

Transition as Treatment: The Best Studies Show the Worst Outcomes

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A pattern begins to emerge as we survey some of the best and longest outcome studies on gender transition: the longer the studies and the better the methods, the more negative the results.

The treatment for this particular disorder is severe: lifelong experimental medicalization, sterilization, and complete removal of healthy body parts—a treatment Dr. Ray Blanchard, one of the world’s foremost sexologists, calls “palliative.” In spite of its severity, however, medical gender transition is no longer a rarity. It is the recommended treatment for [gender dysphoria](#), a diagnosable disorder of incongruence between one’s felt “gender” and one’s natal sex, the prevalence of which is [increasing](#) tremendously throughout the world. More and more children and adolescents are being diagnosed with gender dysphoria, and are undergoing medical treatment prior even to completing puberty.

For those who express caution or concern there is a familiar retort: “Trust the experts.” If you don’t, “you’re a bigot.”

This argument, however, makes a mockery of the fact that three of the most influential sex researchers of the last couple decades—[Ray Blanchard](#), [Michael Bailey](#), and the recently vindicated [Ken Zucker](#)—all have problems with the affirmation-only transition narrative that is currently being promoted. You could add to this list names like [James Cantor](#), [Eric Vilain](#), [Stephen Levine](#), [Debra Soh](#), and [Lisa Littman](#).

I invite you to look with me at the data that these and other researchers draw from. What does the peer-reviewed research say about the effectiveness of medical transition for gender dysphoria? Do puberty blockers, cross-sex hormones, mastectomies, vaginoplasties, and phalloplasties successfully alleviate the mental and emotional distress that gender-dysphoric persons face? Findings are varied, as are the political and

philosophical perspectives of the researchers; but a careful reading of the literature demonstrates that the best studies show the worst outcomes for those who undergo medical transition.

The mainstream narrative often says that medical transition is well-studied, and that there is academic consensus on its effectiveness. In reality, the literature is fraught with study design problems, including convenience sampling, lack of controls, cross-sectional design, small sample sizes, short study lengths, and enormously high drop-out rates among participants. Very few studies on transition escape these issues. For example, a [2018 systematic review](#) of quality-of-life studies of transitioned adults rated only two out of twenty-nine studies as high-quality.

Two of the largest issues are study length (time since treatment) and [lost-to-follow-up](#) rates. It is well recognized in the literature that the year after medical transition is a “honeymoon period,” which [“does not represent a realistic picture of long-term sexual and psychological status.”](#) At what point, however, does a patient’s psychology stabilize? After three years? Five years? Ten years? And at what level? Given that pre-pubertal children are being administered [cross-sex hormones](#) (at twelve years old) and [undergoing surgeries](#) (at thirteen years old), and that this transitioned experience may span sixty to eighty years of their lives, shouldn’t we know whether outcomes are positive after ten years?

Complicating study lengths is the issue of follow-up. [Many researchers](#) state that, once 20 percent of a study’s participants are lost to follow-up, there are significantly detrimental effects to the study’s reliability. [One study](#) investigated those who were lost to follow-up for another surgical procedure and concluded that “patients with problems are likely to avoid follow-up.” Transgender advocates have pointed to a large [2015 German study](#) that shows positive long-term outcomes for those who transition. However, the study has a 49.3 percent lost-to-follow-up rate, raising enormous questions about how almost half the initial group fared.

Three long-term studies have addressed the problem of follow-up loss by looking at objective measures from national registry data. These studies have

either no loss, or extremely low loss to follow-up, and so they supply what may be missing in many other studies.

The largest and longest of these, a [Dutch study in 2011](#) of those on cross-sex hormones, found that, while outcomes for the female-to-males seemed generally positive, for the much larger male-to-female group—72.6 percent of the total—“total mortality was 51 percent higher than in the general population, mainly from increased mortality rates due to suicide, acquired immunodeficiency syndrome [AIDS], cardiovascular disease, drug abuse, and unknown causes.” The timing of the suicides also provides important information. None occurred within two years of treatment, but “there were six suicides after two to five years, seven after five to ten years, and four after more than ten years of cross-sex hormone treatment”.

[Cecilia Dhejne et al.'s 2011](#) Swedish study is among the most well-known studies on transition outcomes—partially due to its surprisingly negative results, and partially due to differences among authors in interpreting the data. The sample was of 324 post-surgery transsexuals with median follow-up time of over ten years, the largest study of those post-SRS (sex-reassignment surgery). Findings included 7.6 times more suicide attempts than controls and nineteen times more completed suicides. Psychiatric hospitalization was 2.8 times higher, even after adjusting for prior psychiatric morbidity.

Most recently, a [2016 Danish study](#) compared psychological treatment before and after SRS in a group of over one hundred transsexuals. Concerning psychiatric morbidity, “no significant differences were found between the number of MtF [male-to-female transitioning] and FtM [female-to-male transitioning] individuals suffering from psychiatric morbidity pre- and post-SRS.” While psychological problems improved for some in the group, it worsened for others, and there was no statistically significant net benefit. Due to the lower numbers in this study, there was no analysis possible of the mortality data; but “ten individuals were registered as deceased post-SRS with an average age of death of 53.5 years,” and there were two suicides—both surprising data.

In fact, out of the six long-term outcome studies (over more than ten years) that have useful data on mental or psychological functioning, no less than five report mixed or poor outcomes. A [small Swedish study](#) in 1986 found that mental health and employment were highly mixed after SRS, leading the author to conclude that “it seems reasonable to expect only marginal improvement psychosocially after surgery.” A [Swiss study in 1998](#) with a high loss to follow-up found significant deterioration in a post-SRS clinical sample. The authors state that the negative outcomes, including a high percentage of regret and inability to work, are likely a function of time.

To date, only one study provides good information on the function of time. [Lindqvist 2017 \(Sweden\)](#), the only longitudinal study of any significant length, measured health prior to treatment, and at one, three, and five years post-SRS. Once again, loss to follow-up was significant: 103 of 146 participants dropped out by year five. Although the study is cheerfully titled, “Quality of Life Improves Early after Gender Reassignment Surgery in Transgender Women,” a careful reading of the data shows it could just have easily been called “Honeymoon Effects of Transition Wear Off Quickly.” The title is not the only place where the authors show considerable bias in their presentation of the data. The group studied showed a significant increase in all measures of the SF-36 ([36-Item Short Form Health Survey](#))—both physical and mental—after one year; although in comparison to population norms they are still low. However, every measure drops at three years, and every measure except physical functioning drops even further at five years, a fact subtly hidden in some of the authors’ language. Although the authors suggest that aging may be the reason for this significant decline, a perusal of SF-36 population norms for [Sweden](#) and [elsewhere](#) demonstrate the implausibility of this reasoning. An objective consideration of the data in Lindqvist 2017 and other studies demonstrates that the short-term psychological benefits, where they occur, are often short-lived.

A study that looks at this question from a different perspective is [Adams 2017](#). While the authors are very clearly pro-transition, some of the findings of their meta-synthesis of the literature on suicidality among transgender individuals provoked surprise. “It seems counterintuitive, on the other hand,” they state, “that suicide attempts are lower before transition (ideation 36.1 percent; attempt 13.1 percent) than over most other periods (past year

attempts being the exception).” For example, suicidal ideation for “past year” was 50.6 percent, whereas for “before transition” it was only 36.1 percent.

A pattern begins to emerge as we survey some of the best and longest outcome studies on transition—the longer the studies, and the better the methods, the more negative the results. A broad understanding of the literature helps us address the controversy surrounding Dhejne’s study, mentioned earlier. Dhejne herself has [argued](#) that her study should not be used to question the efficacy of transition as a treatment. Some authors have read her results in precisely that way, including those who would question an affirmation-only paradigm, such as [Stephen Levine](#), [Roberto D’Angelo](#), and [others](#) who would continue to champion transition. Dhejne has argued that, because the more recent cohort in her study did not have elevated mortality or suicide attempts compared to the controls (although psychiatric hospitalization remained highly elevated), it is likely that more advanced medical treatments and societal acceptance have resulted in better psychological outcomes over time. However, given that the results in the broader literature show that the immediate, and perhaps net positive, psychological effects of transition eventually deteriorate, it seems likely that this is an overly optimistic, politically correct spin on the data. But as D’Angelo states after interacting with Dhejne’s findings, “Most importantly in relation to suicide, none of the studies undertaken to date has yet established whether gender-reassignment actually lowers the risk of completed suicide as it is generally assumed to do.”

Some of the most recent findings of studies in the five-year follow-up range are also beginning to show cracks in the affirmation-only narrative. A [2018 multi-center European study](#) sorted post-surgery transsexuals into satisfied and dissatisfied groups, and found that even the “satisfied” group had “significantly more psychological symptoms and lower satisfaction with life” than control samples. A [recent Swiss study](#) found not only a lower mental quality of life for the surgically transitioned group than for the general population, but also that neither hormone treatment nor surgery predicted positive quality of life. While there are studies in the five-year range that could be used to argue that transition significantly helps the gender dysphoric ([Pimenoff and Pfafflin 2011](#), [Weyers 2009](#), [De Cuypere 2006](#)), a broad overview of all the medium and long-term studies shows, at best,

highly disconcerting results. Although it is a generalization, it is an undeniable and empirically defensible one: the best studies tend to show the worst outcomes.

Honest interaction with the medical literature throws up enormous warning signs, and adults are not the only ones who will pay the price for not heeding them. How will young people who are medically transitioned prior to adulthood fare psychologically after thirty years of transitioned life? What percentage of the medically transitioned have since detransitioned? How many suicides are contained within the groups that are lost to follow-up? To these and other questions there are few answers. Given that treatment of gender dysphoria currently includes such drastic measures as the removal of healthy, functioning body parts, the protracted and [experimental use](#) of cross-sex hormones, and the permanent circumvention of the normal pubertal process, this is nothing short of scandalous.

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About the Author



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