Regret after Gender-Affirming Surgery: A Multidisciplinary Approach to a Multifaceted Patient Experience

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Background: Lasting regret after gender-affirming surgery (GAS) is a difficult multifaceted clinical scenario with profound effects on individual well-being as well as being a politically charged topic. Currently, there are no professional guidelines or standards of care to help providers and patients navigate this entity. This article summarizes the authors' Transgender Health Program's cohesive multidisciplinary lifespan approach to mitigate, evaluate, and treat any form of temporary or permanent regret after GAS.
Methods: A multidisciplinary (primary care, pediatric endocrinology, psychology, social work, plastic surgery, urology, gynecology, and bioethics) workgroup including cisgender, transgender, and gender-diverse professionals met for a duration of 14 months. The incidence of individuals who underwent GAS at the authors' program between 2016 and 2021 and subsequently expressed desire to reverse their gender transition was reported.
Results: Among 1989 individuals who underwent GAS, six (0.3%) either requested reversal surgery or transitioned back to their sex assigned at birth. A multidisciplinary assessment and care pathway for patients who request reversal surgery is presented in the article.
Conclusions: A care environment that welcomes and normalizes authentic expression of gender identity, affirms surgical goals without judgment, and destigmatizes the role of mental health in the surgical process are foundational to mitigating the occurrence of any form of regret. The authors hope this can provide a framework to distinguish normal postoperative distress from temporary forms of grief and regret and regret attributable to societal repercussions, surgical outcomes, or gender identity. *(Plast. Reconstr. Surg.* 152: 206, 2023.)

The goal of gender-affirming surgery (GAS) is to alleviate gender dysphoria related to perceived phenotypical gender incongruence and is associated with improved quality of life and decreased mental health distress in the majority of individuals.[1] Gender transition is not a uniform or linear process and not all people who identify as transgender or gender diverse (TGD) will choose to pursue medical or surgical services to affirm their gender identity or alleviate dysphoria. For those who pursue GAS, regret is exceedingly rare, with current literature citing the incidence between 0.2% and 3%.[1–4] With increased demand secondary to improved access to GAS, the absolute number of patients who may seek reversal surgery or express regret may rise accordingly. Current guidelines for GAS follow the World Professional Association for Transgender Health (WPATH) standard of care (SOC), version 7, which provides recommendations for supporting patients

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through an individualized, well-informed, and safe gender transition.[5] However, the SOC does not contain guidance for providers to support patients who express regret after GAS, and there are no existing professional guidelines for managing these complex clinical scenarios. Moreover, the existing literature lacks granularity around the causes of regret and the difference between regret and other normative psychological responses such as grief following GAS. At a time when transgender rights have become politicized, the topic of "detransitioning" has gained increased visibility. This term refers to individuals who regret their gender transition and may seek reversal surgery and/or hormone cessation or substitution. Although a small number of patients report this experience, the physical and emotional impact of regretting GAS on all domains of an individual's life deserves a nuanced and scientific discussion as antidotes to sensationalized media stories. The continued efforts by interest groups to repeal newly regained access to gender-affirming health care and weaponization of information on regret to revoke progress made increase the potential for greater systemic distrust within the TGD community, subsequently affecting individual experiences of care. The focus on gender-transition regret further detracts from the complex and normative nature of other forms of regret and grief that can follow GAS.

This article presents a summative experience of the Oregon Health & Science University (OHSU) Transgender Health Program (THP) Regret and Request for Reversal Workgroup. The workgroup met over the course of 1 year to establish a cohesive multidisciplinary, lifespan approach to patients who request reversal surgery or express regret. The intent of the workgroup was to better define the experience of regret, design potentially preventive measures, and establish a pathway to reversal surgery. This article provides a framework to distinguish normal postoperative distress from temporary forms of grief and regret and regret attributable to causes other than gender identity (including gender fluidity) from gender-related regret. We hope to contextualize regret after GAS through discussion of regret in other surgical domains and to help guide surgeons who may be less familiar with the kaleidoscope of emotional responses to GAS. We expect this can inform future studies and help readers better understand the complexity of this topic. The pathways presented are intended to allow for dynamic reevaluation of this rare but important aspect of gender-affirming health care across the lifespan.

METHODS

This article outlines the current approach to patients expressing regret after GAS and is a summary of the quality improvement project of the OHSU THP. The project is exempt from institutional review board approval. The approach was established through a workgroup that included both cisgender and TGD professionals from the following disciplines: primary care, pediatric endocrinology, psychology, social work, plastic surgery, urology, gynecology, and bioethics. We also reviewed the incidence of individuals who had GAS at OHSU between January of 2016 and July of 2021 and who expressed desire for or have undergone reversal surgery. Patients who expressed desire for reversal surgery were prospectively collected and compared with the overall number of patients who underwent GAS at our center.

OHSU THP Care Model

Our approach to supporting patients with regret and mitigating occurrence begins with our model of care. THP follows the WPATH SOC and offers multidisciplinary gender-affirming care across the lifespan. The Doernbecher Gender Clinic serves pediatric and adolescent patients and follows a family-centered model of care with multiple points of intervention (eg, endocrinology, social work, psychology). Ongoing exploration and evolution of identity is expected and normalized as part of the consenting process, leaving open the conversation around shifts in identity or transition goals without shame or judgment. Shared decision-making is practiced so that each stakeholder in a young person's life can help gather information and guide the next best decision. Once medical transition is started, close follow-up is scheduled to allow ample opportunities to adjust or change course before any major phenotypical changes occur. Surgical care is only offered after careful multidisciplinary review of support systems, developmental readiness, and adequate involvement of mental health providers in the perioperative period.

For our adult GAS population, we have a dedicated behavioral health team that includes social workers and a psychologist who work in close relationship with the surgical providers. In addition, surgeons work with partners in clinics throughout the hospital that are represented in our workgroup for this article as well as in our monthly multidisciplinary team meetings.

RESULTS

A total of 2863 GAS procedures for 1989 individual patients were performed from January 1,

2016, through July 31, 2021. During this period, six patients requested reversal surgery or transitioned back to their gender assigned at birth (Table 1). Five additional patients who had surgery outside of OHSU presented with requests for GAS reversal ($n = 2$) or underwent surgery for ongoing transition to another gender ($n = 3$). Our current rate of 0.3% is in line with previously published rates of regret (0.2% to 3%).

Types of Regret and Causes

Regret can be defined as the highly negative feeling that the outcome would be better had one made a different choice.[6] Based on workgroup discussions, and the study performed by Narayan et al.,[4] which includes authors from the workgroup, the experience of regret can be classified in temporal and origin dimensions (Table 2). Regret can be temporary (perioperative period of 3 months) or permanent and classified as societal, surgical, and/or gender identity–related regret. The next section starts with an outline of the THP guiding principles in preventing and managing the occurrence of any form of regret. We then outline the etiologies of each of the three origins of regret and describe our practice to prevent, mitigate, and manage its occurrence.

OHSU Approach to Any Regret after GAS

For patients who express regret in the perioperative period, it is incumbent on the surgeon to hold space and validate the individual's expression of regret. For people who have had a recent surgery, the expression of "regret" in many cases is temporary and can mask normal sensations of grief and loss following GAS. Recognition of normal grief that can be associated with surgical trauma and physical change is important but should not eclipse the patient's expression of their experience. Temporary regret is included in the preoperative discussion with the surgeon as a normative experience, in particular after facial GAS. This can be aggravated by postoperative discomfort in an anatomic region that has been the original source of gender dysphoria.

Patients who express regret further out from surgery also should be encouraged to express their emotions, which can include anger and blame toward the treatment team. It is paramount to follow trauma-informed care principles and avoid defensiveness.[7] Individuals who express emotional distress after GAS are connected with our program's mental health provider (MHP) for exploration of their feelings and assistance with working through the experience. Patients who request reversal surgery or surgery for ongoing transition are presented at a multidisciplinary meeting.

Our pathway closely follows the ethical principles of any medical intervention and includes the values and concerns served by the informed consent process (Fig. 1). These are expressive (is reversal surgery in line with the patient's expressed regret and expectations?), facilitative (what can we do to optimize the success?), and protective (harm assessment if outcome is undesired or procedure is not offered). These domains are explored from a multidisciplinary perspective to review etiology, feasibility, stability, and expectations. Domains without definitive answers are then explored further by the respective specialist. In all cases, our program psychologist performs a thorough evaluation of the cause of regret that follows many of the domains outlined above. Revisiting established life goals can help in evaluating changes in social or familial support, personal safety, employment, or romantic relationships and put them into the context of the transition and current experience of regret. Once all domains have been explored with the patient, the group reconvenes to discuss next steps. The same framework is used for patients who had surgery elsewhere and are expressing regret.

Table 1. Demographic Characteristics of Patients Requesting Reversal

Characteristics	Values
Age,[a] yr, mean (range)	24.5 (16–37)
Sex assigned at birth	
Male	17%
Female	83%
Initial transition	
AFAB→trans male	50%
AMAB→nonbinary	17%
AFAB→nonbinary	33%
Type of surgery	
Genital	33%
Orchiectomy	16.7%
Hysterectomy	16.7%
Chest	100%
Feminization	16.7%
Masculinization	83.3%
Social transition duration,[a] yr, mean (range)	4.1 (1–6)
Hormone therapy duration,[a] yr, mean (range)	1.6 (1.5–2)

AFAB, assigned female at birth; AMAB, assigned male at birth.
[a]At time of initial surgical consult.

Regret Related to Surgery (Outcome, Expectations, and Complications)

Surgical regret is a direct outcome related to surgery, such as complications, long-term functional outcomes, and preoperative

Table 2. Types and Causes of Regret

Regret Type	Definition	Potential Causes
True gender-related	Involves a person having undergone a transition in gender by social, medical, or surgical means indicating a formal change in gender identity who then desires to return to the sex assigned at birth or a different gender identity	Misdiagnosis, insufficient exploration of gender identity, barriers to access for nonbinary transition
Social	Refers to a person's desire to return to the sex assigned at birth so as to ease the repercussions of transitioning on their societal life	Feeling unsafe in public, loss of partnership, religious conflict, inability to partake in one's community, encountering professional barriers
Medical	Includes regret originating from a direct outcome of a surgery or an irreversible consequence thereof	Medical complications, dissatisfaction with functional outcome, preoperative decision-making (eg, inadequate or incomplete counselling, change in life goals)

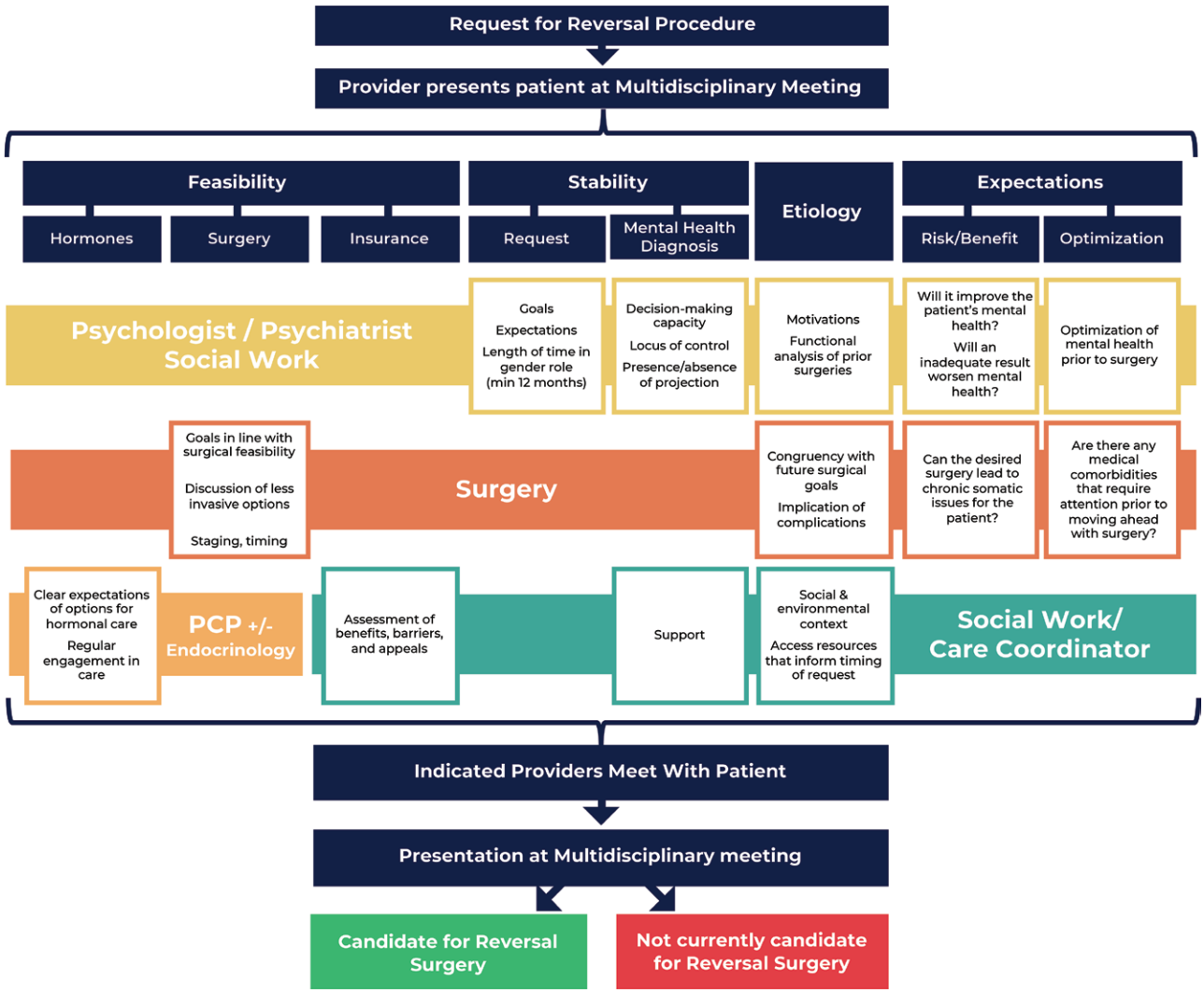

Fig. 1. Flow diagram for multidisciplinary approach to patients seeking reversal surgery.

decision-making.[4] Table 3 presents an overview of reasons for surgical regret that were found in our survey study as well as in the patient population at our institution. Surgical decision-making requires patients and providers to consider potentially significant risks in exchange for a desired but not guaranteed outcome. This process inherently lends itself to discussion of regret, particularly with regard to elective procedures.

Data on surgical regret resulting in a request for surgical reversal are limited; however, gastric bypass surgery provides an example in which

Table 3. Common Themes for Surgical Regret and Approaches

Themes for Surgical Regret	Example	Preventative Measures	If Regret Occurs
Inadequate preoperative counseling	Patient desires different procedure	Patient classes, multidisciplinary check-ins to reestablish goals, peer support, second opinion	Involve mental health professional, revisit preoperative goals, provide close surgical follow-up
Surgical complications	Partial flap loss	Informed consent, reassurance of close follow-up in the event of any complications	
Unmet expectations	Functional or aesthetic outcomes not achieved	Preoperative expectation management including mental health professional	

returning to native anatomy may be attempted through a reversal procedure. In the largest single-institution study of Roux-en-Y gastric bypass reversal, the rate of reversal was reported as 2% of 2009 procedures, which is a similar percentage to the reported data for GAS.[8] This comparison is of interest as both GAS and bariatric surgery include preoperative readiness assessments and multidisciplinary workup, as outlined in the evolving SOC.

A systematic review of studies examining surgical regret in other elective surgical procedures (excluding cosmetic) demonstrated that, on average, 14% of patients report some degree of regret.[6] The review suggests that patients with a higher level of engagement in the decision-making process were less likely to regret their decision, whereas patients who overestimated the benefit of surgery were more likely to regret it. Risk of regret was associated with bimodal age distribution, minority race, low socioeconomic status, and low educational status.[6]

The broad themes related to regret are inadequate preoperative counseling, surgical complications, and unmet expectations (eg, functional, aesthetic outcomes). Preventative measures to avoid surgical regret should therefore be centered around patient education (ie, classes, peer support, shared decision-making, informed consent) and the establishment of realistic preoperative expectations as applicable to the individual by discussions with the surgeon and MHPs. Retrospective adjustments of expectations are exceedingly difficult and should be avoided through the above efforts. An important preventive measure is the education of surgical providers and staff who have the necessary experience in navigating the complexity and holistic nature of GAS and are able to discuss the breadth of surgical options, including options that may be available elsewhere.

Postsurgical interventions if surgical regret occurs include reestablishment of surgical and functional goals (eg, sexual, urinary), retrospective adjustment of expectations, peer support, referral for a second opinion, and addressing any existing untreated mental health conditions. A multidisciplinary approach to care would include joint appointments between providers as well as consultation and discussion of the treatment plan with all providers included in the patient's care. In addition, close follow-up throughout the process will be important, as the complex nature of regret can vacillate. The sensation of regret can be pervasive, and desire for reoperation or reversal may be requested with urgency by the affected individual. Although the urgency should be recognized and validated, additional intervention, if even possible, should be avoided until the nature of regret has been explored fully (Fig. 1), new surgical goals and feasibility have been established, and the anatomic tissue is amenable to surgical manipulation.

Regret Related to Societal Repercussions

A patient's desire to return to the gender assigned at birth because of social regret manifests as a solution to alleviate the negative impact gender transition has had on their social life.[4] Although progress has been made in some geographic and social spaces, conscious and subconscious discrimination against TGD individuals persists, and the visibility that has come from transgender rights has led to increased levels of antitransgender violence. While gender transition may help alleviate some societal repercussions, it may exacerbate others. For example, TGD patients expressing their gender to match their gender identity after surgery may experience a downward shift in societal privilege, encounter new professional barriers, or become excluded as they are no longer acting in accordance with societal expectations related to their gender assigned at birth. On a personal level, patients may experience loss of partnership, rejection within family relationships, or religious or spiritual conflict. A large cross-sectional study by Turban et al. found that the vast majority (82.5%) of TGD individuals who reported detransitioning cited at least one external driving factor.[9]

Preventive measures include evaluation of whether after-surgery expectations accurately reflect and integrate into important sociocultural spaces and relationships. It is valuable to involve a patient's support system in the surgical decision-making process and, if desired, connect them with TGD community members and support groups that can help counteract potential shame, guilt, and internalized transphobia that may surface as a result of rejection. MHPs can work with individuals to examine previous responses to change, grief, and loss; identify preexisting adaptive coping strategies; and facilitate the development of new coping skills. Additional interventions may include connecting patients with gender-affirming resources in the community (eg, affirming health care providers, religious or spiritual communities) or discussing relocation to a more affirming neighborhood or geographic region.

Postsurgical interventions in the setting of societal regret include a majority of the measures mentioned previously and, akin to management of surgical expectations, it is strongly encouraged to evaluate these domains in preoperative discussions. If a patient continues to express desire for reversal surgery, the pathway outlined in Figure 1 would be initiated. Should the patient proceed with reversal surgery, it is important to consider and openly discuss the potential for future retransition. At our center it is not unusual to encounter patients who detransitioned earlier in life, but because of changing societal context, present for retransition (see next section). In this context, discussions with patients should focus on reversal surgery for anatomic regions that are most relevant to their daily societal interactions, causing the most dysphoria, or considered to be most associated with a particular gender identity or expression (eg, explantation of breast implants).

Regret Related to Gender

Gender-related regret involves a person having undergone a transition in gender identity by social, medical, or surgical means, indicating a formal change in gender identity and expression, and desiring a return to either their gender assigned at birth or continued transition to a different expression of gender identity.[4] In other words, a patient regrets transitioning because of a change in their gender identity and desired expression rather than because of a surgical concern or societal repercussion. In both the survey by Narayan et al.[4] and in our own institutional experience, this type of regret can stem from four causes: (1) insufficient exploration of gender identity, including associated life experiences and/or associated mental health conditions; (2) ongoing evolution of gender identity and/or gender fluidity; (3) barriers to access for nonbinary surgical options (eg, undergoing hormonal treatment to qualify for gender-affirming mastectomy or fear of not receiving care if a nonbinary gender identity is disclosed); or (4) retransition following previous detransition (usually related to societal regret at the time).[4]

It may be unrealistic to predict or eliminate gender-related regret (much as with surgical or societal regret), but there are preventive measures to support patient autonomy and minimize mental health distress through a multidisciplinary team approach. Regardless of age or stage of development, surgeons and MHPs can work together to build rapport by affirming patients in their gender identity and expression. Framing the involvement of the MHP as a partner in care and being transparent in the intention to move the patient toward their goals while also giving space to explore possible relevant doubt that may be present is of utmost importance.

The provider team may assist patients in normalizing exploration of gender identity and gender expression and dispelling the perception that there is a linear, singular way to transition. Reviewing nonmedical options for gender affirmation with as much emphasis and value as medical options can help patients, especially youth, consider all their options. Social transition is a broad term that can include pronoun use and congruent gender expression, and may assist in gender exploration and help with managing expectations (eg, wearing a breast prosthesis and assessing societal response); however, there is no literature to suggest that this is preventative as relates to gender-related regret. Gender fluidity or ongoing evolution of gender identity is in many cases not associated with a regret to transition and should be normalized as part of the recovery process. However, GAS can lead to a better understanding of the phenotypical changes that best address an individual's gender dysphoria. For example, in masculinizing genital surgery, a staged approach to phalloplasty allows for reevaluation of phenotypical transition goals between stages. Advocacy for improving access to care for nonbinary patients is an important systemic intervention for reducing gender-related regret and should include descriptive language that accurately reflects the range of surgical interventions available and clear referral pathways for those specific procedures.

The team may help patients sift through negative messages or experiences related to being

TGD (ie, "pervert," "sick," "sinner") as a way to minimize shame and maximize a patient's autonomy in decision-making.

MHPs can work with patients to identify untreated gender-based trauma or other symptoms that may be affecting a patient's experience, desires, and needs. Including an open preoperative conversation around the risk of regret and similar emotions such as grief in the discussions with the MHP and the surgical provider serves to share the decision-making process and destigmatize the topic of regret by acknowledging the various etiologies and establishing it as a possible risk of GAS.

Postsurgical interventions in the setting of gender-related regret focus first on supporting the patient and carefully exploring other possible causes. In cases of persistent desire for reversal surgery, the items outlined in Figure 1 are evaluated from a multidisciplinary lens and the decision to move forward is shared among the involved clinicians in conjunction with the patient. All considerations outlined in the other sections should be included in the assessment and guide the next best steps for the patient. Balancing thoroughness while avoiding gatekeeping and honoring a patient's autonomy is important throughout this process. Assistance with navigating other systems, such as insurance, will likely be needed; pursuit of reversal or continued transition often will result in initial denials, thus requiring appeals and/or peer discussions between surgeons and insurance medical directors. For those providers who do not have access to an interdisciplinary team within their own clinic, engaging locoregional providers versed in gender-affirming care is one avenue to replicate a similar process as developed at our institution.

Limitations

The understanding of gender incongruence is evolving, and much of the presented information is based on the limited data available, our workgroup discussions, TGD community input, and clinical experience. Our experience and approach may not be directly translatable to other health care settings. The literature review was not performed systematically and as such is subject to selection bias. Our institutional incidence of gender-related regret is based on patients who presented to us for surgical reversal and may not capture patients who presented elsewhere or reverted to their gender assigned at birth without the involvement of a health care professional. In addition, our study only captures regret expressed within our study period, and as such, further research is needed to understand the true percentage of patients who desire reversal surgery.

CONCLUSIONS

A care environment that operates within a developmental model, welcomes and normalizes authentic expression of gender identity, affirms surgical goals without judgment, and destigmatizes the role of mental health in the surgical process are foundational to mitigating the occurrence of any form of regret. Within the context of the WPATH SOC, a mental health assessment conducted thoughtfully through a trusted relationship is critical to minimizing societal and gender-related regret. Similarly, a thorough discussion of surgical options, risks, and expectations is crucial to minimize the risk for surgical regret. Our efforts, as outlined in this article, hope to assert that gender-affirming surgery, in many regards, can represent the ideal patient-centered multidisciplinary approach to perioperative care.

The importance of a holistic approach to improve surgical outcomes that includes education and psychological preparation is being advocated in many surgical fields. However, as with any other medical specialty, there is no one intervention or combination of interventions that will entirely prevent the occurrence of regret. The data and approach outlined in this article are intended to help normalize this complex clinical entity and provide a treatment framework for individuals who experience regret.

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APPENDIX

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DISCLOSURE

Dr. Berli is a committee member, surgical chapter, Standards of Care Version 8, World Professional Association of Transgender Health (WPATH) and a consultant and speaker for the WPATH Global Education Initiative. The remaining authors of this article have no commercial associations or financial conflicts of interest to disclose. No funding was received for this article.

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PSYCHOSOCIAL INSIGHTS

Dr. David B. Sarwer, associate dean for research, professor of social and behavioral sciences, director of the Center for Obesity Research and Education, College of Public Health, Temple University, Philadelphia, PA.

Over 1 million individuals living in the United States are believed to be transgender or gender diverse. Although reliable statistics are difficult to obtain, many seek gender-affirming surgical and/or minimally invasive procedures. These procedures are performed ideally by licensed medical providers practicing in specialized centers that include multidisciplinary teams of professionals who can appropriately assess and treat the physical and psychosocial needs of patients throughout the continuum of care. Unfortunately, this is not always the case. Some procedures, particularly the use of nonsurgical injectables, are offered by unlicensed professionals in nonaccredited settings, often with horrific consequences.

Encouragingly, a growing number of professionals working in academic medical centers or highly resourced health systems are dedicating their efforts to provide high-quality, comprehensive gender-affirming care. These initiatives are being accompanied by a quickly evolving body of research on the surgical, medical, and psychosocial aspects of transgender health. Early signals from this work suggest that both surgical and nonsurgical procedures are associated with significant reductions in gender incongruence and psychosocial distress.

In their thoughtful and forward-thinking article, Jedrzejewski and colleagues describe their vast experience with gender-affirming surgery and focus on the issue of postoperative regret. Encouragingly, over a 6-year period of treating almost 2000 individuals, only six requested a reversal of their procedure or transitioned back to their gender assigned at birth. Given the evolving knowledge base, overlying psychosocial issues, and stigma and discrimination faced by transgendered individuals, this number is surprisingly and encouragingly low.

Evidence suggests that the vast majority of plastic surgery patients are satisfied with their treatment outcomes. Some individuals experience a period of psychosocial adjustment to their altered appearance, but only a small percentage experience profound and enduring distress. As seen in the present study, very few report regret to the treatment team and request a reversal of the original procedure.

The great strength of this article is the description of the multidisciplinary care team and its thoughtful approach to preoperative assessment and postoperative management. The values underlying their approach—normalization of authentic expression of gender identity, affirmation of surgical goals without judgment, and destigmatization of mental health concerns—should be adopted by all providers working in this area. The case could be made that all forms of plastic surgical care, and health care more generally, could benefit from greater commitment to these values.

Another strength of the article is the articulation of the preventative measures the team has implemented to reduce the likelihood of postsurgical regret. Tables 2 and 3 are great resources for readers, and dissemination to all members of a transgender care team is encouraged. The use of shared decision-making strategies between patients and providers is greatly appreciated. So, too, is the commitment to postsurgical interventions.

Health care providers, regardless of specialty, are trained to reduce pain and suffering and improve the health and well-being of every patient. We sometimes forget that achieving those goals often takes longer than ideally desired by our patients and ourselves. Guiding patients to make informed decisions about their health and supporting them on their journey to optimal well-being, no matter how long the duration, is one of the great privileges of being a health care professional.

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