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Regret after Sex Reassignment Surgery in a Male-to-Female Transsexual: A Long-Term Follow-Up

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This case report describes a four-decade presentation of a non-homosexual gender dysphoric male patient. The case material was collected from two main sources. One of the authors had weekly therapy sessions with the patient over a period of 2 years almost 15 years after sex reassignment surgery. Information was also gained from the patient's medical records covering the period from the early 1960s to the early 1990s. Over the years, the patient fulfilled the criteria for different diagnoses: overanxious reaction of childhood, fetishism and transvestism during adolescence, and transsexualism during adolescence and early adulthood. The purpose of this report was to shed light on aspects of regret, its manifestation in a male-to-female transsexual with psychiatric co-morbidity, and to show the complexity of the process of adjustment when regret is involved. The present case is an argument for a strict interpretation of the Standards of Care provided by the Harry Benjamin International Gender Dysphoria Association in terms of evaluating patients' mental health, apart from the evaluation of the gender identity disorder, and the patients' subsequent need for treatment interventions.

KEY WORDS: gender dysphoria; gender identity disorder; transsexualism; sex reassignment surgery; sexual orientation.

INTRODUCTION

Persistent regret after sex reassignment surgery (SRS), a treatment aimed to resolve a patient's gender dysphoria, must be considered, along with suicide, as the worst conceivable outcome of SRS. To avoid this, groups such as the Harry Benjamin International Gender Dysphoria Association (HBIGDA) provide Standards of Care regarding SRS (Meyer et al., 2001). Regret, considered the most obvious sign of dissatisfaction after SRS, can manifest itself in several ways (Landén, 1999). It may lead to application for retransformation to the original sex; however, instead of the unsatisfactory possibility of physical reversal, a transsexual may choose to stay in the reassigned role and try to adjust to it (Weitze & Osburg, 1996). Suicide may occur when coping strategies fail.

Regret is quite a complex concept and is influenced by a number of factors including the presence of psychopathology, psychosocial adjustment, the cosmetic and functional results of SRS, the resulting ability to experience pleasure from sexual relations, the existence and quality of a partner, and other interpersonal relations. Lindemalm, Körlin, and Uddenberg (1986) found it useful to differentiate the level of regret in terms of three categories: (1) Definite Regret: patient openly regrets SRS and has applied for retransformation to original sex; (2) Some Regret: indirectly expressed regret and signs of ambivalence about SRS; (3) and No Regret.

Bentler (1976) studied 42 MF transsexuals after SRS, categorized based on their sexual orientation: HS-TS (sexually attracted to males), AS-TS (sexually attracted to neither males nor females), and HT-TS (sexually attracted to females). He found that the HS-TS and AS-TS groups believed that only a small percentage of applicants should receive SRS. According to Bentler, this finding represents a possible hint of regret about their own situation.

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Bouman (1988) found that after SRS 46% of the MF transsexuals never used the vagina for intercourse and that one of the reasons was sexual orientation. Twenty percent of persons in the sample were engaged in lesbian relationships and never used the vagina for intercourse, illustrating that sexual orientation can indirectly affect regret rates when the functional result of SRS is a failure.

The frequency rates for some regret or consistent regret reported in studies since the mid-1980s vary from 30% (Lindemalm et al., 1986) to less than 10% (Blanchard, Steiner, Clemmensen, & Dickey, 1989; Landén, 1999; Lawrence, 2003). Regret raises the question of whether or not the gender identity disorder (GID) has remitted. Marks, Green, and Mataix-Cols (2000) reported five cases of adult GID in whom remission was documented for up to 10 years in response to new sexual relationships and other events.

Factors predictive of regret after SRS have been a focus of research since the 1970s. Dissatisfaction and regret after SRS have been reported to be associated with the following factors: age over 30 years at first request for surgery (Lindemalm, Körlin, & Uddenberg, 1987; Lundström & Wålinder, 1985; Wålinder, Lundström, & Thuwe, 1978); personality disorders, personal and social instability (Bodlund & Kullgren, 1996; Lundström & Wålinder, 1985; Wålinder et al., 1978); secondary transsexualism (Landén, Wålinder, Hambert, & Lundström, 1998; Lundström & Wålinder, 1985; Sörensen, 1981); a heterosexual sexual orientation (Blanchard et al., 1989; Money & Wolff, 1973; Wålinder et al., 1978); poor surgical results (Eldh, Berg, & Gustafsson, 1997; Lawrence, 2003; Lundström, Pauly, & Wålinder, 1984; Ross & Need, 1989); and poor support from the family (Landén et al., 1998; Wålinder et al., 1978).

In-depth reports in the medical literature on the individual gender dysphoric's long-term adjustment in the desired opposite sex role and psychological adjustment after SRS are rare. The present report concerns a four-decade follow-up of a non-homosexual gender dysphoric male, and focuses on this individual's psychosexual development, experience of gender identity, and the significance of life events regarding the outcome. The presentation sheds light on aspects of regret, sources of regret, and the manifestation of regret during an almost 15-year follow-up period after SRS in a patient with psychiatric co-morbidity. The purpose of this report is to present a case belonging to the regret group in order to illustrate factors of clinical significance. Every regret case represents a major clinical and ethical problem. The present case report will hopefully contribute to a growing body of knowledge that in the future will reduce the number of bad choices for SRS and also the number of regret cases.

CASE REPORT

The case material was collected from two main sources: (1) the first author's weekly therapy sessions with the patient over a period of two years during the late 1990s; and (2) information from the patient's medical records covering the period from the early 1960s to the early 1990s. The material was analyzed in two different ways in accordance with the information sources. The patient's narratives were analyzed by noting the typical or critical elements in her reflections and narratives. The medical records were analyzed by identifying clinical diagnoses that developed and were recorded over the years. Information from childhood, adolescence, and adulthood was obtained from the medical records. This information was often also confirmed in the weekly sessions. At follow-up, the patient's own narratives constituted the main source of information. The patient gave written informed consent.

Childhood

Tony was born in the early 1950s to a married couple in their 20s. The family history showed no known psychiatric or neurological disorders. The delivery was without complications. Tony developed normally; he walked at 13 months and spoke in complete sentences at the age of two years. He was toilet-trained at a normal age. When Tony was three years old, his mother wanted to return to work. She experienced Tony as a burden and felt envious of her husband, who was working. As a preschool child, Tony was anxious and experienced significant problems in relating to other children of the same age. He preferred to play with girls and with dolls. He also liked to dress like a girl. At the same time, he was both technically talented and had a rich fantasy life.

Tony began school at the age of seven years, which is normal in Sweden, but it soon became obvious that he had substantial learning difficulties. Testing revealed rather severe dyslexia but normal intelligence; an IQ of 90 and 98 according to the Swedish versions of the Terman–Merill (1960) scale and the Goodenough (1975) scale, respectively. At school, he received extra support in an "ordinary class", while at home Tony became increasingly aggressive towards his mother. He destroyed furniture, and his mother experienced him as difficult to manage. As she could not handle him, he was admitted to a child psychiatric clinic in the early 1960s, at the age of eight years. Observation and testing showed anxiety, regression,

helplessness, and social disinhibition in relation to others. It was concluded at a ward conference that Tony's mother had wished for a girl, which Tony had perceived, that the mother had difficulty controlling her emotional responses, and that his parents disagreed about the upbringing of their child. During Tony's three-month hospitalisation at the child psychiatric clinic, it was noticed that he wanted to dress like a girl. Tony was discharged with diagnoses of "anxiety and aggression neurosis, psycho-infantilism, and maladjusted boy with a castration complex" (quoted from the medical record).

Upon his return home, Tony wanted to sleep in his mother's bed and put on a diaper before going to bed. He also started to dress in some of his mother's clothes. Shortly thereafter, the parents decided to divorce. Tony was initially admitted to a children's home and then discharged to live with his mother. She complained, however, about his aggressiveness. When his mother remarried, her new husband would not allow Tony to live with them, so Tony consequently moved in with his father. He continued to attend school where he received extra support. In his final two years, he was placed in a special class for children with behavior problems. His teachers experienced him as fearful and anxious, and as having poor contact with other children and odd ideas. When he entered puberty at the age of 12–13, he became interested in his stepmother's underwear. These items were sexually arousing to him and he frequently used them to masturbate (with normal ejaculation).

Adolescence

A child psychiatrist was consulted and Tony's behavior was diagnosed as fetishism. Because of his increasing interest in women's clothes, especially underwear, at the age of 18 years Tony was again admitted to a child psychiatric clinic with transvestism as a possible diagnosis. During this hospitalization, Tony said that he was determined to become a woman, and he requested that his penis be removed immediately. He denied any sexual interest in either men or women. While at the clinic, Tony wore men's clothes but had women's underwear underneath. Oral fluphenazine treatment was started but it was unsuccessful, and Tony soon terminated it. He was discharged with a diagnosis of transsexualism and immaturity.

Tony received sick benefits starting at the age of 20. All efforts to help him establish a working life were unsuccessful; the diagnostic team viewed him as rather psycho-infantile (Lindberg, 1950) and odd. During some periods, Tony's preoccupation with his gender problem and his outbursts of aggression divided the family.

Adulthood

Following his 20th birthday, he visited the psychiatric clinic and for the first time he was dressed entirely as a woman. He could control his affect better, with less expressed aggression. Estrogen treatment was initiated after he started cross-dressing. Tony met a man of the same age, moved in with him, and they became engaged. This fiancé had also experienced gender dysphoria, but after meeting Tony he decided to remain a man and support him. Tony functioned as a housewife. In their sexual relationship, Tony's penis was not involved. The relationship lasted for several years, and this man supported Tony's efforts to obtain sex reassignment. During this period, Tony submitted a formal application for sex reassignment in accordance with newly established legislation regulating sex-change treatment. During the time the couple cohabited, Tony obtained a female first name and the application for sex reassignment was approved, as was the application for SRS. After termination of the relationship, the fiancé moved to another part of Sweden where he applied for sex reassignment, including SRS, which was approved and performed.

After a period of time, Tony entered a new relationship, this time with a woman of the same age. The couple cohabited for some years. Tony performed in the male sexual role in this relationship and they were sexually very active with penovaginal intercourse. Tony told the psychiatrist that she functioned well in the male sexual role. During this period, Tony was less interested in hormonal treatment and took estrogen only sporadically. When the relationship ended, Tony was still under psychiatric care. All efforts to get her into an education or work program were unsuccessful, and her disability benefits were replaced by a disability pension. In a later admission to her doctor, Tony said that she had unconsciously misled both herself and the therapists about her sexuality. She had always felt herself sexually attracted to women and she thought that the reason she wanted to become a girl was that this would give her an opportunity to get closer to girls. Tony wanted to continue in the female role and have a sexual relationship in which she performed as a man with a woman. During the years that followed, Tony wanted to wait before undergoing the approved SRS. Ten years after approval of the application for SRS, Tony wanted the request for SRS to be recalled. She claimed that this was because her transsexual friends who had undergone SRS were disappointed with the results of the surgery. About a year after that, she again applied for SRS. During the investigation for the renewed application, Tony asked that the surgery be performed with such skill that the sensitivity of her genitals would be preserved

and the results would be true to nature both in function and appearance. She also hoped that the surgery would improve her quality of life so that she would no longer need to feel like a deviant person. After the SRS, she hoped to relate better to other people.

Tony underwent SRS in 1987 at the age of 35 years. Surgery was initially postponed because Tony had taken a prescription-free medicine (acetylsalicylic acid) that prolonged bleeding time one week before the planned operation and on the day of admission. Postoperatively, Tony used a vaginal mould for a considerable period of time. She then stopped using the mould because of pain and bleeding problems. At a gynecological examination several months after removal of the vaginal mould, she did not have a functioning vagina. Less than a year after that, Tony visited the doctor dressed as a man. She preferred clothes that gave an impression of authority and power. Following that visit, Tony's contact with the health care system came to an end. After several years, Tony again consulted a doctor because of urinary tract problems. As she expressed ambivalence regarding her SRS, she was later referred to psychiatric care, where she met the first author in the late 1990s.

Follow-Up

Tony complained of a deterioration in her psychological well-being and said, "I'm not a real person." She experienced the results of the SRS as a failure. She felt she was "at the bottom of the heap" and was afraid of other people. She would have liked to feel "above all other persons" and wanted people to be afraid of her instead. Tony felt confused about the fact that before the operation she wanted to dress in women's clothes, while after the operation she wanted to dress in men's clothes. She wanted to know why she had become so fixated with men's clothes that expressed authority and strength, and why she had difficulty relating to young girls. Tony said things like, "I want to be myself, but clothes are the problem" and "I feel like a child who doesn't know up from down." She had very few memories from the time before she reached 12 years of age. However, she had clear memories about how, as a boy of 12–13 years of age, she had become interested in women's underwear, and how these clothes aroused sexual feelings that resulted in masturbation. She returned to an event that occurred when she was 12–13 years of age; it was summertime and the family was in the country. Tony was in the garden with his female cousins and his stepmother. When they started to eat, he was told to "leave the girls alone at the table." He then sat down on a blanket on the grass, thinking, "You shouldn't be a boy because boys aren't allowed to be with the others."

Tony learned about transsexualism through a newspaper article describing a female-to-male (FM) transsexual. This was the beginning of her interest in sex reassignment. Tony said that she lied most of the time during the investigations before sex reassignment (and SRS). Her transsexual friends gave her "the right answers." Tony said she did not really want her SRS but felt "forced by society." Shortly before submitting the renewed application for SRS, Tony joined a youth group where she made sexual advances towards a young woman. In the social turmoil that resulted, Tony considered suicide but decided to go ahead with the SRS instead. She wished there "was a tunnel she could enter from which she would come out either as a complete anatomical man or a complete anatomical woman." Tony often thought about the time when she had had sexual relationships with women and was able to perform intercourse in the male role. In some of her dreams she was a man again, without female attributes, and was having sex with women. She fell in love with young women who were typically feminine. Tony had contacts with lesbian women but did not feel attracted to them. She said "I'm a man after all."

After the SRS, when Tony dressed in the kind of men's wear for which she had developed a preference, she felt a "strong sense of well-being," without any sexual feelings, and she felt like a "strong person." However, almost 15 years after the SRS, she described her situation in the following way: "I feel an endless longing to be away from here, in another time and another place, to become safe and happy, where I am a man and where I am appreciated and where the man and the woman within me are separated into the two poor people they are. I want to become two persons instead of being one body with two personalities fighting to come out. If I'd had a better life, maybe I would never have changed sex. But not feeling at peace with yourself, feeling that you are not one person but two young persons—one boy and one girl—in an old woman's body in terms of appearance and an old man's body genetically, that is a disaster." At different times during follow-up, the patient was offered psychotropic treatment with setraline and olanzapine, but she refused based on her former "bad experience" with fluphenazine.

DISCUSSION

A heterosexual orientation in biological males is common when older applicants request SRS, often after

having had a transvestitic career. These applicants could be called secondary transsexuals and are subject to several proposed risk factors for regret after SRS. In contrast, Lawrence (2003) found only a few occasional regrets in her study of 232 MF transsexuals after SRS, despite the fact that more than two thirds were aged 40 years or older at the time of SRS, two thirds had been married to a female, and nearly half had been biological parents. However, the participants in Lawrence's study were well adjusted and characterized by personal and social stability, contrary to the case under discussion. Tony had been hampered since early childhood by psychiatric symptoms and, according to her medical records, she had met the DSM-II (American Psychiatric Association, 1968) criteria for Overanxious Reaction of Childhood since her preschool years, and by puberty she met the criteria for Fetishism and Transvestism. In adolescence and early adulthood, Tony met the criteria for Transsexualism according to Wålinder (1967, 1968).

Starting in the early 1970s, Tony was treated at a psychiatric university clinic, but not at the special clinic for transsexual patients. In the 1970s, when Tony wanted to postpone the SRS and told her doctor about her satisfying sexual relationship with a woman of the same age, a leading expert in the field was consulted. He advised caution regarding further steps such as SRS. Although Tony said in the late 1990s that she "mostly lied" during the investigation before the SRS, according to the medical records she told her doctor about her heterosexual orientation, sexual function, and reasons for the sex change. After experiencing a social crisis involving a great deal of distress and anxiety, Tony decided in favor of SRS. According to the medical records, she said before the surgery that she wanted the results of the SRS to be true to nature both in "looks and function."

Poor results of SRS that remind the patient and partner of the patient's transsexual background are an important risk factor for regret (Ross & Need, 1989). Tony often complained that her failed SRS contributed to her feeling of being a "freak." Her gender identity was not stable over time; sometimes she felt like neither a man nor a woman but like a neuter, while at other times she had the feeling of being an individual with two sexes. However, she also commented, "After all, I am a man." At follow-up, Tony expressed strong feelings of being an outsider and of being abandoned by significant others. Clinically, Tony was characterized as being sensitive to stress with easily provoked anxiety, having a tendency for regression, and weak ego boundaries. She was egocentric and exhibited a sense of self that was filled with conflicts, narcissistic traits and, at the same time, strong feelings of inferiority. She had significant problems in relating to others. Her sense of identity was weak and fluctuating. She had feelings of deprivation and emptiness and complained of being bored. At follow-up, she fulfilled the criteria for Borderline Personality Disorder according to DSM-IV-TR (American Psychiatric Association, 2000).

During follow-up, she had outbursts of regret over her SRS and attributed her painful situation to the SRS. At the same time, she was pleased with the results of epilation and estrogen treatment, resulting in no facial hair. The estrogen treatment had resulted in well developed breasts with which Tony was partly dissatisfied. She was still taking estrogen and said that during the 1990s, when she had no contact with the health care system, she had bought estrogen from transsexual friends. She did not request a prescription for testosterone. Nor did Tony take legal measures to return to the male role, although she preferred male clothing. Concerning regret, Tony appears to fit into the category of "some regret" of Lindemalm et al. (1986). This may be due to the patient's personality and how this impaired her sense of self. During the long follow-up period, the patient's gender identity fluctuated and was never stable. Her wish for SRS was mainly characterized by ambivalence but during a stressful period she decided for and underwent SRS. Her ideal condition, confirmed from the medical records and at follow-up, is living as a female, feminized by hormones, but with male genitals, i.e., she-male status (Blanchard, 1993). During the two years of follow-up, her score on the DSM-IV-TR Axis V for Global Assessment of Functioning was 35. She has never been able to work, and it is our opinion that her situation can be illustrated as follows: "Psycho-social functional capacity seems in general to be independent of whether measures for sex reassignment are taken or not" (Lundström & Wålinder, 1984).

SRS did not resolve Tony's gender dysphoria; instead, it reduced her sexual outlet and pleasure, something she deplored. In her case, SRS could be considered a mistake. At the time of the renewed request for SRS, the patient did not fulfil the criteria for transsexualism according to DSM-III (American Psychiatric Association, 1980) (no stable wish for SRS during a period of two years). According to the SOC of the HBIGDA, "clinicians have increasingly become aware that not all persons with gender identity disorders need or want all three elements of triadic therapy" ("hormones, real-life experience, surgery"). In the case of Tony, awareness of this might have prevented SRS. The present case is an argument for a strict interpretation of the SOC in terms of evaluating the patient's mental health, apart from the evaluation of the gender identity disorder, and the patient's subsequent need for treatment interventions.

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