
Relationships

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Post-operative romantic and sexual relationships are complex matters but ones in which a number of seemingly discrete life situations can be distinguished, and from which useful generalisations can be drawn.

The first useful generalisation is that pre-operative relationships are rarely unaltered by gender reassignment surgery. They are usually either strengthened or destroyed, destruction seeming as common as enhancement despite all protestations by partners that such surgery is welcome and unreservedly supported. Surgical nurses have often had to support patients whose boyfriends have dumped them immediately after gender reassignment surgery. Often the situation surprises neither nurses nor patient. One assumes that the partners concerned must have experienced well-contained gynaeandrophilia. They seem to have been content in a relationship with a woman with a penis, even if the sexual involvement of the woman's penis was always a possibility rather than an actuality. The loss of the possibility seems to end their interest.

The second useful generalisation is that although there is some change in sexual orientation with gender reassignment surgery this is not a very marked effect. More usually, sexual drive (particularly autogynaephilic drive) is reduced.¹

Post-operative male-to-female patients find themselves making relationships in a number of possible contexts. One is that where the partner clearly knows of the change of role and subsequent gender reassignment surgery. Another is that where such knowledge is suspected but not definite. A third is that where the partner clearly suspects nothing and believes the patient to be a born female.

In the first, where the partner clearly knows the circumstances, a problem for the patient is that of knowing the motivation of the partner, especially if he is male. Patients may wish for a heterosexual man, but fear an androgynaephilic suitor.

A reasonable tactic in these circumstances is for the patient to go out for a meal with the man concerned, and talk about things. If after 20 minutes the man has exhausted the patient's gender reassignment surgery as a topic of conversation and moved on to unrelated but preferably mutual matters, the signs are good. On the other hand if after 40 minutes nothing else has been discussed, there is the strong suggestion that it is this aspect of the patient, and no other, that appeals to the man in question.

The other contexts seem to have in common the problem of how to tell the person concerned of the role change and subsequent gender reassignment surgery.

It seems unwise to impart this information in a bar or pub. The person told it will have been drinking, probably on an empty stomach, and thus might be unpredictable. They will already have paid for their drink and hence will have no reservations, if at all shocked, about putting down their unfinished drink and walking out.

Better, perhaps, to impart this news in a restaurant. Particularly after the first course has been eaten and before the main course has arrived. The surprised person will be less likely to be drunk and less likely abruptly to leave, since to do so would squarely place the bill for the first part of the meal on the remaining diner. The surprised person would have been looking forward to the main course, and may decide to eat it and then settle the bill and leave without any pudding or coffee. The time taken to eat the main course may be the time needed for them to reason that they really liked the woman before this news was imparted, and that it ought not to change things very much.

Those post-operative patients who are particularly attractive and convincingly feminine may paradoxically encounter a greater degree of relationship difficulties. Those involved with them, unaware of their change of role, behave as if a knowledge base appropriate to the apparent sex is present. The next case illustrates this.

Case report: missing mores

NB benefited particularly well from a change of gender role, gaining in confidence at work and becoming an attractive and very successful business executive. Gender reassignment surgery consolidated her role, and she thrived in individual and employment terms.

NB wanted a boyfriend, and found that despite physical attractiveness and personal charm there were problems. She quickly discovered that men were frightened of her when they realised she earned vastly more than they did. She learned to initially conceal this aspect of her life. Despite this tactic, though, she found it difficult to make a relationship with a man. Being born male, in her teenage years she had never blundered through the mechanics of finding a boyfriend as had her born female peers. She had never herself sought to gain a girlfriend, as to have done so would have felt disturbing, despite her then male social status. In her later female role she was unclear whether it was all right for her to ask men out, or to take their phone numbers and subsequently to call them. She worried whether she would seem disturbingly forward by so doing.

NB reported that her female friends were all unaware of her change of gender role. She was scared to ask their advice for fear of evoking situations where she would be compelled to lie to them or give herself away. What advice she had obliquely sought had proved unhelpful. She reported that her friends had either been attached so long they had forgotten how they made their relationship, or were single and seemingly no more able than she to get a boyfriend.

Many post-operative relationship problems derive neither from physical post-operative status itself, nor from the social or psychological complications that go with such status. Rather, they are ordinary relationship problems encountered unusually late in life, as the following illustrates.

Case report: 'stage of life' sexual and relationship difficulties

LW reported at a post-operative follow-up appointment that she had problems with achieving orgasm with her (male) sexual partners. LW climaxed perfectly well with masturbation but not with a partner. It seemed that her born female peers had given her the impression that an easy orgasm was quite usual in sexual intercourse.

LW's situation seemed to be typical of a late teens to early 20s woman, but she was in her mid-30s. Standard advice to teach her partner to masturbate her (and perhaps vice versa) seemed applicable, along with the observation that she simply might not yet have fallen in love with someone, the falling in love bit tending as it does to render the loved person particularly attractive. It was felt LW might learn faster than a woman in her late teens, by virtue of greater psychological maturity. She was not easily able to talk to friends about such matters, even those who knew of her earlier gender reassignment surgery, partly because such a stage of life was all a long time ago for them. It did occur to LW that those friends who were said to be orgasmic with absolutely anyone might also enjoy eating anything. She concluded that a lack of dietary discrimination would not be seen as a badge of honour and neither ought a similar lack of discrimination in sexual responsiveness.

After gender reassignment surgery any problems with personality will not usually resolve, save for the extent expected by time alone, as the following illustrates.

Case report: relationship problems unaltered by role change and gender reassignment surgery

GC was a secondary transsexual whose earlier relationships (including a marriage) had always been characterised by her great dependency. She underwent gender reassignment surgery in her middle 50s, and passed very well thereafter as a middle-aged woman.

The gender reassignment surgery did not change her personality. She remained very clingy and dependent. There followed a series of attachments to social acquaintances, often beginning with the provision of such small services as baby-sitting and childminding. Each of these attachments ended when GC became too clingy and sought too much time in the company of her acquaintances. GC's reaction to the termination of these social relationships was usually deliberate self-harm, usually by means of an overdose.

GC tried to make a closer relationship with the daughter from her earlier marriage. Although the relationship started reasonably well, her dependency was such that in the end her daughter broke all contact with her. GC was so persistent in seeking her attention that in the end her daughter took out an injunction to prevent further contact, which GC

immediately broke. She was convicted, given a suspended sentence and thereafter stopped trying to contact her daughter.

GC saw part of a television documentary, which featured the intimate relationship between two young women. She reported this as having deeply affected her. She reported that such a relationship was what she wanted more than anything, and that she had always wanted it but had never previously known that this was so.

GC began to attend lesbian venues, but found that her previous problems with relationships recurred. She coincidentally won a modest prize from the National Lottery and began to pay lesbian prostitutes. GC realised that this would last only as long as her lottery win funds. Insolvency was delayed (but deepened) when she obtained a number of credit cards and spent up to the limit on each. The sexual content of the experiences seemed slight and not to be a major motivator; indeed she usually paid only for the company of the women. She reported omitting to take her customary hypnotic in order to be able to stay awake and take pleasure in the sensation of being next to the young woman sleeping beside her. GC described herself as being 'in love' with some of the women concerned; her idea of what this involved seemed rather empty of content. She felt that because she was in love with a woman it would lead them to spend their every moment in each other's company, usually doing nothing other than staying indoors enjoying the sensation of being together.

When her funds ran out GC decided to divert herself with a long-term and incomplete hobby project. She accepted that were she to accrue more funds she would be likely to return to attempting to buy friends and company.

Successful, longer-term relationships in very convincing patients may be complicated not by the feelings of the parties concerned, but by a partner's decision to keep his or her wider family in ignorance of the patient's situation. As the relationship deepens and lasts ever longer, the demands from the partner's parents for marriage and children grow the more strident. Since the Gender Recognition Act (*see* p. 261), marriage has been perfectly possible, though some churches might refuse to solemnise the marriage and thus alert the potential in-laws to some sort of difficulty. Grandchildren prove a thornier problem. Statements of irreversible infertility, while perfectly correct, seem to invite probing medical questions and treatment suggestions from relations who would never make such impolitely detailed enquiries about any other aspect of the patient's medical history (*see* 'Fertility issues', p. 285).

A particularly difficult situation is that in which the patient has contracted a relationship with a man who has remained unaware of her earlier status for a very long time. At least one such has additionally not been detected as originally male by her GP. It is hard to see how someone in these circumstances can tell the truth so late in the relationship, and it may be difficult for her to obtain an appropriate birth certificate and marry her long-term boyfriend, as to do so might prompt questions of why this is being done at this time and not earlier. It remains untested whether her concealed earlier male status would be

reasonable grounds for divorcing a woman. One suspects that in a younger patient, failure to dispel the natural implication of ordinary female fertility would make this more likely.

Reference

- 1 Lawrence AA. Sexuality before and after male-to-female sex reassignment surgery. *Archives of Sexual Behavior* 2005; **34**: 147–66.

