I Have Transitioned; I Wish I Would Have Known. . . Case Studies of Expectations

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Abstract

As people who identify as transgender continue to come into the spotlight of both the medical and political community, more conflicts arise in many arenas as sides are taken, laws are questioned, and ethics are reviewed. Questioning gender identity is vastly different from taking steps to surgically transition. Gender identity and sexuality are affected. Quality of life (QOL), as well as feelings of gender congruence are brought into play with hormone replacement, gender assignment surgery (GAS), and embracing of the new identity. With so much at stake, and so much to lose, the question begs, "Are people who sense regret, and wish to transition back to their birth gender truly supported and able?" Studies have shown both sides. This author agrees that for the truth to be revealed through research, the people who have actually experienced GAS, and surgically transitioned for an amount of time, ought to be involved in answering this question. Qualitative research captures the lived experience. This study involves case studies of people who transitioned late in life, then de-transitioned due to a variety of variables. Two common themes are how well-meaning health care professionals promoted a belief that becoming a "real" woman for men transitioning to women was a possibility, and that transition would make them happy.

Keywords: gender surgery, gender reassignment surgery, gender congruence, dysphoria, transsexual, cross-dress

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Societal barriers, loss of previous quality of life (QOL) as living in their birth gender, as well as the realization that no amount of feminizing surgery for men transitioning to women, could make them the gender of their choice, led to a return of the gender assigned at birth. This is in line with what Lehmann et al. (2021) note of this population with dysphoria. This population can become emotionally distressed when they sense their presentation as inauthentic, does not align with how they hope to present, and is compounded with how difficult that presentation is to maintain. These research outcomes aligned with the themes and outcome of the following case studies. Further research suggests, expectations on sexuality and subsequent sexual well-being are not addressed; orgasm function and capacity are not well understood (Zaliznyak et al., 2022). Of no surprise, recent research highlights the

importance for this exploration with a proper means to assess within this new territory ().

Personal narratives through qualitative research for such topics as gender assignment surgery (GAS) and personal outcome satisfaction are vital to capture a true and rich picture. The people who have had these experiences ought to be core members of the research group. Further, exploration of variables that affect establishment of gender confirmation and self-acceptance, are best revealed through semi-structured interviews that allow for free-expression and self-reflection (Rajkovic et al., 2022). This exchange can only occur within a safe environment. It is important to establish trust prior to beginning the research and data collection process. Judgement and shaming have been a daily experience for many of these participants (). Lack of social acceptance can contribute to negativity (Hansen & Żółtak, 2022). Health care discrimination and lack of provider knowledge contributes to mistrust (Kattari et al., 2021). Disparities in outcomes are not limited to this unique population but appear to be compounded by race, with higher reoperation odds among African American patients (Trilles et al., 2022). Lack of safe housing and violence contribute to vulnerability (Jackson et al., 2022). The following narratives were built upon this philosophy of understanding in hopes of capturing the true picture of those who have had GAS, lived that gender for longer than 5 years, and were willing to share what having the procedure truly awarded physically, socially, and emotionally.

With the population of people who identify as transgender now 1.5 million in the United States, the importance of assessing outcomes from transition is building in correlation to this growing population (Swe et al., 2022). Agochukwu-Mmonu et al. (2022) agree that "The development of patient-reported outcomes for patients undergoing genital gender-affirming surgery is the first step in ensuring high quality patient-centered care" (p.1 in abstract and conclusion). However, if they have not acclimated, why not? What are the variables and barriers to gender self-acceptance? Were expectations met?

Literature Review

Our medical system is not properly addressing the special needs for the transgender community (van Heesewijk et al., 2022). Disparities regarding surgery needs remain (Awe et al., 2022). Though well-being is being studied (Aldridge et al., 2022). There is still no tool to assess sexual well-being (Özer et al., 2023). Sexuality is an important human aspect (AOTA, 2014). More research is warranted within this social realm of society. Potential negative consequences may be mitigated with a better understanding for perceptions for gender identity. Societal familiarity may assist to this end (Hansen & Żółtak, 2022). This population is vulnerable to suicide. To make matters worse, "outness" has been tied to higher levels of suicide than within the cisgender and heterosexual populations. Suicide due to outness appears strongest during adolescence. Outness is the extent of disclosure regarding one's LGBTQ+ status to others (Feinstein et al., 2022). To conclude, affirming policies, laws of protection, and minimizing health disparities are a start to reducing overall negative health consequences ().

Of importance is to consider what acceptance means. Lemma and Savulescu (2023) note that clinicians are required to approve (validate) a patient's self-diagnosis. Accepting means that the clinician believes that the person who self-diagnoses as having gender dysphoria and is transgender, has their own individual perspective, and therefore, knows what can have a positive effect on their dilemma. Those considering transitioning due to

self-diagnosis could be assisted with an exploration as to what will assist with their well-being. Both conscious and unconscious factors ought to be respectfully explored (Lemma & Savulescu, 2023). In essence, we must be mindful of this vulnerable population and assist in helping and guiding without paternalistic intention. Aldridge et al. (2022), promote the importance of improving the knowledge of non-specialist healthcare providers, as well as encouraging protective legislation, social support systems and bringing to the general public an awareness for some of the issues the trans community routinely endures.

Few studies have assessed long-term outcomes following GAS for QOL, sexual well-being and satisfaction in new identity. Marchiano (2021), reviews and critiques the affirmative model of care for youth who demonstrate gender dysphoria. She notes that although in the last several years there has been a great global rise in the number younger people who identify as transgender, there also appears to be an increase in the number of younger people who are returning to the identity of their birth gender and de-transitioning after medical transition. Olson et al. (2022) note the opposite. Their results suggest that re-transitions are uncommon. They note that those who identify as transgender, and who socially transitioned at young ages, continue to identify in their choice. Both authors agree that it's important for clinicians and families to help youth with their struggles with gender identity to minimize distress. It appears that there are arguments on both sides for medical transition versus not, as well as conflicts of the number of people who transition and de-transition. Lemma and Savulescu (2023), summarize and provide an approach to this dilemma very well when they conclude:

> If we accept that the decision to medically transition needs to be at least substantially autonomous and substantially independent from controlling forces, then such a decision should only be taken after a period of exploration given the potential controlling influences (internal and external) that may bear on this particular decision. Unqualified acceptance can reduce the opportunity to explore the possible unconscious meaning of their transgender identification which, in turn, might lead them to consider options other than medically transitioning. This will likely enhance their long-term well-being (p.7).

Gaps in Research

More research is warranted regarding sexual functioning following GAS (Barcelos et al., 2022), as well as sexual well-being (Özer et al., 2023). The evidence is not strong that GAS improves sexual functioning (Barcelos et al., 2022), quite the contrary in some cases (Van Duyne, 2020); (personal communication Participant 1, 05/01/2022; Participant 2 05/19/2022). Although our study demonstrated that disparities in surgery that go beyond GAS remain, a study by Awe et al. (2022)Awe et al. (2022) proposed a call for more research to further study where gaps exist relevant to surgical practices in general (Awe et al., 2022). Also, Agochukwu-Mmonu et al. (2022) propose the critical need for a validated patient reported outcome measure following GAS.

Research Purpose

The purpose of this research is to capture the stories of people who have had the gender affirming surgery, actually lived the experience of their new identity for more than 5

years, and explore whether they still embrace their new identity. Are there barriers to gender self-acceptance? Were expectations met? Questioning gender identity or socially transitioning (living as the gender of choice but without surgery, hormones, or medical procedures), is vastly different from taking steps to surgically/medically transition. With surgical/medical transition (hormone replacement therapy and medical procedures such as GAS), gender identity and sexuality are permanently affected. Quality of life (QOL), as well as feelings of gender congruence are brought into play with hormone replacement, GAS, and embracing of the new identity. With so much at stake, and so much to lose, the question begs, "Are people who sense regret, and wish to transition back to their birth gender truly supported and able?" Studies have shown both sides (). This author agrees that for the truth to be revealed through research, the people who have actually experienced GAS, and surgically transitioned for a given amount of time, ought to be involved in answering this question.

The benefit of the study could potentially highlight the experiences of those who have not recently transitioned, but who have lived the experience for a substantial length of time following surgical/medical transition. These individuals may help inform those who are thinking about taking this irreversible surgical step.

Participant Criteria

Inclusion criteria: Adult (age 18 or older), have had GAS and experienced living as that gender for 5 years or more following GAS.

Exclusion criteria: No GAS, not an adult, and have not lived as the gender not assigned at birth for less than 5 years.

Tools

A 23-question survey followed by a 12-question semi-structured interview (Appendix A)was used in both face-to-face and Zoom interviews. This survey was developed by the Principal Investigator (PI). It was fill in the blank and multiple choice in an attempt to not suggest answers and keep the survey neutral. The participants were given the survey to complete along with the semi-structured interview questions to review. The interview questions were given prior, so that the participants could be prepared to answer. Some of the questions could trigger anxiety or upset due to their nature i.e. adverse childhood events (ACE). Following the interview, each participant was given The Beck Questionnaire for Depression (Beck Depression inventory, n.d.), Generalized Anxiety Disorder Screener (GAD-7) (GAD-7 Anxiety Inventory, n.d.), The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), The Bladder Self-Assessment Questionnaire (B-SAQ), and a brief Sexual Wellbeing questionnaire (Appendix B).

Methods

Snowball sampling was used to recruit study participants. People who identify as transgender are a hidden population due to variables such as harsh politics, and fears of harm learned from past experiences (Van Duyne, 2020). People with dysphoria are a "hard-to-reach-group" (Lehmann et al., 2021). I was able to get referrals from initially sampled participants to other persons who were believed to have the characteristic of my research interests. Once inclusion criteria were verbally established and informed consent was given

by the participants, the initial survey was provided. Once the survey was completed and reviewed by the Principal Investigator (PI)/researcher, the answers were explored for further clarification. Participants were asked to self-reflect, but were not led. Repetition of answers was used to encourage further expression in answers and highlight intent of meaning. A recorder was used at throughout the entire interview process. The semi-structured interview began after a short break following completion of the survey and after the PI completed the review of answers from the survey.

The semi-structured interview was question/answer with a similar self-reflection component for the responses. Paraphrasing and repetition was used to ensure understanding by the PI. Notes were taken to enrich the data gathering experience. Their answers were visually/audio recorded for transcription via Zoom. This activity was participant-led (discussions were free-flowing and reflective; options were given for being recorded auditorily and/or visually during sessions; participant comfort with involvement was foremost for promotion of respect and authenticity of responses to questions and research tools).

Next, The Beck Questionnaire for Depression, Generalized Anxiety Disorder Screener (GAD-7), The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), The Bladder Self-Assessment Questionnaire (B-SAQ), and a brief Sexual Wellbeing questionnaire were given one at a time. These questionnaires and screening tools were reviewed after participant completion and before moving to the next questionnaire or screening tool. Notes were taken to explain or expand upon the topic of each tool. These tools as well as questionnaires are included at the end of this article.

Participants were asked to take breaks every 30 minutes unless they asked to not take breaks. Most verbalized that 30-45-minute periods were adequate. The entire process took 2 ½ hours for each participant. Each were seen individually in a place or method of their choosing (public restaurant or venue, Zoom, or home setting). If participants chose to remain anonymous, they were told they could keep their video cameras off. They were informed that Zoom sessions would be taped for transcription and face-to-face sessions would be recorded, but only if participants agreed. They were assured that if they chose not be recorded, they would not be excluded from the study. Tapes were given for transcription to a bonded medical transcriptionist for safety and accuracy of data. There was one Zoom audio/video session, one face-to-face session, and one telephone /email session. No one asked to be anonymous.

Confidentiality

All participants were assigned a number which was put on the surveys, questionnaires, or screenings provided by the PI. The numbers assisted to link participants to responses and were entered into the computer system for qualitative breakdown of themes, similar threads, and an objective data summary review. The research material is kept in the PI's locked university office within a locked cabinet and on a locked university issued computer. The informed consent forms and the research material are all kept separately. All data will be stored in this fashion and then destroyed following university protocol.

The Interview Process and Discussion

I asked participants to talk about their experiences with encouragement through a semi-structured interview, as well as reviewing answers to questionnaires and the topics

(anxiety, depression, PTSD, Wellbeing, health outcomes following GAS to include urinary incontinence through the B-SAQ). I used a case study outline, but approached this study with a phenomenological approach. I endeavored to set aside my own beliefs and preconceived ideas about what I was investigating. In spirit, I bracketed so that I could better learn about my participants' perceptions, without including my own views. I engaged in deep self-reflection before meeting with each participant. I wrote down my own thoughts about the phenomenon. These experiences were an excellent way for me to bracket my own perceptions and identify my bias ahead of time so that I would identify them. I would then speak with a participant and collect data, analyze, and transform the data. By doing this, I was able to share their stories.

When I collected the data, I kept two things in mind: authenticity and that person's "truth." For this reason, I recorded the interviews and wrote their words verbatim. As they spoke, I would wonder how they experienced the phenomenon, and what had influenced the perception and experience with this phenomenon. I talked about their life histories, the details of the experiences, and asked them to reflect on the meaning using specific examples. I next analyzed and transformed the data into a summarizing article that reflected their heart's message.

I looked for themes and worked to bring the phenomenon down to its core which was essentially bringing out the meaning of the experiences. I believe that by sharing their stories, it assists to bring to light descriptions of what they have gone through and helps to expose things which were previously unknown.

Themes

Through qualitative thematic analysis of interviews, I identified 6 themes. These themes reflect the experience of yearning for acceptance from family and society as well as that of confusion: unrealized expectations, isolation, sunk-in effect, communication casualties, bias-embedded medicine, inward-directed negativity.

The unrealized expectations were prevalent and noted throughout the interview process for all participants. Although each of the participants had gone through facial feminization, larynx-shaving, rhinoplasty, lip augmentation, breast augmentation (all but one participant), and bottom surgery (neo-vagina), all had difficulty looking in the mirror. Some of them either avoided looking in the mirror altogether, or unscrewed the lightbulbs so they could not see themselves clearly. With each surgery there was new hope. There were promises from surgeons and other medical support that it would help them to achieve their feminine ideal, only to have it dashed when they looked in the mirror. Expectations were unmet and very much lacking in their own eyes. Each participant noted that when they looked in the mirror, they, "Still saw the man I was before." The participants also noted that they quickly realized that becoming a woman was more than just having a surgery and changing their gender marker. They quickly realized that they had not gone through developmental milestones to make them a "real" woman (participant's #1 musings). They had not gone through junior high and puberty. They had not had sleepovers and practiced putting on makeup and trying on a variety of different clothes with peers as a young female. Even though their current support systems offered them makeup tips or sent them to people who could teach them how to dress and attempt to try out their new femininity, their efforts felt futile and below the

mark. They felt like imposters. The fear of being "found out" was frightening. This fear led to a sense of isolation.

Isolation is another common theme. The participants noted that after they had their bottom surgery, they realized that making friends would be difficult. They realized that friendships are based on trust, and they now had a deep secret. If they wished to have an intimate relationship, they would need to disclose their surgery. Therein lay another issue: the participants all noted that their sexuality changed following their surgery. GAS, in simple terms, and many cases, involves inverting the penis to make a neo-vagina. Some participants end up having more than one surgery for the aesthetic factor. They wish for a more authentic labia or clitoris for example (Morris et al., 2022). Higher numbers of surgeries can result in more scar tissue and nerve damage; this changes sexuality or sexual-wellbeing as was the case for one of the participants (personal communication P1, 04/18/22). This topic was not discussed with any of the participants by the physicians. They were instructed to dilate their neo-vagina, but sexual well-being was not discussed before, during, or after their procedure. When asked about orgasm during the interview, participants noted that if they did have an orgasm, it was normally after much stimulation to the prostate or they would have a nocturnal emission much like when they would have a wet dream as a teenager. All noted that sexual acts were not as comfortable as prior to their GAS. There was a sense of feeling awkward and unsure, as well as feeling uncomfortable with their new genitalia. The gender dysphoria was not helped, but at times was heightened with sexual acts. This sentiment was upheld by (Lindley et al., 2022) "... gender dysphoria is more salient to sexual acts that involve receiving versus providing sexual pleasure (p. 1)." With each surgery, and with each loss, all participants noted that the urge to keep trying, due to what they had already paid for physically, financially, and emotionally, made it hard to give up. This is called the sunk-in effect.

The sunk-in effect did not begin to let up until they were essentially 5+ (two participants at year seven) years post-surgery. All the participants noted by the time they were five years in, they felt they had already put too much time and effort in to make this gender identity effort work. It was too much effort, discouraging, and not what they expected. It was then they realized de-transitioning (back) to their birth gender was the only next step. To this end, communication casualties (with inadequate informed consent) and bias-embedded medicine went hand-in-hand.

Regarding biased-embedded medicine, all participants noted their initial counselors encouraged them in verbal and nonverbal ways to have the GAS. Many of the surgeons and healthcare professionals were the same: encouraging. It seemed that no one wished to tell them that they should slow down or reconsider this step. The word transgender was not always used when health care workers spoke to them, but the participants had all done their homework and had labeled themselves transgender. They approached counselors and surgeons with their self-diagnosis and were met with assurances that GAS was the only way for them to feel a sense of peace and harmony. These biased exchanges led to hope and expectations of a future with peace and harmony. Finally, the inner conflict would be gone. All of the participants noted a sense of joy going into the surgery. Some noted a sense of trepidation in conjunction with their joyful anticipation of their long hoped for outcome. There was a sense that once they had their surgery they would receive the sense of acceptance, attention, and significance from society for which they yearned.

All shared that when they were little, as young as four and five, they yearned to be a girl. They noticed either their cousins or their sisters being treated with special privileges by family members and by society. They felt girls were put up on a pedestal, and if they could be a girl, they too would move into a place of security, comfort, and acceptance. These feelings of conflict and confusion moved from early childhood into early adolescence. Most of the participants noted that as boys and men they felt unattractive by Western standards either by their physical appearance and/or by a characteristic(s). Most of them engaged in exercise and/or joined athletics such as swimming to overcome feelings of self-negativity. The non-verbal and verbal communication casualties gave hope, but it was a false hope. The continued yearning to meet their own gender ideal standards, coupled with the regular unmet expectation that having GAS would gift the security, comfort, and acceptance so desired, was dashed after several years. A recent article by Lemma and Savulescu (2023), supported these collective thoughts and reflections.

All participants noted negative self-speak and negative thoughts of themselves. They worked very hard to keep busy in extracurricular activities and in their studies to wear themselves out so that these thoughts would stop or minimize. All of the participants disclosed that even with de-transitioning, they occasionally still have negative self-thoughts and fleeting moments of thinking of re-transitioning. One participant did the transition once again but is now considering transitioning back to their birth gender. None of the participants believe that they are truly transgender, but they do believe there is something deeply embedded in them that makes them question and embark on this roller-coaster journey of gender identity and the subsequent cycle of confusion and negative self-thought and self-speak. Psychological distress can lead to depression and anxiety, as well as affect work performance, therefore reducing occupational well-being (Pereira et al., 2022). It is not surprising that people who identify as transgender have such a high suicide risk as a population compared to the general public ().

Bias in any shape can cause issues with positive outcomes. These six themes supported the bias-based research of Casanova-Perez et al. (2021), who reviewed the health care experiences of people who are categorized as marginalized (Black, Indigenous, People of Color [BIPOC] and Lesbian, Gay, Bisexual, Transgender and Gender Diverse [LGBTQ+]), through qualitative study. Multiple studies have highlighted how people within the BIPOC, as well as the LGBTQ+ communities, have lower provider quality of care as well as poor health care outcomes due to bias (Medina-Martinez et al., 2021). This can be compounded with disability (Mulcahy et al., 2022).

Participants

All participants have had GAS and experienced living as that gender for 5 years or more, following their GAS. Some participants were still living as this chosen gender following their procedure, others had transitioned back to their gender assigned at birth, but after 5 or more years. All were adult and lived in varied states, across the United States, to include far eastern, western, and northern states.

Meet Participants #1; Participant #2; Participant #3

Table 1

Feminizing Surgical Procedures & Behaviors Following Detransition

Year of Detransition	**Facial Feminization**	**Other**	**Fetishes**	**Cross-dressing**	**Selfies with intent to capture any of these categories for self**
Participant #1 2010	2017		Yes; pantyhose & makeup	Yes	Yes
Participant #2 2010	2017		Yes; toe nail polish	Yes	Yes, but now no
Participant #3					

The Interviews: Portraits of Confusion and Unmet Expectations

P1: Medical doctor who is in their 60s. Working in Midwest. Transitioned male to female in their 40s. Re-transitioned to male in their 50s. Transitioned back to female in their late 50s. They are considering transitioning back to male when they retire in their mid to late 60s. Has been married three times as a man. Remarried their third wife as a female. Was married initially to that wife as a male. Regret at year 5 plus.

P2: Engineer who is in their 50s. Working in West. Transitioned male to female in their early 30s. Re-transitioned female to male in their late 30s. Was married as a male to a woman twice. Transitioned during their second marriage a month after being married with her blessing. The marriage ended in divorce after six years. First marriage ended year three, second year 6, and third 11 years and still married (He is now married to a woman as a man). Has had a phalloplasty since transitioning back to male. One to two years after phalloplasty, had it reversed due to multiple medical problems. It was not functional. Regret began year 6.

P3: Retired in their 80s. Did not wish to be formally interviewed but did give verbal consent and permission. Spoke briefly to answer the research questions, as well as give a personal story of a person who had had the surgery and had poor outcomes and even worse follow-up or support following the procedure. Retired; living in the East. Married. Married after transition back to birth gender. Lived as gender of their choice for more than 10 years; regret following year seven. Researcher: "The purpose of this research is to capture the stories of people who have had GAS, lived the experience for more than 5 years, and explore whether they still embrace their new identity. Also, if they have not acclimated, why not? What are the variables and barriers to gender self-acceptance? Were expectations met? Can

you speak on this research question?"

P1: *"I had my surgery well over a decade ago, 2005. Since then, I have been on this roller coaster for gender identity and dysphoria. I feel like a salmon swimming upstream. Even though I am getting beat up by the rocks (society) I continue on my journey. Even though I do not believe there is such a thing as transgender, I do believe there is something to this. I do not know what this is. I do know that I am tired of labels. I just want to get on with my life and I would wish that people can understand that I don't appreciate feeling like a pariah or something to be stared at. So, if you ask me what variables and barriers have kept me from achieving gender self-acceptance, I would have to say that it is a combination of society, but also myself. I do not believe that a man can be made into a woman or vice a versa. Just because I've had body parts fashioned or removed it does not make me the gender of my choice. Yes, I wish that I could have achieved my goal on one hand, however on the other hand at this point in my life I truly do not want to be a woman. I do not have gender self-acceptance because I do not see myself as a woman. I have not gone through the milestones of junior high and I have not had the menstrual cycles or lived the trials as a born-woman, or all of the other things that I've noticed girls, young women, and actual women have. So yes, I can speak on the research question. In all honesty, I wish I had never had the surgery. I wish that somebody would've told me that there was another way and that I should just learn to accept my male self. I never accepted myself as male and I believe that that was the root of my problem. If I could've had counseling and I could've had someone who put a plan in place so that I could learn to love my male side and myself I believe that things would've turned out much differently for me. One thing, I would have all the money in my bank account versus the pockets of the surgeons and other support systems. I would be more than likely happily married, with a couple of children versus alone and not produced any children. That ship has sailed. Or as my former boss used to say,' that dog can no longer hunt'. No, I do not embrace this identity. I went back to being male once; I have plans to do that again in the future after I retire."*

Researcher: "The purpose of this research is to capture the stories of people who have had the surgery, lived the experience for more than 5 years, and explore whether they still embrace their new identity. Also, if they have not acclimated, why not? What are the variables and barriers to gender self-acceptance? Were expectations met? Can you speak on this research question?"

P2: *"I lived as a woman for several years following surgery. I felt that having surgery and becoming female was my only choice. I was molested when I was a very young boy by someone who I trusted. This experience deeply affected me and I kept it buried deep inside. I suppose it changed how I saw the world. I believe most people are looking for a sense of acceptance, security, and significance. I didn't feel this way after my childhood event. Later in life I went to counseling. I was in counseling for a very long time. One session I told her that I thought that maybe I should try gender surgery. She got up came around the desk and hugged me. She told me that she was glad that I had finally gotten to this place in our counseling. She quickly filled out the paperwork and made the proper connections. The next thing I knew I was scheduled for gender assignment surgery. I was told that it would help me*

with my gender dysphoria. The word transgender was never used but I diagnosed myself and used this term to describe myself."

Researcher: "Was informed consent reviewed, as far as what to expect following surgery (GAS) ever discussed? Did they ever discuss sexual well-being?"

P2: *" I don't remember whether informed consent was ever reviewed. No one discussed sexual well-being. All I knew was that this (surgery) was the only way for me to feel all right again. I mean, it appeared to be what my counselor had been waiting for all along."*

Researcher: "Back to the original question. . . ?"

P2: *"I was all right at first living as a woman. But within a couple of years, I was no longer all right with it. My struggles continued but now they were different struggles. I was in a relationship with a woman who encouraged and enabled my behavior. I now realize that that just prolonged the path I was on. I wish that someone would've told me back then that I did not have to have the surgery in order to stop feeling so confused and unhappy with myself. I wanted to have that sense of acceptance, significance, security. I believed living as a woman would give this to me. It did not. Over time I have continued to struggle and felt that if I went back to being a woman that things would be all right. After going back to being male, I did have facial feminizing surgery. Despite having the surgery, I made the decision to remain male and I am at peace and happy with that decision. What I found now is that whenever I am feeling conflicted I don't turn towards myself, I turned to Jesus Christ. I turned to Him to give me strength. I wish I would've done this before instead of listening to someone who seemed to have already made up her mind that I needed to have surgery in order to be happy, because none of this was the case. To answer your question, if someone, such as a counselor would have told me that I was accepted, significant, and helped me to feel a sense of security, things would've turned out much differently. As I've said, I found what I needed through Jesus. My barriers to gender self-acceptance was that I did not accept myself as male probably because of what happened to me when I was very young."*

Researcher: "The purpose of this research is to capture the stories of people who have had the surgery, lived the experience for more than 5 years, and explore whether they still embrace their new identity. Also, if they have not acclimated, why not? What are the variables and barriers to gender self-acceptance? Were expectations met? Can you speak on this research question?"

P3: *"I had gender surgery and lived as a woman for several years. At first following the surgery, I felt a sense of relief. I thought I had done the right thing and that I would finally feel at peace. That feeling was short-lived. My gender dysphoria was tied to an adverse childhood event (ACE). When I was very young, I had a family member who used to dress me up like a little girl. Being dressed as a little girl was the only way that I got acceptance from her. This went on for many years. I believe that many people who are male and have gender surgery have had ACE. No. I do not embrace that identity. As a matter of fact, I do not believe that there is anything such as transgender. I believe that things happen to people*

when they are growing up and it pushes them to behave in ways and to seek things they would not normally do. To make matters worse, society is now promoting this (surgeries). Children are being given hormones and being encouraged to have these surgeries. There are a lot of children who have had trauma in their childhood; these surgeries are being used to heal what has happened to them. They need counseling to heal and to learn to accept themselves. Childhood wounds can be barriers to self-acceptance. People are not misassigned a gender at birth, the issue is a broken core identity."

Researcher: "You had a story?"

P3: *"Much of the time gender dysphoria is tied to psychiatric issues. What I have found is that many people who are having gender dysphoria have trauma that stems from their childhood and it comes out in psychological disorders such as depression, attention deficit disorders, and anxiety. I know someone who was receiving psychiatric care from age 13, and was diagnosed with bipolar disorder and schizophrenia that stemmed from sexual and physical abuse. Even though he was diagnosed with this disorder he was also given the diagnosis of gender dysphoria. As a result, he was given hormones and finally gender affirming surgery. Less than six months after the surgery he was stating that he did not have gender dysphoria. He reached out to his counselors and they told him that they had done their part in that it was up to him now to move forward. As a result, he reached out to people in support groups who had made a similar mistake such as he did, to receive the emotional support; however, the physical trauma had already been done and there was nothing available to turn back time. Since having the surgery, he has lamented that his ability to marry and have children have been taken from him. He realizes that probably the childhood trauma coupled with his psychiatric issues made him feel a sense of unbalance and confusion. He recognized early on that the surgery was not the answer and if anything has made things dramatically worse. He feels more alone and isolated due to the outcomes of the surgery."*

Researcher: "Was your sexual well being discussed with you before, during, or after your surgery by health care personnel? Can you have an orgasm without stimulation to your prostate? What is your estimation, from speaking to your peers, of the percentage of people who have detransitioned or are contemplating it after more than 5 years post-surgery, following living as the gender they were not assigned at birth?"

P1: *"No. Sexual well-being was not a topic. It was more about that I wanted the surgery to become what I hoped would bring me happiness and end this inner battle and turmoil. I wanted peace and harmony. I always felt at war with myself. I do not have orgasms. I have had 'fear releases' when I sleep. I have major anxiety. When it builds, I have 'fear orgasm' releases; it is like a wet dream. It is not pleasant, but it is a release of prostate fluid. I can orgasm but only with stimulation such as rubbing to my prostate. It takes a long time. I do not like to ask my wife to do it because it is too uncomfortable for both of us. Occasionally I do it to myself, but it takes a very long time and is not worth the time and effort in the end. (Regarding detransition) I cannot imagine what the percentage is. It must be high when I consider myself and those I know in my situation. Maybe 30 or 40 or even over 50%.*

People do this and disappear. I do not know why people do what they do. Maybe it is a trend with young people to identify as trans or nonbinary? Maybe it is tied to poor mental health? There are a lot of unknowns."

P2: *"These are not tough questions. My sexual well-being has never been discussed. I never even knew there was such a thing until you asked me, and I answered the questionnaire. So, no. I have orgasms, but they are wet dreams and infrequent. No. I do not have orgasms with stimulation. For detransition? I believe the percentage is 55% or higher. It is not low like what you might read about. The people I talk with have regret and have transitioned back; they do not always want to talk about it. These are not younger people but mostly people like me who did this later and have lived with it. The expectations were not met. The transition did not help them long term. The people who helped them to transition probably do not know that they have gone back."*

P3: *"My sexual well-being was never discussed. It was never a topic. The topic was that I had a condition, and it would remain until I had the surgery and became what I was meant to be. A woman. That was all. No. I have not and do not have orgasms. Not since my surgery. It was not a topic they or I brought up. It was not something of importance. It was more important that I become what I was meant to be. I wanted to feel less conflicted and was told this was the solution. Percentage? I have no idea. It is higher than 5% and I would guess probably 55-65% as a low point. Probably closer to 70-75% but then people fade away, they die or continue to live the fantasy because they have lost too much to go back."*

Participant Musings

Participant #1: "What if someone has gender dysphoria and the distress is really tied to something like autism? It seems like I read that somewhere. It makes sense, I mean this used to be considered a mental disease and tied to being homosexual or at least a step in that direction." According to two 2022 studies, one by Cooper et al. (2023) and another by Hendriks et al. (2022), this musing of tethering autism to gender dysphoria has been researched. Mazzoli et al. (2022), found a marked decrease in Autism Spectrum Disorder traits following gender affirming hormone therapy. Participant #3: "I think this is all about sexuality and the thrill of wearing women's clothes [if assigned male at birth]. Think about it. Do women get turned on by putting on their clothes each morning? I do not think so." Participant #2: "I don't think there's anything called transgender. I think this involves the need for security, acceptance, and significance. I believe everyone who goes down this path has problems in these areas. A person just has to find another way to get them (security, acceptance, and significance). I have finally found my way through Jesus Christ. Being considered transgender and having these surgeries used to be taboo, but now it's become a trend and popular especially among the youth. My fear is that many younger people will have this procedure and be supported to go through with it, but what I've noticed is once you have the procedure then you are truly on your own. I know somebody who had the procedure in their early 20s and it was all paid for, but not by them. Now they're having regret 2 years later and they have been told that they are on their own." Participant 1: "I can't believe I ever thought having the surgery and taking hormones would make me a real woman or happy. I

have ruined my life but what do I do now? I deluded myself. I wanted to be seen and not invisible. I suppose I have finally succeeded in that, but not how I had hoped."

Table 2

Questionnaires, Surveys, Screenings (2022)

	Beck	**B-SAQ**	**GADD-7**	**PTSD**
Participant #1 JES	16 Mild Mood Disturbance	8/8	2/6	Yes; all yes or 5
Participant #2 BB	3-Normal	4/3-Great Deal	*0/0	Yes; all no or No PTSD
Participant #3				

*DNP-Did not participate in completing surveys or questionnaires.

P1-The Beck Questionnaire demonstrated mild Mood disturbance with a score of 16. The B-Saq
showed a score of Great Deal of Bother and Great Deal of symptoms. The GADD-7 scored 2/6 for
none for anxiety disorder.

P2-The Beck questionnaire did not demonstrate depression. The score of 3 reveals that the ups
and downs of daily living are considered normal. No depression. The B-SAQ showed a Great
deal of symptoms with a score of 4 and a Great Deal of bother with a score of 3. Participant
reported that his symptoms went away when he "went through the steps to freedom in 2017." His words. The PTSD questionnaire showed no symptoms. Score of No to each question or 0 score.

P3-reported he had been abused as a child.

These surveys and questionnaires were not used to diagnose mainly to attempt to find correlations within the case participants.

Limitations

There were only three participants. Though the participants met criteria and lived in various states across the nation, the sample size was small. Participant #3 did not wish to be formally interviewed or answer the surveys and questionnaires. He talked on the phone and he sent email as well as shared articles that supported his view of the research question. As with the others, he was debriefed for accuracy of data.

Table 3

Sexual Wellbeing

	Fetish: before, after & currently	**Sexuality (normal/ hypo/hyper)**	**masturbate (yes/no)**	**Partner Relations (yes/no)**
Participant #1.	yes, yes, yes	hypo	Occ w/toys	Yes, 1-sided
Participant #2.	yes, yes, no	hypo	No, but have wet dreams	Yes, 1-sided
Participant #3.	*DNP	DNP	DNP	DNP

Definitions:

Sexuality
Hyper: think all the time; more than daily
Hypo: rarely think about it
Normal: think about it daily to a few times/week.

Masturbate: with adult toys or hand or other.

Partner relations: involves touching in a sexual manner. Does not need to involve penetration. Explain whether the relations are 2-way or more 1-sided as giving.

*DNP-Did not participate in answering questions.

Conclusion

Regret is a personal and complex feeling. Types of regret ought to be explored to better explain data, according to Bustos et al. (2021). Some research reports note regret is 1% or less; Bustos et al. (2021) is one such systematic review. This data is gleaned from a variety of participants in a variety of stages following their GAS. More follow-up studies and time may help highlight the reality of QOL and true outcomes following these procedures (Pavanello Decaro et al., 2021). Bustos et al. (2021) admit that the results of their review of regret are subjective, that standardized questionnaires are lacking, and that more thorough follow-ups are warranted for better insight into regret following GAS. To this end, though the cases are rising for GAS, there does seem to be a trend for youth de-transitioning (Marchiano, 2021). A recent study on gender dysphoria, showed older people were less troubled by this issue. That it is not gender but more age-related, and that gender dysphoria effects more of the younger generations than older adults (Oshima et al., 2022).

There is still much that needs exploring within this topic and population. According to Özer et al. (2023), there is still no tool to assess sexual well-being at the time of their 2022 study. Though well-being has been explored in some recent studies (Aldridge et al., 2022), the areas addressed are not whether sexual well-being was addressed before, during or after

Table 4

Timeline, 2022

Age Began Cross-dressing	**Year of transition**	**Major Conflicts (Year/Age)**	**a-face feminizing b-breast aug c-other**	**Year/Age Detrans**	**Year/Age Re-trans**
Participant #1 Age 8-9 yrs old wore mother's pantyhose	Age 45 2004	2004 2010 2015 2021	a-2016 b-2004 and 2016 c-2004-2006	2010	2016
Participant #2 Age 8-9 yrs old makeup	Age 30 2002	2008 2010 2016-2017	a-2017 c-2002-2008	2010	n/a
Participant #3	n/a	n/a	n/a	n/a	n/a
Fetish- dressing	Yes all				
Cross- dressing	Yes all				

#1 (2004-2006) "I did multiple surgeries all at once to be done within 2-3 years except facial feminizing surgery following transition".

#2 (2002-2005) "I had multiple surgeries except facial feminizing then gave up year six following transition". No breast augmentation. Larynx (Adam's apple) shaving & brow shave 2002, bottom surgery 2002, rhinoplasty, voice surgery (tighten larynx to increase pitch), 2nd Adam's apple shave. Detransition to Male Reversed voice surgery with straining vocal cords. Phalloplasty 2010; reversal 2012

transition, but more so external variables (i.e. how the public views the transgender community, protective legislature, health care worker medical prowess, and the need for social support). Because of this, we touched on this topic with our sexual well-being questionnaire, coupled with the combined survey and semi-structured interview. Sexual well-being cannot be eliminated as a factor in QOL and overall positivity in daily living following GAS. It seems that QOL and gender congruence may be high following GAS (Pavanello Decaro et al., 2021), but can decline over time, especially after 5 or more years, with de-transitioning an outcome in not only youth (), but adults. Even with surgery, some find the surgeries do not meet expectations for physical outcomes which causes distress and regret (Lehmann et al., 2021). Long term studies from 2011 support though gender dysphoria may lessen, other issues and barriers can come into play or be magnified (Dhejne et al., 2011).

> Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, although alleviating

> gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group (Dhejne et al., 2011, p. 7).

In conclusion, people who have had GAS, though a growing population, are also trending in some groups to return to birth gender (Marchiano, 2021). Our study also confirms that many who have de-transitioned are under-reported making regret following GAS an unknown percentage currently. Though GAS may help with gender dysphoria, it does not necessarily help with the inner conflict or other issues that occur due to and following transition (). Protecting the rights of people who are transgender means helping them with acceptance of themselves, but not necessarily by guiding them to have surgeries or steering them with a paternalistic approach to care (Lemma & Savulescu, 2023). Autonomy and promotion of self-acceptance must be upheld in approach to care... "understanding oneself at the conscious and unconscious level" (Lemma & Savulescu, 2023, p. 7). It appears that there ought to be a balance for best outcomes. Gatekeepers were in place prior to decision-making, and now self-diagnosis appears to be a variable in moving forward quickly with GAS. Lifecare planners are in a unique position to support their clients who may be questioning gender, choices of gender identity past and present as well as dealing with the frustrations of unmet expectations. Moving away from a Gatekeeping Model to an Informed Consent Model of care may be one solution (Verbeek et al., 2022). Life care planners have a unique and holistic perspective and individual scopes of practice. This places such providers in a favorable position to address mental health issues as well as the physical and vocational needs that continue to challenge this unique population.

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Appendix a

Semi-Structured Interview Questions

Please review and *Wait* for researcher before answering. Your answers may be recorded.

VI. Your Truth

1. Were you ever told you were transgender? Yes No If so, by whom?
2. Do you believe there is such a condition called transgender? Yes No I do not know
3. What advice would you give health professionals for best outcomes for people who come to them for answers to their gender questions?
4. What do you wish you had been told or advised?
5. If you were told that you would be happy as a result of this procedure, did you find any truth in that?
6. Please expand on question 5 of Procedure Outcomes regarding the surgery and hormone's effects on selfcare and hobbies/exercise.
7. Do you believe you have experienced adverse childhood events (ACE)? Examples: emotional or physical abuse, hunger, parental divorce (this is not a complete list).
8. If ACE was experienced, do you believe this experience(s) had any effect on your development as your gender assigned at birth? Have you ever been diagnosed with a mental health condition? If yes go to next questions. If no go to #9.
   If so at what age? Do you have any insight into why you may have this condition? Has it resolved or gotten worse or the same? Does it change for any reason?
9. Following your procedure, did you experience new barriers, not experienced prior to your procedure? Examples: denied access to healthcare, housing, employment (this is not a complete list).
10. Following your procedure, and while living as the gender not of birth, did you experience a difference in society's reaction to you? If so, what specifically?
11. Following the procedure, do you believe you "passed" as the gender not of birth? If not, what were some examples that led you to this conclusion?
12. Some articles I have read report that regret following GAS is only 1%. Do you have any thoughts on that percentage?

Appendix B

Sexual Wellbeing Following Gender Affirming Surgery (GAS)

Sexual wellbeing… "promotes healthy relationships with sex and our bodies, and encourages positive physical, mental and social well-being" (Allia Future Business Centre, 2022).

1. Following review of the definition of sexual wellbeing above, was sexual wellbeing discussed with you *prior* to your GAS by your surgeon and/or their care team? Yes No
2. If yes, were you told that your sexual wellbeing would become (choose one) better same unchanged Not discussed
3. Was sexual wellbeing discussed *following* your GAS by your surgeon and/or their care team? Yes No
4. Did you believe that your sexual wellbeing would improve following GAS? Yes No
5. Has your sexual wellbeing changed since your GAS? Yes No

Please use this space below to explain any of your answers.

Reference

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Appendix C

Expectation Survey

*Number/Date_____

The purpose of this survey is to gather data that will help educate those who may be contemplating having surgeries such as gender reassignment or gender assignment surgeries (GAS) to make an informed decision. People who have had these surgeries can speak to some of the needed truths to this end. The above-mentioned gender surgeries will be referred to as GAS for this survey. Criteria: Adult (age 18 and older), who have had gender affirming surgery (GAS), who are 5 or more years out, and who have lived as the gender of their choice for 5 or more years.

Participant meets research criteria as outlined in informed consent. Yes___ No___

This survey takes approximately 5 minutes to complete. If a question makes you uncomfortable you may leave it blank. *Your name will be converted to a number to uphold anonymity.

I. Demographics

1. (Circle 1) Age 20-30 30-40 40-50 50-60 60-70 70-80 80-90 90-beyond
2. Have you had a procedure referred to as gender reassignment surgery (GAS)? Yes No

If you answered No, Stop Here. Do Not Proceed.

3. At what age did you have your GAS surgery? _____
4. What gender were you born? Male Female

II. Beliefs

1. Do you believe that a person can change their gender through gender reassignment or gender assignment surgery (GAS)? Yes No
2. Do you believe a person can change their gender through a medically supervised hormone replacement regimen? Yes No
3. Do you believe a combination of hormone replacement and GAS can change a person's gender? Yes No
4. Do you believe that a person's external physical characteristics determine their gender? i.e. breast augmentation or external genitalia? Yes No

III. Medical Advice/Expectations (counselor = Psychiatrist, licensed counselor, social worker and Medical = GAS surgeon)

1. Were you told by medical personnel or counselors that having a GAS procedure would make you the gender of your choice? Yes No
   If yes by who? (Circle 1 or both) Medical Counselor
2. Were you told that gender is a choice? Yes No
   If yes, by who? (Circle 1 or both) Medical Counselor
3. Were you told that your quality of life (Qol) would improve if you have GAS? Yes No
   If yes, by who? (Circle 1 or both) Medical Counselor
4. Were you told that you would not be happy unless you had the GAS? Yes No
   If yes, by who? (Circle 1 or both) Medical Counselor

Appendix C

5. Were you told that you would not be happy unless you fully embraced living as the gender you were born? Yes No
   If yes, by who? (Circle 1 or both) Medical Counselor

6. Were you told that you may have complications with urinary incontinence following your surgery? Yes No
   If yes, by who? (Circle 1 or both) Medical Counselor
   6a. If you were told you may have urinary incontinence, were you told it may be chronic or lifelong? Yes No
   If yes, by who? (Circle 1 or both) Medical Counselor
7. Where you told that your ability to orgasm may be affected? Yes No
   If yes, by who? (Circle 1 or both) Medical Counselor
   7a. If you were told your ability to orgasm would be affected, were you told this could be a lifelong or chronic issue? Yes No
   If yes, by who? (Circle 1 or both) Medical Counselor

V. Procedure Outcomes

1. Do you experience urinary incontinence as a result of your procedure? Yes No
2. Do you experience orgasms since your procedure? Yes No
3. Did your Qol improve at any time following your procedure Yes No
   If yes, when and for how long did it last? When _____ Length of time_____
4. (Mental aspect) Do you believe the GAS procedure had a net positive effect overall? Yes No
5. (Physical aspect) Do you believe the procedure and/or hormones effected your body's performance in selfcare or other activities such as hobbies and exercise? If so, use the space provided to explain:

VI. Regret

1. Did you feel *regret* following your surgery? Yes No
   If you answered No, Stop Here. Do Not Proceed.
2. How soon following your surgery did you feel *regret*? (mark or circle 1 choice)
   Right away
   Within 6 months
   Years 1 2 3 4 5 6 7 8 9 10 _____
3. Do you wish you had never had the GAS procedure? Yes I wish I never had it No I am glad I did it

Sexual Wellbeing Following Gender Affirming Surgery (GAS)

Sexual wellbeing… "promotes healthy relationships with sex and our bodies, and encourages positive physical, mental and social well-being" (Allia Future Business Centre, 2022).

1. Following review of the definition of sexual wellbeing above, was sexual wellbeing discussed with you *prior* to your GAS by your surgeon and/or their care team? Yes No
2. If yes, were you told that your sexual wellbeing would become (choose one) better same unchanged Not discussed
3. Was sexual wellbeing discussed *following* your GAS by your surgeon and/or their care team? Yes No
4. Did you believe that your sexual wellbeing would improve following GAS? Yes No
5. Has your sexual wellbeing changed since your GAS? Yes No
   Please use this space below to explain any of your answers.

Reference

Allia Future Business Centre (2022). What is sexual wellbeing? https://futurebusinesscentre.co.uk/blog/what-is-sexual-well-being#:~:text=Sexual%20well-being%2C%20or%20%E2%80%98sexual%20self-care%E2%80%99%20is%20a%20phrase,and%20encourages%20positive%20physical%2C%20mental%20and%20social%20well-being.