living successfully in this new role. Their adaptations leave them vulnerable to decompensations. Although this phenomenon has been well documented in Sweden in everyone who had SRS over 30 years,[23] the study did not contain a control group of those with Gender Dysphoria who did not have SRS. The study used age- and gender-matched controls from the general population (10 controls per subject). The researchers' conclusion was that individuals who have SRS should have postoperative lifelong psychiatric care. Their position was based on the need to prevent suicide attempts and completed suicides, which were 7.6 and 19 times more frequent than in the controls, respectively. In prison, the inability to function well is usually reflected in episodes of punishments and losses of work opportunities and other privileges. These delay consideration of SRS. Being happy after SRS is not to be equated with improving function. Improved function is a simple concept when it comes to incontinence after a prostatectomy, but is complicated when it applies to dealing with diverse aspects of life skills, which may not have been well developed before incarceration.

Speculations about SRS as a Cause of Future Pain

SRS is assumed to lessen the pain of gender dysphoria significantly. The possibility that SRS, after it accomplishes this goal, could lead to additional sources of crippling pain is rarely considered.

Although gender specialists have witnessed most of their patients to be happy when they are seen after SRS, it is clear from many follow-up studies that most of these individuals cannot be followed up for careful study of their adjustments over time. In studies that originally established the endorsement of SRS among gender specialists, 70 percent of patients were lost to follow-up.[31] It is possible that inmates who have undergone SRS, thus achieving their previous quest and purpose for living, will face continued incarceration and the emptiness of a life without a sustained purpose. This may be a recipe for a new form of pain and behavioral dyscontrol.

The hope is to be transferred to women's prison, which is assumed to be a happy prospect of acceptance as a woman. Such a transfer may pose significant security concerns in some cases. Female prisoners, many of whom have been victims of domestic violence and abuse, may be wary of a trans inmate with a history of violence and may keep the inmate feeling like an outsider. Living among female prisoners represents a different more relevant real-life experience than feminizing in a male environment. Postoperative inmates may discover that they are profoundly different from natal criminal women and become unhappy with their decision to transition. They may flunk their second "real life test." Many of these individuals have very poor interpersonal skills, which are not likely to be improved by SRS. If they develop a romantic attachment to another female inmate, it may lead to regret for having lost their male genitalia.

Legal battles provide inmates with a heroic purpose, because success in the courtroom will enable others to follow. The inmates attain an elevated status over other prisoners in their minds. To many peers, they are weird, but to themselves, they are special because of Gender Dysphoria. Over time, this feeling will dissipate, and they will be disappointed that others do not view them that way.

Inmates have a difficult time dealing with the possibility that SRS can create significant anatomic and functional complications. There is no guarantee of

surgical cosmetic and functional success. Individuals with poor surgical outcomes are thought to have fared worse over time than those without functional and anatomic complications.

Final Thoughts

I do not envy the role of the judge in having to make determinations about SRS. Testimony of experts can be confusing. In 2006, a federal judge asked me to be his witness in the *Kosilek* case after he had heard from both the plaintiff's and the Massachusetts Department of Corrections' (DOC) experts.[32] He wanted an opinion from someone whom he thought had "a balanced perspective." The question was whether the DOC's treatment was adequate without SRS for the inmate's disorder. The argument was that the plaintiff's Eighth Amendment rights, prohibiting cruel and unusual punishment, were being violated by the DOC's refusal to offer SRS. My report discussed the limited state of knowledge based on science in this area, the reasons for the aversion among many MHPs to dealing in depth with trans patients, and my opinion that Michelle Kosilek's social and hormonal feminization constituted adequate care. I thought that the threat of autocastration or suicide without SRS was exaggerated. I stressed the commonality of periodic suicidal ideation among prisoners and the competence of corrections clinicians to handle these emergencies. I was aware that previous lawsuits had forced the DOC to recognize the unique psychological plight of such inmates and to make accommodations that were currently available to Ms. Kosilek.[6,7] In December 2011, five years after my testimony, the judge ordered the DOC to provide SRS. The DOC appealed. In December 2014, a five-judge panel ruled three to two in favor of the DOC.[33] Thereafter, the Supreme Court declined to hear the case.

Decades ago, I summarily discharged a patient when he threatened to kill the therapist who informed him that our eight-person gender team did not recommend hormones quite yet. I informed this poorly put together man that it was not just doctors who had responsibilities to patients; he egregiously violated his responsibility to his doctor. In prison, when inmates threaten to kill a clinician, they are put in a special unit, but their Gender Dysphoria treatment is not withdrawn. Continuing crime neither cancels the inmate's right to treatment nor qualifies in the court room as evidence of continuing character pathology. The death threat understandably causes the human beings who are responsible for the inmate to limit their investment in her. A new wary therapist is then assigned. This increases the inmate's conviction that she is being victimized in yet another iteration of personality-disordered behavior.

This scenario brings us back to the specious simplicity of over-reliance on the medical illness paradigm. Threats to harm others or self, threats to sue, refusals to cooperate with existing programs, and new demands for accommodations are clinically experienced by corrections staff as manipulations. It is frequently clinically unclear where to draw the line between genuine psychological pain and the motive to annoy. Plaintiff's wishes are presented in court as medically necessary to ease the suffering. It is a far more challenging burden to explain how character pathology and gender dysphoria interact and how the sense of victimization during childhood morphs into a sense of victimization at the hands of the department of corrections. The inmate's career of victimizing others is excluded from consideration. If medical necessity were rephrased as "psychologically helpful" or "psychologically pleasing to the inmate," the experts would be asked to explain why, but employing medical necessity takes us back to a paradigm that is useful for diseases such as prostate cancer but is confusing for this culturally young, complex psychological state of suffering.

I have been an advocate of corrections MHPs developing into inmate gender specialists. It is asking much of gender experts from the community to make judgments about inmates' requests for SRS. A program to develop in-house expertise requires considerable assistance and support from the various layers of administration. I favor it for these reasons: first, the prevalence of Gender Dysphoria is much higher in prison populations than in the general population[30]; second, its incidence in that setting seems to be increasing; third, corrections MHPs can readily provide for some of the unique needs of these inmates, and they are experienced with how the inmates' character traits create behaviors; fourth, litigation paralyzes the therapeutic alliance and limits the value of counseling while it furthers the inmates' sense of being victimized; and fifth, it may be cheaper than litigation costs. However, such a program does not entirely prevent litigation, because some prisoners do not accept their staff's judgment that SRS is not in their best interest. When the precedent for inmate SRS is established, in-house gender specialists, not outside experts, will have to process these frequent requests.

When SRS begins to be offered, corrections clinicians and administrators will face the question of whether to recommend it to those who function poorly in the hope that their dysfunctional behavior will improve because of their new anatomic state, or whether to grant SRS only to those whose lives have been functionally and subjectively improved by increasing feminization. The latter is what allows clinicians to write letters of recommendation for SRS in the community. Ironically, some of these individuals delay SRS for years, and a few elect not to have SRS. Whatever corrections personnel decide, there is much to learn. Many of us only hope that legal restraints do not limit the ability of clinical science to profit from whatever happens.

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