

Fact check: study shows transition makes trans people suicidal

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Abstract

A 2011 Swedish study proves that trans people are more suicidal due to transition, are likely rapists and that trans women exhibit male socialization. Or does it? Perhaps you've heard that a Swedish study found that trans people who access medical care are more likely to commit suicide. Writing for the Wall Street Journal, former Johns Hopkins [...]

Article



A 2011 Swedish study proves that trans people are more suicidal due to transition, are likely rapists and that trans women exhibit male socialization. Or does it?

Perhaps you've heard that a Swedish study found that trans people who access medical care are more likely to commit suicide. Writing for the Wall Street Journal, former Johns Hopkins chief psychiatrist and anti-LGBT activist Dr. Paul McHugh cited a Swedish study to make the following fact assertion:

A 2011 study at the Karolinska Institute in Sweden produced the most illuminating results yet regarding the transgendered [sic], evidence that should give advocates pause. The long-term study--up to 30 years--followed 324 people who had sex-reassignment surgery. The study revealed that beginning

about 10 years after having the surgery, the transgendered [sic] began to experience increasing mental difficulties. Most shockingly, their suicide mortality rose almost 20-fold above the comparable nontransgender population. This disturbing result has as yet no explanation but probably reflects the growing sense of isolation reported by the aging transgendered [sic] after surgery. The high suicide rate certainly challenges the surgery prescription.

McHugh's fact assertions were uncritically repeated by The American Conservative, Lifesite, The Christian Post, The Washington Times, Newsmax, One News Now, The Libertarian Republic, and Fox News. While McHugh's misrepresentation of the study was debunked, the "trans medical care = suicide" meme was born. Since McHugh's Wall Street Journal article, this meme has managed to worm its way into everything from news outlets to comment sections.

Echoing McHugh, TERF opinion leader, author, and lecturer Dr. Sheila Jeffreys wrote in her 2014 book, *Gender Hurts*:

There is still a remarkable absence of recent studies that follow up those who have SRS to find out whether this treatment is efficacious despite the great expansion of the industry of transgendering [sic]. A 2011 long-term follow-up study from Sweden found that sex reassignment was not efficacious because after sex reassignment transgenders [sic] had higher risks of psychiatric morbidity, suicidal behaviour and mortality overall than the general population, when using controls of the same birth sex. The study concluded that 'sex reassignment' may alleviate 'gender dysphoria' but 'may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment' (Dhejne et al., 2011). 1

Jeffreys' source for "factual material" on trans issues, Linda V. Shanko (AKA "Gallus Mag") of Gender Trender wrote:²

The only long-term study of transgender outcomes concluded that "Male to Female" transsexuals retain male-pattern criminality, including crimes against women. Are all transwomen predators? Of course not: They are predators at exactly the same rates as any other males. Now that the public is starting to pay attention, that genie won't be going back into the bottle anytime soon. What is once seen cannot be unseen.

TERF3 Attorney Elizabeth Hungerford of Sex Not Gender cited the study as evidence of the often appealed to yet never quantified "male socialization" TERFs assert trans women forever exhibit. Hungerford said the study "vindicates the experience of many women that transwomen as a group retain-or are unable to fully discard- some male pattern behaviors associated with male socialization... The criminal conviction rates documented in this study provide empirical evidence for this view."

Fact Checking the Hyperbole

I've only scratched the surface of the amount of anti-trans hyperbole that cites the 2011 study titled, *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden* by Dr. Cecilia Dhejne, et al. I contacted Dhejne after I witnessed her work used to support the claim that trans women are rapists and she agreed to the following interview:

Cristan Williams: How did you first hear about trans people and when was it that you first met a trans

person?

Cecilia Dhejne: I don't recall when I first heard about someone being transgender, though I think I first became aware of the existence of trans people as a teenager. In 1985 I took classes in sexology and around that time I also participated in a Nordic Association for Clinical Sexology meeting where I heard Dr. Friedeman Pfäflin speak about his work with trans people in Germany. Additionally, at the same conference, I was able to hear Dr. Espen Esther Pirelli Benestad talk about his experience. I began working with trans people clinically in 1999 and from there, I started up the gender team in Stockholm.

Williams: Would you please talk about how you became interested in researching trans health outcomes?

Dhejne: In 1999 when I started the Stockholm gender team, we were conducting diagnostic evaluations to help trans people start their social and medical transition. Our team included psychologists and a social worker, and we worked in close collaboration with endocrinologists, plastic surgeons as well as speech and language pathologists at the Karolinska University Hospital.

At that time, the need for quality research was obvious to our team; we wanted our work to be evidence-based. For instance, the endocrinologist had continued to see patients post-transition and while many reported that they were quite happy, others reported difficulties. We, therefore, wanted to better document, measure and understand the needs of our patient population.

If we found a need for a more robust service delivery model to increase treatment efficacy, that would invariably impact programmatic budgets and, of course, those changes would need to be justified by a documented need. Moreover, data-driven treatment models can present opportunities to publish findings which, in turn, helps increase the overall quality of evidence-based trans care.

Williams: Before I contacted you for this interview, were you aware of the way your work was being misrepresented?

Dhejne: Yes! It's very frustrating! I've even seen professors use my work to support ridiculous claims. I've often had to respond myself by commenting on articles, speaking with journalists, and talking about this problem at conferences. The Huffington Post wrote an article about the way my research is misrepresented. At the same time, I know of instances where ethical researchers and clinicians have used this study to expand and improve access to trans healthcare and impact systems of anti-trans oppression.

Of course trans medical and psychological care is efficacious. A 2010 meta-analysis confirmed by studies thereafter show that medical gender confirming interventions reduces gender dysphoria.

Williams: Earlier this year an Ohio news outlet cited your study to support the following fact assertion as part of an argument for denying trans people equal rights:

Would the proposed ordinance truly advance the public good and the dignity of our transgender citizens? Significant evidence shows that, after sex reassignment, transsexuals "have considerably higher risks for mortality, suicidal behavior, and psychiatric morbidity than the general population," according to a long-term cohort study in Sweden reported in 2011.

If current treatment, that is, psychiatric support in dressing and living as the opposite sex and

ultimately sex-reassignment surgery, does not benefit transgender individuals, then neither will access to the preferred bathroom. Rational thinking concludes that the proposed ordinance benefits neither the transgender individual nor the general public.

The story references your 2011 study. This study states, “The overall mortality for sex-reassigned persons was higher during follow-up (aHR 2.8; 95% CI 1.8-4.3) than for controls of the same birth sex, particularly death from suicide (aHR 19.1; 95% CI 5.8-62.9). Sex-reassigned persons also had an increased risk for suicide attempts (aHR 4.9; 95% CI 2.9-8.5) and psychiatric inpatient care (aHR 2.8; 95% CI 2.0-3.9).” However, those citing your work never seem to note that your study also includes the following very large caveat:

It is therefore important to note that the current study is only informative with respect to transsexual persons health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism. In other words, the results should not be interpreted such as sex reassignment per se increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia. This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit.

Moreover, people using your study to support spurious anti-trans fact claims also seem to not understand that your study findings aggregate two chronological groups. In simple language, would you please explain what the above paragraph means and what your study findings show for those trans people transitioning after 1989?

Dhejne: The aim of trans medical interventions is to bring a trans person’s body more in line with their gender identity, resulting in the measurable diminishment of their gender dysphoria. However trans people as a group also experience significant social oppression in the form of bullying, abuse, rape and hate crimes. Medical transition alone won’t resolve the effects of crushing social oppression: social anxiety, depression and posttraumatic stress.

What we’ve found is that treatment models which ignore the effect of cultural oppression and outright hate aren’t enough. We need to understand that our treatment models must be responsive to not only gender dysphoria, but the effects of anti-trans hate as well. That’s what improved care means.

Williams: Would you please comment on the below examples of the way your work is being used and represented within the media:

Source: Washington Post

Source: TownHall

Source: Dr. Paul McHugh via LifeSite

Source: Medium

Source: The Dr. Drew Show as noted on Twitter

Dhejne: People who misuse the study always omit the fact that the study clearly states that it is not an

evaluation of gender dysphoria treatment. If we look at the literature, we find that several recent studies conclude that WPATH Standards of Care compliant treatment decrease gender dysphoria and improves mental health.

Williams: Other anti-trans activists have seized upon your study to make certain fact assertions about a supposed inherent criminal nature trans women possess, as exemplified by the following Twitter exchange:

Using simple language, would you please speak to those using your work to support the fact assertion that trans women and cis men are alike when it comes to perpetrating incidences of rape, murder, torture, etc? In other words, would you please clarify the following:

- A.) As to the “male pattern regarding criminality” your study reviewed, would you please speak to whether your sample is representative of the trans population as a whole?
- B.) Does your study support the notion that trans women, epidemiologically speaking, are likely rapists?
- C.) Did your study show that trans women, epidemiologically speaking, are just as likely to rape cis women as cis men?
- D.) In the way that your study’s morbidity and mortality sample is reviewed as two chronological groups, did you use the same chronological metric for your criminality sample and, if so, what did you find?
- E.) Is your “male pattern regarding criminality” a simple comparison of percentages of overall conviction rates between cis males and trans women or is it a quantitative conviction category comparison between the two? In other words, trans women (who may experience around a 50% unemployment rate^{4 5 6}) will generally bear a greater burden of convictions associated with social oppression, poverty and homelessness (squatting, loitering, panhandling, prostitution and non-violent crimes such as drug use and petty theft) than cis men. When your study looked at the “male pattern regarding criminality” between cis men and trans women, are you saying that your data shows that cis men are being convicted for crimes associated with oppression, poverty and homelessness at a rate similar to that found in the trans population?

Dhejne: The individual in the image who is making claims about trans criminality, specifically rape likelihood, is misrepresenting the study findings. The study as a whole covers the period between 1973 and 2003. If one divides the cohort into two groups, 1973 to 1988 and 1989 to 2003, one observes that for the latter group (1989 - 2003), differences in mortality, suicide attempts, and crime disappear. This means that for the 1989 to 2003 group, we did not find a male pattern of criminality.

As to the criminality metric itself, we were measuring and comparing the total number of convictions, not conviction type. We were not saying that cisgender males are convicted of crimes associated with marginalization and poverty. We didn’t control for that and we were certainly not saying that we found that trans women were a rape risk. What we were saying was that for the 1973 to 1988 cohort group and the cisgender male group, both experienced similar rates of convictions. As I said, this pattern is not observed in the 1989 to 2003 cohort group.

The difference we observed between the 1989 to 2003 cohort and the control group is that the trans cohort group accessed more mental health care, which is appropriate given the level of ongoing

discrimination the group faces. What the data tells us is that things are getting measurably better and the issues we found affecting the 1973 to 1988 cohort group likely reflects a time when trans health and psychological care was less effective and social stigma was far worse.

There you have it. To be clear:

- No, the study does not show that medical transition results in suicide or suicidal ideation. The study explicitly states that such is not the case and those using this study to make that claim are using fallacious logic.
 - No, the study does not prove that trans women are rapists or likely to be rapists. The “male pattern of criminality” found in the 1973 to 1988 cohort group was not a euphemism for rape.
 - No, the study does not prove that trans women exhibit male socialization. The “male pattern of criminality” found in the 1973 to 1988 cohort group was not a claim that trans women were convicted of the same types of crime as cis men.
1. Jeffreys, Sheila. “Doing Transgender: Really Hurting.” In *Gender Hurts: A Feminist Analysis of the Politics of Transgenderism*, 60-61. NY, NY: Routledge, 2014.
 2. “I am grateful, too, to the new wave of radical feminism both online and offline. Radical feminist bloggers such as Gallus Mag from ‘GenderTrender’ (n.d.a) and Dirt from ‘Dirt from Dirt’, among others, have provided invaluable factual material, references and ideas on their blogs, without which it would have been harder to write this book.” - Ibid, viii.
 3. “It’s just that I DO want to exclude some trans people from some situations, depending on the context... So yeah, I am a TERF. And I’m not ashamed. At all.” - Hungerford, Elizabeth “June 11 at 2:47 pm.” Facebook. June 11, 2015. Accessed June 19, 2015. <http://i.imgur.com/GVrakZz.png>
 4. 37% Unemployment: Xavier, J., Bobbin, M., & Singer, B. (2005). A needs assessment of transgendered people of color living in Washington, DC. *International Journal of Transgenderism*, 8(2/3), 31-47. doi: 10.1300/J485v08n02_04
 5. 67% Unemployment: Kenagy, G. (2005). The health and social service needs of transgender people in Philadelphia. *International Journal of Transgenderism*, 8(2/3), 45-56. doi: 10.1300/J485v08n02_05
 6. 42% Unemployment: Kenagy, G., & Bostwick, W. (2005). The health and social service needs of transgender people in Chicago. *International Journal of Transgenderism*, 8(2/3), 57-66. doi: 10.1300/J485v08n02_06

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