Mental Health Evaluation for Gender Confirmation Surgery

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KEYWORDS

• Gender • Surgery • Gender dysphoria • Mental health • Gender-affirming

KEY POINTS

- Mental health professionals evaluate individuals to determine their readiness and eligibility for gender-affirming surgeries in compliance with the World Professional Association for Transgender Health Standards of Care.
- Treatment of gender-dysphoric individuals is often provided in multidisciplinary settings, because the condition requires collaborative care.
- The mental health provider refers patients to surgeons, after conducting a comprehensive assessment and documenting the findings in a letter.
- One referral letter is required for breast/chest surgery; 2 letters are required for genital surgery or the removal of reproductive organs.

INTRODUCTION

In recent years, there has been a tectonic change in the field of transgender health care. Evidence-based science, media exposure, and the narratives of people experiencing gender incongruity have dramatically increased the number of individuals requesting gender-affirming surgeries and informed new models of care. The needs and goals of gender-diverse people have often outpaced knowledge, practice, and research.

Not all individuals who desire or require gender-affirming surgeries, however, are appropriate candidates for surgical interventions. Given the profound (and often irreversible) nature of gender surgeries, the heterogeneity of the patient population, and the likelihood of co-occurring medical and/or mental health issues, assessments conducted by experienced mental health providers are considered essential for promoting optimal care and positive outcomes. The demand for surgeries exceeds the aggregate of professionals with sufficient experience to conduct thorough assessments and refer appropriate patients to surgeons. Too often, surgeons receive a cursory referral letter from a mental health professional, not an individualized assessment that genuinely informs care.

If a surgeon is fortunate to be part of a center that uses a multidisciplinary approach, a truly comprehensive assessment can often be reached by team consensus. Although each specialist has deep, specific knowledge, the ability to collaborate, particularly in complex cases, expands practitioner knowledge and greatly improves outcomes. Also, in a multidisciplinary center, patients and providers benefit from support with management of the perioperative and postoperative course. Often, patients do not fully understand the process of surgery and/or the demands of postoperative care. Some fail to anticipate the need for a support system or, being resource-poor, cannot access essential postoperative care. Research documents that unemployed, low-income, and/or isolated individuals often report lower quality of life postsurgery.[1] Multidisciplinary centers address these concerns, thereby improving surgical outcomes, reducing complications, and better meeting patient expectations.

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Understanding the value of communication between clinicians, surgeons who are not physically embedded in a team setting often create a virtual network of colleagues. Many patients have consulted with several providers, such as primary care physicians, endocrinologists, speech pathologists, nurse practitioners, and others. Seeking input from colleagues complements standardized medical informatics and provides insight into an individual's unique gender identity and self-determined goals.

HISTORICAL APPROACH TO SURGICAL APPLICANTS

Modern surgical sex reassignment (now known as gender-affirming surgery) began in earnest in the twentieth century, necessitated by the traumatic injuries sustained in World War I. Advances in soft tissue reconstructive techniques and the synthesis of sex steroid hormones allowed for the previously impossible alteration of secondary sex characteristics.[2] It was not until Christine Jorgensen's "sex change surgery" in 1953, however, that what was then referred to as "transsexualism" captured the public's attention. With the exception of a few surgeons in Mexico, Morocco, and South America, most hospitals prohibited the procedures. There were near-universal ethical, religious, and moral objections to the surgery, which the psychiatric community depicted as "psychosurgery."[3] Although a few clinics treated gender-dysphoric patients, legal consequences fomented. In 1966, the same year that Johns Hopkins opened its pioneer treatment program, an Argentinean surgeon was convicted of assault for performing a "sex–change operation."[4]

In 1978, a New York court ruled that the operation was "an experimental form of psychotherapy by which mutilating surgery is conducted on a person with the intent of setting his mind at ease."[4] By the late 1970s, most of the early clinics shuttered their doors, ceding to negative public opinion and potential liability issues.

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH STANDARDS OF CARE

A few dedicated professionals who offered care to gender-dysphoric people formed the Harry Benjamin International Gender Dysphoria Association, named for the German endocrinologist who identified the condition. In 1979, they published the first Standards of Care (SOC), compelled by concern for those who were driven by desperation to pursue illicit or dangerous treatments.

At that time, little was known about gender dysphoria, albeit it was presumed a rare phenomenon. Against a swirling backdrop of controversy, and the belief that the condition was undergirded by severe psychopathology, those who sought surgical interventions underwent prolonged and stringent screening.[5–8]

John Hoopes, a plastic surgeon who headed the Gender Identity Clinic (Hopkins Hospital, Baltimore, MD), told the *New York Times*, "This program, including the surgery is investigational. The most important result of our efforts will be to determine precisely what constitutes a transsexual and what makes him remain that way."[9]

It fell to the mental health professional to identify those patients who were "true transsexuals," potential candidates for surgical treatment. To make that determination, patients had to undergo extensive psychiatric evaluation, take hormones, and live in their preferred gender, a trial known as the *real life test*. The screening process was onerous. A candidate had to provide a cohesive narrative of "being trapped in the wrong body," and to recount early childhood memories and behaviors consistent with the desire to be the opposite gender. In addition to undergoing mandatory psychotherapy, it was essential to have a "heterosexual" orientation. The conflation of sex and gender usually led to the selection of hyperfeminine applicants. To avoid the dreaded outcome of surgical regret, the mental health professional exercised an abundance of caution. In effect, the mental health professional became a gatekeeper.

With the refinement of medical protocols, rapid acceleration of scientific knowledge, and the evolution of techno-cultural environments, the SOC were revised in 1980, 1981, 1990, 2001, and 2011. Even the name of the organization was changed from the Harry Benjamin International Gender Dysphoria Association to the World Professional Association for Transgender Health, to depathologize the condition and to acknowledge the diversity of gender identities.

CURRENT MENTAL HEALTH EVALUATIONS FOR SURGERY

It is the role of the mental health professional to provide an assessment and referral letter for individuals seeking surgical treatment. The current SOC, version 7 (SOC 7), outlines different criteria for breast/chest surgery (mastectomy, chest reconstruction, and mammoplasty) than for genital surgery. One referral letter is required for breast/chest surgery, whereas 2 referral letters are required for genital surgery or removal of reproductive organs.[10]

When 2 letters are required, the therapist who has followed a patient usually provides one, and the other is a second opinion from a mental health