

# Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?

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Received: 14 September 2015 / Revised: 12 January 2016 / Accepted: 18 January 2016 / Published online: 15 March 2016  
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**Abstract** Gender dysphoria (GD), a feeling of persistent discomfort with one's biologic sex or assigned gender, is estimated to be more prevalent in male prison inmates than in nonincarcerated males; there may be 3000–4000 male inmates with GD in prisons in the United States. An increasing number of U.S. prison systems now offer gender dysphoric inmates diagnostic evaluation, psychotherapy, cross-sex hormone therapy, and opportunities, albeit limited, to enact their preferred gender role. Sex reassignment surgery (SRS), however, has not been offered to inmates except in response to litigation. In the first case of its kind, the California Department of Corrections and Rehabilitation recently agreed to provide SRS to an inmate and developed policy guidelines for its future provision. In other recent cases, U.S. courts have ruled that male inmates with GD are entitled to SRS when it is medically necessary. Although these decisions may facilitate the provision of SRS to inmates in the future, many U.S. prison systems will probably remain reluctant to offer SRS unless legally compelled to do so. In this review, we address the medical necessity of SRS for male inmates with GD. We also discuss eligibility criteria and the practical considerations involved in providing SRS to inmates. We conclude by offering recommendations for physicians, mental health professionals, and prison administrators, designed to facilitate provision of SRS to inmates with GD in a manner that provides humane treatment, maximizes the likelihood of successful

outcomes, minimizes risk of regret, and generates data that can help inform future decisions.

**Keywords** Gender dysphoria · Transsexualism · Medical necessity · Sex reassignment surgery · Standards of care

## Introduction

Gender dysphoria (GD) is a psychiatric disorder in which affected persons experience severe, persistent discomfort with their biologic sex or assigned gender (American Psychiatric Association [APA], 2013). GD was previously called gender identity disorder (GID; APA, 2000).

The most extreme form of GD is transsexualism (Blanchard, 1993), which is characterized by the intense desire to live as a member of the other sex and (usually) to undergo hormonal and surgical treatment to make one's primary and secondary sex characteristics resemble those of the other sex (World Health Organization, 1992). The term transgender defines a broader category of persons who experience cross-gender identification or display significant gender-variant behaviors but who may or may not meet diagnostic criteria for GD or transsexualism (Lawrence & Zucker, 2014). Cross-sex hormone treatment and sex reassignment surgery (SRS) are widely accepted treatments for GD or transsexualism in community-dwelling patients.

In Western countries, the estimated prevalence of male-to-female (MtF) transsexualism in community-dwelling adults is about 1 in 10,000 to 1 in 12,000 (e.g., Arcelus et al., 2015; De Cuypere et al., 2007; Judge, O'Donovan, Callaghan, Gaoatswe, & O'Shea, 2014). Among male prison inmates in the United States, the prevalence appears to be significantly higher (Glezer, McNeil, & Binder, 2013). In a study conducted in the California prison system, Sexton, Jenness, and Sumner (2010) interviewed

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332 male inmates with transgender identification, out of a reported total male inmate population of 146,360; this represented a prevalence of about 1 in 440, albeit some of the inmates may not have met full diagnostic criteria for GD. More recently, Mintz (2015) reported that 385 California inmates, presumably both males and females, were receiving cross-sex hormone therapy, a strong indicator of GD. In 2013, the most recent year for which figures are available, there were 135,981 inmates, 95 % of whom were male, in state and federal prisons in California (Carson, 2014); this suggests a prevalence of cross-sex hormone therapy in California inmates of about 1 in 350. The first author, who has served as a consultant to the prison system of a large midwestern state, calculated a prevalence of transgender identification of about 1 in 500 in male inmates, based solely on the transgender inmates she had personally evaluated. Given that over 1.4 million male inmates were confined in U.S. state and federal prisons in 2013 (Carson, 2014), there could easily be 3000–4000 males with GD in U.S. prisons.

Following diagnostic evaluation, the recommended elements of treatment for GD include psychotherapy, cross-sex hormone therapy, adopting the desired gender role in everyday life, and SRS to make the individual's primary and secondary sex characteristics resemble those of the desired sex (Byne et al., 2012; Coleman et al., 2011). For males, SRS typically consists of orchiectomy, penectomy, and vaginoplasty. Not all persons with GD seek all of these treatments, but some persons with GD may need them all, including SRS, if their GD is to be effectively treated (Coleman et al., 2011).

Prison systems in the United States increasingly recognize the diagnosis of GD, provide psychological evaluation for it, and offer psychotherapy to inmates who have been diagnosed with GD. Many now offer feminizing hormone therapy to male inmates with GD, and some allow them to wear women's clothing and hairstyles and use women's cosmetics (Brown, 2014; Brown & McDuffie, 2009; Glezer et al., 2013; Sumner & Jenness, 2014). But providing SRS for male inmates with GD has been more controversial. We are aware of only one instance in which a U.S. prison system has agreed to provide SRS for an inmate (see *Quine v. Beard*, 2015). Nevertheless, the California Department of Corrections and Rehabilitation (CDCR) subsequently issued formal *Guidelines for Review of Requests for Sex Reassignment Surgery* (California Correctional Health Care Services [CCHCS], 2015), suggesting that it is prepared to provide SRS to some inmates with GD. Further, despite public and political objections to using taxpayer dollars to fund SRS for inmates, U.S. courts are now consistently ruling that prison policies that de facto prohibit SRS are unconstitutional. Accordingly, prison authorities have been forced to consider whether provision of SRS is medically necessary for some inmates with GD, which inmates should be eligible for it, and what the probable outcomes of providing SRS would be, including implications for prison assignment and security.

These questions and the conflicting opinions they evoke were recently brought into focus by four legal decisions. Two

were in the case of *Kosilek v. Spencer* (2014a, 2014b). In January 2014, a three-judge panel of the U.S. Court of Appeals for the First Circuit ruled 2–1 (*Kosilek v. Spencer*, 2014a) that the Massachusetts Department of Correction (MDOC) was obliged to provide SRS for inmate Michelle (formerly Robert) Kosilek, a biologic male with a long history of GD who was serving a life sentence without possibility of parole for the strangulation murder of his wife. In December 2014, the entire Court of Appeals for the First Circuit ruled 3–2 (*Kosilek v. Spencer*, 2014b) to reverse that decision, effectively denying SRS to Kosilek. The U.S. Supreme Court subsequently declined to hear an appeal. A third decision was in the case of *Norsworthy v. Beard* (2015): In April 2015, the U.S. District Court for the Northern District of California ruled that the CDCR was obliged to provide SRS for inmate Michelle (formerly Jeffrey) Norsworthy, another biologic male with a long, well-documented history of GD who had been serving a sentence of 17 years-to-life for murder since 1987. This decision was rendered moot in August 2015 when Norsworthy was paroled (“Transgender California inmate,” 2015). Also in August 2015, in a settlement agreement (*Quine v. Beard*, 2015), the CDCR agreed to provide SRS to inmate Shiloh (formerly Rodney James) Quine, a biologic male who is serving a life sentence for murder, kidnapping, and robbery (St. John, 2015), and to transfer Quine to a women's prison after SRS. If this agreement is carried out, it will represent the first instance we know of in which a U.S. prison system has actually provided SRS to an inmate.

In this article, we address the medical necessity of offering SRS to male inmates with GD within U.S. prisons, eligibility criteria for SRS, and related practical considerations. Our analysis reflects our experience in evaluating and treating community patients with GD, a review of the relevant literature, and the experience of the first author in evaluating more than 65 incarcerated or civilly committed males with known or suspected GD in three U.S. states.

## Standards of Care

To meaningfully discuss the question of SRS for inmates, it is essential to examine the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (SOC; Coleman et al., 2011), the most recent guidelines promulgated by the World Professional Association for Transgender Health (WPATH), and how these guidelines apply to correctional populations. The SOC have been widely adopted by physicians and mental health professionals who treat community-dwelling persons with GD, and they have been regarded as authoritative by U.S. courts in cases involving prisoners with GD (e.g., *Kosilek v. Spencer*, 2012, 2014a, 2014b; *Norsworthy v. Beard*, 2015). But the SOC are not without controversy. Although they were formulated by experienced clinicians and scholars, most SOC recommendations are based on low-quality

evidence, such as case series and expert opinion (Byne et al., 2012; De Cuyper & Vercruyse, 2009). The SOC also do not represent the experiences and practices of all GD experts, and some provisions of the SOC seem to reflect political considerations rather than scientific evidence or clinical experience (Zucker, Lawrence, & Kreukels, 2016; see also Levine & Solomon, 2009).

Moreover, the SOC were not developed based on extensive clinical experience with incarcerated persons, many of whom have histories, characteristics, and vulnerabilities that differ substantially from community-dwelling persons with GD. The earliest version of the SOC was published in 1979 by WPATH's predecessor, the Harry Benjamin International Gender Dysphoria Association (HBIGDA; Walker et al., 1990); subsequent versions were published in 1980, 1981, 1990, 1998, 2001, and 2011 (Coleman et al., 2011; HBIGDA, 1998, 2001; Walker et al., 1990). But the SOC only began to explicitly address the treatment of prisoners in the 1998 version, nearly 20 years after the original publication, and this was only to recommend that persons who had been treated with cross-sex hormones before incarceration continue to receive them in prison. In the 2001 version, this recommendation was expanded to include other treatments begun before incarceration (e.g., psychotherapy); housing considerations for prisoners were also briefly addressed.

The situation changed dramatically in the 2011 version of the SOC, which explicitly asserted that all provisions of the SOC were applicable to all persons in prisons and other institutions:

The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation... All elements of assessment and treatment as described in the SOC can be provided to people living in institutions... Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the SOC, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria... Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the SOC. (Coleman et al., 2011, pp. 206–207)

We have no disagreement with the aspirations set forth in this statement: We accept the ethical principle that living in prison or another institution does not, in and of itself, justify withholding medically necessary treatments that are available to community-dwelling persons. We also concur that, despite the complexities involved, prisons must make reasonable efforts to provide medically necessary treatments, including SRS, to inmates, and we would further emphasize that U.S. courts have consistently so ruled. Nevertheless, the unqualified statement that “all elements of assessment and treatment as described in the SOC can be provided to people living in institutions” (Coleman et al., 2011, p. 206) does not reflect extensive clinical experience. Indeed, it is fair to say that this assertion, while admirable in principle, re-

mains to be demonstrated in practice in correctional environments. Its confident simplicity may not adequately take account of the clinical and contextual complexities that inmates with GD present.

Many inmates who seek treatment for GD in prison never sought treatment in the community. Many have lived troubled, chaotic lives characterized by early family and economic instability, substance abuse and other psychiatric problems, failed school and employment experiences, and early involvement in crime. Inmates who seek treatment for GD typically display little resemblance to the patients who present for treatment in the community, and prison life bears little resemblance to life in the community. The SOC were not developed with the complexities, vulnerabilities, and life circumstances of incarcerated persons in mind.

### Is Sex Reassignment Surgery Medically Necessary for Some Inmates With Gender Dysphoria?

The medical necessity of SRS is a fundamental issue, because U.S. courts have consistently ruled that failure to provide inmates with necessary medical treatment, deliberate indifference to their medical needs, and disregard for the suffering resulting from unmet medical needs constitute violations of the Eighth Amendment's prohibition of cruel and unusual punishment (Glezer et al., 2013). We concur with the SOC's contention that SRS can be medically necessary for some, though not all, persons with GD, including some prison inmates.

In explicating our position, we emphasize four points. First, a determination of medical necessity reflects the exercise of professional judgment, but professionals sometimes disagree about the medical necessity of certain treatments—particularly SRS as a treatment for GD. Second, SRS is a safe, effective, and widely accepted treatment for GD; disputing the medical necessity of SRS based on assertions to the contrary is unsupported. Third, SRS can be judged medically necessary for some persons with GD, especially males, when their GD reflects intense distress about the incongruence between their external genitalia and their gender identity; this incongruence can only be corrected through genital surgery. Finally, other grounds for asserting the medical necessity of SRS, such as treating suicidality or depression, are more problematic.

### Determining Medical Necessity

In the United States, the term “medical necessity” is most commonly encountered in the context of the obligations of third-party payers (e.g., private health insurance companies, Medicare, and Medicaid) to cover the costs of medical treatment. The definition of medical necessity has effectively become standardized in the United States in recent years; here is one common definition:

“Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

- (a) in accordance with generally accepted standards of medical practice;
- (b) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease; and
- (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment. (Kaminski, 2007, p. 3)

Thus, a recommended treatment is considered medically necessary if a qualified professional, exercising prudent clinical judgment, determines that it is necessary. But professionals sometimes disagree about the medical necessity of certain treatments, and this has been particularly true of SRS as a treatment for GD. Disagreements about the medical necessity of SRS have historically involved most of the fundamental issues mentioned previously: Whether a recommendation of SRS is consistent with the exercise of prudent clinical judgment; whether such a recommendation is consistent with accepted standards of practice; whether SRS constitutes an effective treatment for GD, or at least some types of GD; and whether alternatives to SRS would be as likely to produce equivalent therapeutic results. Accumulated evidence has demonstrated that for all but the last of these issues, objections to the medical necessity of SRS are difficult to sustain, and arguments based on them have increasingly been rejected in U.S. court cases. At present, most challenges to the medical necessity of SRS seem to rely on opinions by some professionals that alternatives to SRS can provide equally effective, or at least adequately effective, treatment for GD.

### Safety, Efficacy, and Acceptance of Sex Reassignment Surgery

Efforts to contest the medical necessity of SRS on the grounds that it is unsafe, ineffective, or inconsistent with accepted standards of practice are unsupportable. SRS has been an accepted treatment

for GD in every version of the SOC from their initial publication in 1979 (Coleman et al., 2011; HBGDA, 1998, 2001; Walker et al., 1990). SRS, in conjunction with cross-sex hormone therapy, has repeatedly been demonstrated to be associated with substantial reduction in GD symptoms, high levels of patient satisfaction, few significant complications, and minimal instances of regret (Dhejne, Öberg, Arver, & Landén, 2014; Gijs & Brewaeys, 2007; Heylens, Verroken, De Cock, T’Sjoen, & De Cuypere, 2014; Kuiper & Cohen-Kettenis, 1988; Lawrence, 2003; Mate-Kole, Freschi, & Robin, 1990; Monstrey, Vercruyssen, & De Cuypere, 2009; Murad et al., 2010; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005).

The Departmental Appeals Board of the United States Department of Health and Human Services (DHHS) reached these same conclusions when it determined that transsexual surgery was eligible for coverage under the Medicare program (DHHS Departmental Appeals Board, 2014), reversing the conclusions of a 1981 report that had questioned the safety and efficacy of SRS. Based on expert medical testimony and a review of the published literature, the Appeals Board stated that “We have no difficulty concluding that the new evidence, which includes medical studies published in the more than 32 years since issuance of the 1981 report... demonstrates that transsexual surgery is safe and effective and not experimental” (DHHS Departmental Appeals Board, 2014, p. 8).

We would caution, however, that these favorable conclusions are derived from experience with community-dwelling patients. Although it is reasonable to assume that they would also apply to prison inmates, empirical evidence to support this assumption is lacking. SRS remains untested in incarcerated persons, who often differ in significant ways from community patients.

### Sex Reassignment Surgery for Dysphoria Related to Genital Anatomy

GD typically reflects intense distress about both one’s anatomic sex characteristics and assigned gender role, but sometimes distress about anatomic sex is particularly intense. This is recognized in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 2013), which states that the diagnostic criteria for GD can be fulfilled solely on the basis of distress related to “a strong desire to be rid of one’s primary and/or secondary sex characteristics” and “a strong desire for the primary and/or secondary sex characteristics of the other gender” (p. 452). The four previous editions of the DSM also emphasized the importance of distress related to anatomic sex characteristics, especially the external genitalia, in the earlier diagnoses of GID (APA, 1994, 2000) and transsexualism (APA, 1980, 1987). For clarity, we refer to GD that reflects intense distress about one’s genital anatomy as *genital anatomic GD*. Genital anatomic GD, like other GD symptoms, can vary in intensity over time and can sometimes remit, temporarily or permanently. But when genital

anatomic GD has been unremitting and intense over a long time period, treatment becomes necessary.

The phenomenon of severe, persistent genital anatomic GD thus explains why SRS can sometimes be medically necessary for gender dysphoric males. Only SRS can eliminate what many of these individuals find particularly distressing: their male external genitalia, which act as powerful and incontrovertible indicators of maleness. SRS constitutes a specific and singularly effective treatment for unremitting genital anatomic GD, one that offers what no alternative treatment can provide. For males in whom this type of GD is intense and persistent, including some inmates, SRS can sometimes be medically necessary, and no alternative treatments are likely to be equally or adequately effective.

Much of the resistance to offering SRS to inmates with genital anatomic GD appears to reflect doubts about the legitimacy of the GD diagnosis itself or whether the distress that these inmates report is genuine. Such skepticism is not surprising: The phenomenon of genital anatomic GD is so inconsistent with ordinary experience that it is almost impossible to adequately comprehend. Consequently, there is a tendency to minimize the distress that inmates with genital anatomic GD report or to attribute their complaints to hysteria, psychosis, malingering, or exaggeration, especially given that these phenomena are prevalent in correctional environments. It is particularly hard to comprehend reports of genital anatomic GD by males whose appearance and behavior are not recognizably feminine, because their feelings of “wrong embodiment” (Prosser, 1998) appear so inconsistent with their physical and behavioral presentations. Such inconsistency does not, however, make their distress any less real. Only the repeated experience of hearing persons with genital anatomic GD describe their anguish is likely to help others understand the psychological reality of this condition and the medical necessity of SRS as a treatment for it.

### Medical Necessity of Sex Reassignment Surgery to Treat Associated Psychiatric Conditions

SRS is demonstrably effective in treating GD, especially genital anatomic GD, in community populations (Heylens, Verroken, et al., 2014) and plausibly also in prison populations. But health professionals and attorneys commonly argue that the reason SRS is medically necessary for inmates is to prevent or treat other psychiatric conditions, such as depression or suicidality, which are assumed to be consequences of GD. Such arguments make intuitive sense, but they are problematic for several reasons.

Unfortunately, SRS is not very effective in treating associated psychiatric conditions. Community-dwelling persons with GD display an elevated prevalence of comorbid mental health problems, including mood disorders, anxiety disorders, and suicidality (Guzmán-Parra et al., 2015; Heylens, Elaut, et al., 2014), and these comorbid conditions do not significantly improve after

SRS (Dhejne et al., 2011; see also Asscheman et al., 2011). Comorbid psychiatric conditions usually do improve, at least initially, after cross-sex hormone therapy. But while subsequent SRS usually ameliorates GD and increases overall life satisfaction, it appears to confer little or no additional improvement in other psychiatric symptoms (Heylens, Verroken, et al., 2014; see also Gómez-Gil et al., 2012; Udeze, Abdelmawla, Khoosal, & Terry, 2008).

The tendency to couch arguments for the medical necessity of SRS in terms of treating depression and suicidality is understandable: These conditions are familiar, and there is little disagreement that they deserve to be treated. In contrast, GD, especially genital anatomic GD, is unfamiliar, the distress it causes is often assumed to be feigned or exaggerated, and many citizens and lawmakers believe that inmates with GD simply do not deserve SRS (Leonard, 2014). But the argument that SRS is medically necessary primarily to treat or prevent depression or suicidality is not supported by empirical evidence, and it is also problematic for other reasons.

Such an argument invites the counterargument that inmates' complaints of depression or suicidal threats or gestures can simply be manipulative and that prison authorities cannot acquiesce to them without inviting further manipulation. For example, the decision in *Kosilek v. Spencer* (2014a) contains this summary of the MDOC's position: “providing Kosilek with [sex reassignment] surgery in response to her threats of suicide would be contrary to well-established correctional practices. Inmates should not be permitted to manipulate the system utilizing a ‘do it or else’ theory” (p. 48; some internal quotation marks omitted). Moreover, arguing that SRS is medically necessary to prevent suicide could establish an unhelpful precedent, with suicidal threats or gestures becoming de facto prerequisites for SRS. We were encouraged to note that both expert consultants in *Quine v. Beard* (2015) considered relief of GD to be the primary basis for recommending SRS for Quine, with reduced risk of suicidality a secondary consideration.

### Eligibility Requirements for Sex Reassignment Surgery

According to the SOC, persons for whom SRS has been determined to be medically necessary must still satisfy certain eligibility requirements before SRS can be performed. These can be either the usual or “standard” eligibility requirements or requirements that have been modified pursuant the provisions of the SOC that permit flexibility when indicated. The six standard eligibility requirements for SRS are:

- (1) Persistent, well-documented gender dysphoria;
- (2) Capacity to make a fully informed decision and to consent for treatment;

- (3) Age of majority in a given country;
- (4) If significant medical or mental health concerns are present, they must be well controlled;
- (5) 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual);
- (6) 12 continuous months of living in a gender role that is congruent with the patient's identity. (Coleman et al., 2011, p. 202)

For most male inmates, fulfillment of all of these standard eligibility requirements should be a precondition for SRS. We believe that many inmates can satisfy all of these requirements without undue difficulty, although their ability to fulfill the requirement of living for 12 months in a gender role congruent with their gender identity remains contentious. For a few inmates, we believe that the 12-month living requirement could legitimately be relaxed or waived. For all inmates, however, we believe it would be prudent to initially impose some additional eligibility requirements, given the current lack of experience in providing SRS to prisoners.

Of the six standard eligibility requirements, two—age of majority and 12 months of continuous cross-sex hormone therapy, the latter with some exceptions permitted—are neither complicated nor controversial. Hormone therapy is recognized to be an effective treatment for GD and one that typically would already have been provided to inmates who were being considered for SRS. The other standard eligibility requirements involve more complicated considerations as they relate to prison populations.

### Persistent, Well-Documented Gender Dysphoria

Evaluating the genuineness, severity, and persistence of GD in inmates can be challenging, especially in persons who have significant comorbid mental health problems. Moreover, the phenomena to which inmates' complaints of GD are often attributed—psychosis, hysteria, malingering, and manipulative exaggeration—plausibly do account for some of these complaints. Deciding the genuineness, severity, and persistence of GD is ultimately an individual professional judgment, one that should be rendered by practitioners who are experienced in assessing both GD and comorbid psychopathology in correctional populations.

The importance of conducting a thorough evaluation of GD symptoms and comorbid conditions in inmates seeking SRS cannot be overstated. But assessment is not a quick or simple process in either community or correctional settings. In the community, mental health professionals who make primary recommendations for SRS typically see their patients on multiple occasions over several months or years in a process that often involves dozens of hours of face-to-face contact (Law-

rence, 2003). In inmates seeking SRS, evaluation of GD symptoms and comorbid conditions is ordinarily conducted by outside consultants, because prison-based mental health providers rarely have the necessary expertise and experience. In the first author's experience, evaluations for SRS in correctional settings tend to be comparatively brief. Consultants often base their conclusions primarily on self-reported symptoms of GD elicited in a single interview and seldom engage in longitudinal assessment, even though inmates typically present greater diagnostic complexity than their community counterparts.

When conducting an initial evaluation for either hormone therapy or SRS, the first author spends an average of 6 hr face-to-face with an inmate, often with follow-up telephone interviews if additional information is required. If there are inadequate grounds for making a confident diagnosis of GD, she will defer diagnosis and recommend a year or more of psychotherapeutic treatment, followed by re-evaluation if the inmate's symptoms and requests for treatment persist. The evaluation process also includes a review of records, sometimes involving thousands of pages of clinical, institutional, and legal files. The author commonly recommends formal psychological testing, and she consults extensively with clinical providers and prison staff who are familiar with the inmate's day-to-day functioning. Whenever possible, she also consults with family members and other external informants to verify the inmate's self-reported history.

Although thoroughly documenting the severity and persistence of GD in inmates is a time-consuming and often difficult process, some features of inmates' medical and psychiatric histories can contribute to greater diagnostic confidence. Foremost among these would be documented evidence (not just self-report) of GD symptoms prior to entering prison, especially if there is also evidence of previous medically supervised hormone therapy; such evidence, however, is rarely available. Other features that can contribute to diagnostic confidence include a documented history of intense and unremitting GD symptoms in prison, an absence of significant comorbid psychopathology that could complicate differential diagnosis (e.g., schizophrenia or bipolar disorder), and evidence of a positive response to cross-sex hormone therapy and whatever elements of identity-congruent living (e.g., clothing, makeup, hairstyle) have been permitted.

### Capacity to Give Informed Consent

Providing meaningful informed consent can be difficult for an incarcerated person. Inmates have limited access to current information and lack opportunities to learn about SRS from persons who have undergone it themselves. A few learn about GD, transsexualism, and SRS for the first time in prison; some are highly impressionable and are easily influenced by other inmates. Many have a simplistic or inaccurate understanding of the typical results of SRS, are unaware of potential com-

plications, and do not understand what will be required of them in terms of postoperative care and medical follow-up. Due to intellectual limitations, emotional immaturity, or severe personality disorders, some inmates have unrealistic expectations concerning life in a female gender role, either in prison or following release.

Providing informed consent for SRS does not require that candidates anticipate and consider every possible consequence of the sex reassignment process. For male inmates, however, one foreseeable consequence that deserves careful consideration is the likelihood of being assigned to a women's prison following SRS. Most inmates with GD would probably welcome this, but some might not, and a few might even decide to forgo SRS if this were a predictable consequence. A change in prison assignment after SRS could also adversely affect relationships with family members and friends. Assignment to a women's prison provides unequivocal evidence of having undergone sex reassignment. If family members and friends had not previously been aware of an inmate's desire for sex reassignment—and inmates sometimes attempt to conceal this—then assignment to a women's prison would make the inmate's circumstances obvious. While many inmates who have been incarcerated for years have lost all connections to family and community, some still have fragile threads of connection to a parent, a sibling, or a child. Disclosure could strain these tenuous but significant connections to the outside world, making inmates more vulnerable to feelings of isolation and hopelessness. The first author has observed that many inmates with GD can effectively face the challenge of disclosure to family members and friends and sometimes discover unexpected understanding and support for their desire to live as women. In other cases, however, they experience rejection. This variability in response is not unlike what nonincarcerated persons with GD encounter, but the risk of irreparable isolation is greater for inmates. On a purely practical level, transfer to a women's prison could also make visitation more challenging: Because there are comparatively few women's prisons, most inmates would probably be reassigned to a location more distant from their community of origin after SRS.

### **Satisfactory Control of Comorbid Mental Health Problems**

Eligibility for SRS is conditional on satisfactory control of comorbid mental health conditions for three principal reasons: to guarantee that candidates have met the minimal prerequisites for providing meaningful informed consent (i.e., that their reality testing is unimpaired), to establish that they have the capacity to cooperate in preoperative and postoperative care, and to ensure that they possess sufficient mental and emotional stability to cope with the changed life circumstances they will face after SRS, which will usually include transfer to the unfamiliar environment of a women's prison. All of these rationales are explic-

itly set forth or strongly implied by language in the SOC (Coleman et al., 2011, pp. 202–203, 205). Fulfillment of this standard eligibility requirement implies satisfactory management of psychoses, significant mood and anxiety disorders, dissociative disorders, and severe personality disorders.

Antisocial personality disorder (ASPD) and its most extreme manifestation, psychopathy (Hare & Neumann, 2008), deserve specific consideration. These conditions are prevalent among inmates and constitute enduring aspects of personality that are difficult or impossible to modify and challenging to manage. Some clinicians would argue that these conditions are so resistant to treatment that they can never be considered “well controlled.” It is also important to consider whether symptoms that appear to be adequately controlled in the structured environment of prison will remain so when inmates are released into the community, where sustained functional stability depends on internalized skills rather than external control. Inmates with psychopathy often engage in repeated patterns of aggression and conflict with staff and peers; they are difficult to manage and are frequently placed in disciplinary segregation for rule violations. They are commonly defiant, provocative, and litigious. Accordingly, we consider severe psychopathy a contraindication to SRS.

However, some inmates with ASPD and relatively mild psychopathy arguably can give valid informed consent and cooperate in their own care when it is in their interest to do so. A sustained history of compliance with recommended psychiatric and psychological treatment, cooperation with clinicians and prison officials, and a satisfactory disciplinary record should serve as reasonable indicators that their comorbid personality disorder does not dominate their affective, behavioral, or interpersonal functioning or impair their ability to cooperate in their own care.

As noted previously, inmates with GD not uncommonly experience depressive symptoms or suicidal ideation when treatment for GD is unavailable or when expression of their gender identity is constrained. Deciding whether these symptoms imply that comorbid mental health problems are not satisfactorily controlled is always an individual professional judgment. Eligibility for SRS does not require that comorbid mental health symptoms be completely absent, only that they do not interfere with the ability to provide informed consent, to cooperate in preoperative and postoperative care, and to face with some likelihood of success the changed life circumstances that will result from SRS. Some persons with GD who think about suicide or who are despondent about their inability to obtain treatment or express their gender identity can do all of these things.

### **Twelve Months of Living in a Gender Role Congruent With One's Gender Identity**

This is the most misunderstood and contentious of the standard eligibility requirements for SRS. Requirements of this type were first adopted over 40 years ago at the Stanford University Gender

Reorientation Program. The Stanford clinicians recognized that providing SRS was controversial, and they “were avowedly seeking candidates who would have the best chances for success so that the overall program could or would be continued” (Fisk, 1974, p. 7). They might have preferred to offer SRS only to persons who could be diagnosed as “true transsexuals”—a diagnostic category no longer considered meaningful—but this proved impossible, because candidates for SRS often misrepresented or distorted their histories, confounding accurate diagnosis. Consequently, the Stanford clinicians chose to deemphasize diagnosis per se as an eligibility criterion and instead focused on whether prospective candidates could successfully live full-time in the gender role of the other sex for an extended period—typically 1 to 3 years. Laub and Fisk (1974) argued that:

Indeed, for prognosis, it is probable that the diagnostic category is of much less importance than the patient’s preoperative performance in a one- to 3[sic]-year therapeutic trial of living in the gender role of his choice—with demonstrable economic, social, psychological, and sexual success during that period. (pp. 401–402)

Five years later, in 1979, successfully living full-time “in the social role of the genetically other sex” (Walker et al., 1990, p. 5) for 12 months became a standard eligibility requirement for SRS in the first version of the SOC. A similar requirement has been included in all subsequent versions, including the present one. Although formal descriptions of this requirement have become increasingly ambiguous over the years, language explaining the rationale and suggested parameters of this requirement actually became more detailed in the most recent version of the SOC, implying that the requirement is not considered a mere formality.

The fifth version of the SOC (HBIGDA, 1998) introduced the term *real-life experience* to describe this 12-month period of living in the desired gender role; the term also appeared in the sixth version (HBIGDA, 2001), but not in the seventh and most recent version (Coleman et al., 2011). Nevertheless, the term continues to be widely used. The current version of the SOC merely states that candidates for SRS are required to live for 12 months “in a gender role that is congruent with the patient’s identity” (p. 202). This formulation “would seem to be almost entirely open to individual interpretation” (Lawrence, 2014, p. 702) but is usually interpreted to mean living in a gender role typical of the other biologic sex.

We contend that some male inmates with GD can and do live in a gender role typical of the other biologic sex within men’s prisons and therefore can technically fulfill this standard eligibility requirement. Inmates with GD often display remarkable tenacity and resourcefulness in their attempts to live in something resembling female-typical gender roles in men’s prisons. They adopt female-typical names, vocal mannerisms, and ways of moving; they wear female-typical garments when these are obtainable and improvise them when they are not; they modify their bodies by shaping their eyebrows and shaving their faces

and bodies; and they avail themselves of permanent epilation and feminizing hormone therapy when these treatments are made available. Moreover, inmates with GD often band together in informal groups for social and emotional support, thereby receiving validation of their cross-gender identities. Within the relative safety of these groups, they can practice behaving in a more overtly feminine manner, thereby enacting the gender role that is congruent with their gender identity. Their efforts to live in something resembling a female-typical gender role often equal or exceed those of males with GD who are not in prison.

However, we question whether this standard eligibility requirement has much practical or prognostic relevance for inmates. Whether or not one believes that fulfilling this requirement contributes to greater postoperative satisfaction or avoidance of regret in community-dwelling patients—and the evidence is slim to nonexistent (Bockting, 2008; Levine, 2009)—it at least provides community patients an opportunity to experience what their lives after SRS might be like before undergoing irreversible surgery. This would not be the case for inmates with GD who attempt to live in female-typical gender roles within men’s prisons. If they were to undergo SRS, they would almost certainly be assigned thereafter to women’s prisons, where their lives would immediately become dramatically different. Living in a female-typical role in a men’s prison could not effectively prepare them for this. There is no way for inmates to know, first hand and in advance, what life in a women’s prison would be like. Inmates who would eventually be released from prison similarly would have no way of knowing what life as a woman outside of a correctional environment would be like. Recognizing these facts, some prison officials have argued that inmates with GD cannot have a meaningful experience in a gender role typical of the other sex in men’s prisons and therefore cannot fulfill this standard eligibility requirement (e.g., *Kosilek v. Spencer*, 2014a, pp. 31–32; *Kosilek v. Spencer*, 2014b, pp. 24–25, 27; *Norsworthy v. Beard*, 2015, p. 15). Other commentators (e.g., Alexander & Meshelemiah, 2010) have expressed similar opinions. In our view, their position reflects a misinterpretation of this standard eligibility requirement of the SOC; but the concerns they raise nevertheless deserve to be taken seriously.

Because inmates who undergo SRS will almost always be assigned to a women’s prison thereafter, the immediate social consequences of SRS will be far greater for inmates than for their community counterparts. The first author has observed that most candidates she has evaluated for SRS appear to have realistic expectations concerning postoperative life in a women’s prison, albeit acknowledging some anxiety and recognizing that they will face interpersonal challenges. But if an inmate were to regret assignment to a women’s prison after SRS, returning to life in a men’s prison would probably be difficult or impossible; the risk of psychological deterioration in such circumstances makes it essential to proceed cautiously.

The future availability of SRS for other inmates could be imperiled if early recipients were to experience regret or psy-



chological decompensation; therefore, it is crucial to avoid catastrophic outcomes, particularly early on. Accordingly, we believe it would be advisable for prison officials to initially impose additional eligibility requirements for SRS, at least until some clinical experience and outcome data have been acquired.

### Standard Eligibility Requirements for Sex Reassignment Surgery Can Be Modified

The SOC explicitly allow the standard eligibility requirements for SRS to be modified when indicated:

The criteria put forth in this document for...surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. (Coleman et al., 2011, p. 166)

This means that additional or more stringent eligibility requirements for SRS can be imposed in certain circumstances. Some community clinics impose more stringent requirements, such as a longer period of cross-living or hormonal treatment or required participation in individual or group psychotherapy. More stringent eligibility requirements would also be allowable in correctional settings. Because clinical experience with SRS in correctional settings is currently nonexistent, we believe that initially imposing additional eligibility requirements would be advisable. These should include:

- (1) prominent genital anatomic GD;
- (2) a long period of expected incarceration after SRS;
- (3) a satisfactory disciplinary record and demonstrated capacity to cooperate with providers and comply with recommended treatment;
- (4) a period of psychotherapy, if recommended by the responsible practitioner; and
- (5) willingness to be assigned to a women's prison after SRS.

Most of these additional requirements have parallels in the criteria for recommending SRS set forth explicitly or implicitly in the CCHCS guidelines:

No available, additional treatments other than SRS...are likely to alleviate the distress...At least two (2) years remaining before his/her anticipated parole or release date...Expected to successfully...adjust medically and psychologically to confinement postoperatively with inmates of his/her postoperative gender...The patient is cooperative and adherent with prescribed therapies and follows provider's orders. (CCHCS, 2015, pp. 3, 7)

There are two principal reasons that we recommend initially offering SRS only to inmates for whom a long period of incarceration is expected. First, although SRS is an effective treatment for GD, it is associated with a greatly increased postoperative risk of completed suicide and comorbid psychiatric conditions requiring hospitalization (Dhejne et al., 2011). Inmates who remain in prison for a long period after undergoing SRS would have guaranteed access to psychiatric services to address these potential problems, something that might not be true after release. Second, as we will discuss later, for inmates who undergo SRS and are subsequently released, there is a risk of remission of their feminine gender identification, possibly accompanied by regret about having undergone SRS. A lengthy period of time in which to consolidate one's new gender identity and gender role in prison could plausibly mitigate these risks.

Although a satisfactory disciplinary record was not explicitly included in the CCHCS guidelines as a decision criterion, we consider this to be an important indicator of willingness to cooperate with treatment. Consequently, we believe it should be an additional eligibility requirement for SRS, at least initially. We would emphasize, however, that imposing these or other additional eligibility requirements for SRS cannot merely be a pretext for making SRS de facto unavailable to inmates.

The standard eligibility requirements for SRS can also be relaxed or waived. Consider, for example, an inmate with prominent genital anatomic GD, incarcerated for a long term or for life, who had some experience living in a female-typical gender role prior to entering prison, whose response to hormonal treatment has been positive, but who has had limited opportunities to engage in female-typical gender role behavior while in prison. This is precisely the kind of unique situation that could justify relaxing or waiving the standard requirement of living for 12 months in a gender role congruent with one's gender identity. The first author has observed that some inmates clearly meet all the standard eligibility requirements for SRS other than having unambiguously fulfilled the 12-month cross-living requirement. In such circumstances, for appropriately selected inmates, the potential benefit of a flexible approach to this requirement—relief of genital anatomic GD—would almost certainly outweigh any possible risk of regret.

### Consequences of Offering Sex Reassignment Surgery to Inmates

Although it is legally and ethically obligatory to make SRS available to inmates for whom it is medically necessary, it is also important to anticipate and address the practical consequences of doing so. These include the need to develop policies for prison assignment after SRS, anticipate possible safety and security concerns, and consider post-release issues. Some of these matters loom large in the minds of prison officials, but we contend that

none of them constitute insurmountable barriers to offering SRS to carefully selected inmates.

### Prison Assignment After Sex Reassignment Surgery

Routine assignment to a women's prison after SRS would be the simplest, most rational, and most therapeutically beneficial policy. Not surprisingly, it is the policy that the CDCR guidelines implicitly adopted, stating that one criterion for recommending SRS would be whether "the patient can be expected to successfully and safely transfer and adjust medically and psychologically to confinement postoperatively with inmates of his/her postoperative gender" (CCHCS, 2015, p. 3). Routine reassignment to a women's prison would maintain consistency with current policies in nearly all U.S. correctional systems, in which assignment is based on external genital anatomy (Sumner & Jenness, 2014). It would also be consistent with how the few MtF transsexuals who have undergone SRS before entering prison have been assigned (e.g., "Prison near Purdy," 2003). From a therapeutic perspective, assigning inmates to a women's prison after SRS could be expected to ameliorate GD symptoms associated with inmates' limited ability to live and be treated as women while residing in male-only facilities.

Paradoxically, a policy of routine assignment to a women's prison after SRS might deter some inmates from seeking SRS. In the California prison system, 82 % of male transgender inmates report that they are exclusively sexually attracted to men (Jenness, 2010), and these inmates often derive significant satisfaction from the social, romantic, and sexual attentions of masculine male inmates. In summarizing interviews with several hundred male transgender inmates in the California prison system, some of whom might not meet full diagnostic criteria for GD, Jenness and Fenstermaker (2014) observed:

Throughout the interviews, transgender prisoners expressed appreciation for caring interactions with real men that served to recognize them as women. These simple, but much desired, interactions include being walked across the yard, given cuts in the chow line, and having an umbrella held over your head in the rain. (pp. 24–25)

Knowing that they would forfeit these rewarding interactions with men if they were reassigned to a women's prison might cause some inmates to forgo SRS. Moreover, a few male transgender inmates appear to dislike the company of women and would prefer not to be housed with them:

When a transgender prisoner...was asked whether she would prefer to be housed in a men's prison or a women's prison, she immediately replied, "Men's." She added, "That's a hard one. I don't want to be with women because they are vicious. They are worse than men. Their hormones are going all the time. Imagine being around 60 women and

two are on their period at the same time! God. Imagine how bad that would be?". (Jenness & Fenstermaker, 2014, pp. 16–17)

Inmates might be forced to choose between SRS, with its potential to reduce their genital anatomic GD, and the opportunity to enact a feminine gender role in relation to men, with its potential to ameliorate the social or interpersonal components of their GD. Notwithstanding these considerations, the first author has observed that all seven inmates she has evaluated for SRS over the past 18 months, whether sexually attracted to men or to women, have indicated that they would welcome the opportunity to live among women, and in many cases to be free of the sexual tension they experience in relation to male inmates.

Some male prisoners for whom SRS is medically necessary have a history of violent behavior toward women. Kosilek, the plaintiff who sued the MDOC to obtain SRS, had been convicted of murdering a woman (*Kosilek v. Spencer*, 2014a). Norsworthy, the plaintiff who sued the CDCR to obtain SRS, had a history of domestic violence against women (*Norsworthy v. Beard*, 2015). Prison officials have sometimes interpreted such histories as effectively precluding assignment to a women's prison after SRS. In the Norsworthy case, CDCR official Kelly Harrington opined that:

Norsworthy would be "at significant risk of being assaulted or victimized by female offenders" in a women's facility because of her history of domestic violence against her girlfriend before her arrest...Harrington is also concerned that "Norsworthy might herself victimize female inmates." (*Norsworthy v. Beard*, 2015, p. 17)

However, in what is perhaps the only known case in which a MtF transsexual who had undergone SRS was sent to a women's prison after committing a violent crime against a female victim, the offender—"Jo" Shandley, convicted of murdering her sister—was housed uneventfully in the Washington Correctional Center for Women ("Prison near Purdy," 2003; see also *Kosilek v. Spencer*, 2012, p. 108; *Kosilek v. Spencer*, 2014a, p. 49).

Moreover, natal women who have been convicted of violent crimes against other women, including victims they knew personally, are assigned to women's prisons as a matter of course. The most recent information from the U.S. Department of Justice (Greenfield & Snell, 1999) revealed that over three-quarters of violent crimes committed by female offenders involved female-on-female violence and that in about 8 % of these cases the victims were intimates or relatives of the perpetrator. Consequently, women's prisons can be assumed to have experience dealing with violent offenders whose victims have been other women. Judge Jon Tigar made this point when he wrote in *Norsworthy v. Beard* (2015):

Any suggestion that housing a female inmate with a history of violence against women would be a novel security challenge is hard to square with the fact that CDCR already houses

many women with a history of violence, including violence against their female partners. (p. 27)

The other options for prison assignment after SRS—assignment to a special facility for transgender inmates, administrative segregation, or continued assignment to a men’s prison—are more problematic. Assignment to a special unit for transgender inmates could sometimes be a reasonable option, but such facilities are not available in most states, and transfer to a unit for transgender prisoners in another state, pursuant to the Interstate Compact on Adult Offender Supervision (Interstate Commission for Adult Offender Supervision, 2014), could not be guaranteed. Moreover, some inmates would probably reject and challenge being housed in units for transgender inmates, believing such an arrangement to be discriminatory and stigmatizing. Prolonged administrative segregation would be inhumane and probably would not stand up to legal challenge (Fleischaker, 2014). Continued assignment to a men’s prison after SRS would be inconsistent with current genital-based assignment policies and would probably increase an already elevated risk of sexual victimization. In addition, all of these alternative assignment options would forgo the potential therapeutic benefits of placement in a women’s prison, in which inmates with GD could more freely and fully enact their desired gender role.

### Security Considerations Related to Sex Reassignment Surgery

We mention security considerations for reasons of completeness, not because we think they pose serious impediments to providing SRS. We have already addressed the most significant security issues related to housing inmates in women’s prisons following SRS. Prison officials have sometimes expressed concern about the risk of escape attempts if inmates were transported to a distant location to undergo SRS and then transported back to prison. We consider these objections pretextual rather than substantive. In the *Kosilek* case, the MDOC initially raised this issue, but MDOC Commissioner Harold Clarke subsequently minimized these concerns in his testimony:

Clarke too initially opined that Kosilek posed an unacceptable risk of flight if transported out of Massachusetts in part because he had fled the state after killing his wife... However, Clarke ultimately testified that he could say “[w]ith some degree of certainty” that the DOC would “take all the precautions necessary to secure that transport, secure the place where it’s going to take place, and care for [Kosilek] in terms of providing appropriate custody prior to returning [Kosilek] back to the state.” (*Kosilek v. Spencer*, 2012, p. 104)

### Post-Release Considerations Following Sex Reassignment Surgery

Practitioners who recommend SRS for inmates who will eventually be released from prison should think carefully about how SRS might affect these inmates’ lives after release. In particular, they should consider the risk of post-release regret about having undergone SRS. Clinicians have repeatedly observed that changes in life circumstances can affect the severity of GD symptoms and the intensity of the desire for sex reassignment and SRS (Levine, 1993; Lothstein, 1979; Marks, Green, & Mataix-Cols, 2000; Roback, Felleman, & Abramowitz, 1984). Males with only minimal or moderate GD symptoms before entering prison sometimes experience an increase in the severity of their GD symptoms after incarceration, accompanied by the onset or intensification of cross-gender identification and the desire to undergo sex reassignment and SRS. This phenomenon raises the concern that, if these inmates were to undergo SRS and were subsequently released from prison, their feminine gender identification might diminish or remit entirely and their desire to live as women might decline or disappear. Practitioners must be mindful of the possibility that inmates who avidly sought and eventually underwent SRS in prison might regret having done so after being released.

Why is the prison environment sometimes associated with an increase in the severity of GD and an intensification of the desire for sex reassignment? Several factors plausibly contribute. Before entering prison, many inmates with incipient GD lived unstable or chaotic lives, characterized by familial and interpersonal instability, childhood abuse or neglect, out-of-home placements, poverty, school failure, substance abuse, untreated mental illness, and early and chronic criminality. In prison, some of these problems may resolve or remit, allowing inmates enough stability to seriously confront their GD for the first time. Other inmates may have had little or no information about the meaning of their GD symptoms or about their options for living in a gender role more congruent with their gender identity; some may have lacked language to describe their feelings, learning terms such as transgender for the first time in prison. Transgender subcultures within prisons provide information, descriptive language, and role models for inmates who are beginning to think about these issues. Although the natural history of GD in males often involves intensification of symptoms over time, social forces in the outside world can hold GD symptoms in check and deter individuals from pursuing sex reassignment. These restraining forces can include the desire to preserve relationships with spouses, children, and friends (Blanchard, 1994) and to maintain employment, legal or otherwise. When incarceration removes these social constraints, GD can intensify. The prison environment also offers inmates opportunities to enact female-

typical social and sexual behaviors in relation to masculine men; these interactions can strengthen or consolidate cross-gender identification in males with GD and can be associated with intensification of GD symptoms. Conversely, GD can sometimes intensify in prison as a result of constraints on feminine self-expression: Inmates who had cross-dressed, engaged in prostitution, or entertained as drag queens may only experience clinically significant GD once those activities have become impossible in the context of incarceration.

After release from prison, however, inmates' circumstances may revert to the status quo ante. Their lives can once again become chaotic in the face of joblessness, homelessness, substance abuse, or untreated mental illness. Opportunities for cross-gender expression that were unavailable during incarceration may again become available to them. Social forces that once constrained cross-gender expression may again exert their influence. In males with GD who are sexually attracted to women, the opportunity to engage in new romantic relationships with women is sometimes associated with remission of GD symptoms and loss of the desire to live as a woman (Lawrence, 2013; Marks et al., 2000; Shore, 1984; Steiner, 1985); release from prison would allow such opportunities. For inmates who had undergone SRS before being released, these forces could potentially be associated with partial or complete remission of their feminine gender identification and desire to live as women; some of these individuals might come to regret SRS. We believe it is plausible that having a longer period of time to consolidate one's feminine gender identity and gender role after SRS might make these outcomes, especially postoperative regret, less likely. Consequently, until more inmates have undergone SRS and more outcome data for this population have been accumulated, we believe it would be prudent to offer SRS only to those inmates for whom a long period of incarceration is anticipated (cf. Colopy, 2012, p. 267).

Regret following SRS is a rare but recognized phenomenon in nonincarcerated MtF transsexuals. A large longitudinal study in Sweden found that 2.2% of MtF transsexuals regretted having undergone sex reassignment and SRS, as evidenced by application to return to male legal gender status (Dhejne et al., 2014). Factors associated with an increased risk of regret following SRS include poor family support, late-onset GD, inadequate differential diagnosis, and dissatisfaction with the physical and functional outcomes of surgery. Some of these factors, especially poor family support, could potentially increase the risk of post-release regret in inmates who underwent SRS while in prison.

It is important to acknowledge, however, that if an inmate were to undergo SRS in prison and subsequently revert to living in a male gender role after release, this would not necessarily indicate that the inmate regretted SRS, that GD had been incorrectly diagnosed, or that SRS had not been medically indicated or had been provided in error. Some persons who undergo SRS outside of correctional environments report that this treatment successfully ameliorated their GD symptoms but nevertheless revert to living in their original gender role, usually for complex social

reasons. Kuiper and Cohen-Kettenis (1998) described three such MtF patients and observed that:

[Some] individuals do not live any longer in the previously desired sex, but do not express any regret. Some may even state that they are happy about their decision, and still consider themselves transsexuals, but choose to live in the original gender role again for social reasons. (p. 2)

This is consistent with the perspective that the fundamental therapeutic value of SRS lies in its ability to alleviate genital anatomic GD and that SRS can provide this therapeutic benefit even when individuals decide to revert to their original gender role after surgery.

### Recommendations for Providing Sex Reassignment Surgery to Male Inmates With Gender Dysphoria

We hope that prison systems will begin providing SRS for carefully selected inmates not because they are legally compelled to do so but because they recognize that SRS is an effective and ethically obligatory treatment for the particular form of suffering that some inmates with GD experience. We recognize that to do so, prison systems will have to address policy, security, and operational complexities as well as legislative, judicial, and public relations challenges. But the status quo of waiting for legal mandates not only leaves inmates with unmet treatment needs but is also prohibitively expensive. Based on our clinical experience and review of the relevant literature, we offer the following recommendations:

- (1) Prison officials and physicians and mental health practitioners who evaluate and treat inmates should recognize that SRS can be medically necessary for some male inmates with GD. Prison systems should begin offering SRS to inmates for whom it is medically necessary, even when not faced with the threat of legal compulsion.
- (2) The eligibility requirements for SRS for male inmates with GD should include the first five standard eligibility requirements set forth in the SOC (Coleman et al., 2011).
- (3) The SOC standard eligibility requirement of 12 continuous months of living in a gender role congruent with the patient's gender identity should either have been
  - (a) satisfied in the judgment of the responsible practitioner or
  - (b) explicitly waived by the responsible practitioner, as permitted by the SOC.
- (4) Until greater experience is accumulated, practitioners should initially impose some additional eligibility requirements, as permitted by the SOC, in order to maximize the likelihood of successful outcomes and minimize the likelihood of regrets. These should include

- (a) prominent genital anatomic GD;
  - (b) a long period of expected incarceration after SRS;
  - (c) a satisfactory disciplinary record and demonstrated capacity to cooperate with providers and comply with recommended treatment;
  - (d) a period of psychotherapy, if recommended by the responsible practitioner; and
  - (e) willingness to be assigned to a women's prison after SRS.
- (5) Inmates should routinely be assigned to a women's prison after SRS, although assignment to a specialized unit for transgender inmates might be acceptable in some cases.
- (6) Consistent with inmate confidentiality, practitioners and the prison systems that employ them should collect, analyze, and publish the outcome data, for their own use and for the use of other prison systems.
- (7) The additional eligibility requirements suggested above should be modified as indicated, based on accumulated experience and the outcome data.

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