

# Psychosocial functioning of transsexuals in Belgium

De Cuyper G, Jannes C, Rubens R. Psychosocial functioning of transsexuals in Belgium.

Acta Psychiatr Scand 1995; 91: 180-184. © Munksgaard 1995.

Male-to-female (M-F) transsexuals differ consistently from female-to-male (F-M) transsexuals in their sociodemographic characteristics, cross-gender and sexual history and the degree to which personality disorder is concomitant to their transsexuality. As a group, female-to-male transsexuals are more homogeneous. Both groups are impaired in their mental functioning, but the male-to-female population is more mentally disordered. In a comparison between Dutch transsexuals and their Belgian counterparts, the latter were shown to have more mental problems.

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Key words: transsexual; psychosocial  
functioning; personality disorder; cross-gender  
behaviour

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Accepted for publication October 29, 1994

Transsexualism is the most extreme expression of gender dysphoria (1). Individuals who diagnose themselves as transsexual tend to regard sex reassignment surgery (SRS) as the only possible relief from their gender dysphoric suffering. Although the patients themselves take the initiative in diagnosing their condition, and specifically request SRS as the therapy of first choice, the role of the gender team dealing with these patients remains essential in confirming the diagnosis, in evaluating the coping capacities and in guiding the sex change.

The team of the Gender Identity Clinic in Gent (Belgium) has adopted the standards of care developed by Benjamin (2). The psychiatrist's role in the team is crucial in evaluating the applicant's mental health. For each SRS candidate, mental comorbidity is diagnosed on Axis I and a personality disorder, if any, on Axis II of DSM-III-R. Applicants for SRS who are found to be psychotic are excluded from SRS. During the 2 years of real life, which is required as an additional diagnostic test, the applicants' mental functioning is assessed in an extensive procedure that provides the opportunity for a subtle decision-making process as well as for a better understanding of the "fascinating" wish to change sex.

Whether the transsexual patient is mentally disturbed or not, is the subject of an ongoing discussion. In the first place, there is the issue of the pathological nature of transsexualism itself: not all authors agree with the DSM-III-R in classifying transsexualism as a mental disorder. Secondly, the frequency and the type of mental comorbidity vary consider-

ably with different authors, with disorders such as depression, conduct disorder, substance abuse, and even more so with Axis II pathologies (3-6).

An intriguing research topic is the difference in mental comorbidity between male-to-female and female-to-male transsexuals. Lothstein (5) carried out a survey of the psychological testing with transsexuals over a 30-year period. His general findings, which were based on group tests, were that female-to-male transsexuals lacked significant psychopathology, that they were even indistinguishable from a nonpatient control group and that they were healthier than their male-to-female counterparts. The individual analysis of the male-to-female transsexuals also suggested that they appeared to be less stable and more mentally disturbed than female-to-male ones. The difference in behaviour of male and female transsexuals was described by Pauly (7), who found that female-to-male transsexuals have an exclusively homosexual behaviour, are better adjusted, less suspicious and more realistic in their appraisal of what is feasible for them.

Dixen et al. (8) have subsequently compared 479 male (22% transsexuals) and 285 female (78% transsexuals) applicants for SRS. They conclude that males have a less stable professional occupation and social history than females and tend to show more symptoms of mental distress. Their explanation for these results is that, in industrialized society, female-to-male transsexuals experience less difficulty in passing for someone of the opposite gender than male transsexuals. This is also the hypothesis that

has been put forward by Green in *The "Sissy Boy Syndrome" and the development of homosexuality* (9).

A study in Singapore (10), which finds that both males and females are homosexually oriented (i.e., attracted to the same biological sex), is at odds with Western studies (Table 1 from Blanchard - 11). The males were less well educated and held lower-level jobs. Verschoor & Poortinga (12), on the contrary, concluded their study as follows "... although male behaviour by female transsexuals is easier to be realised than female behaviour by male transsexuals, female as well as male transsexuals are prone to psychological disturbances involving contempt of their bodies and sex-related bodily functions." The aim of our study is to investigate the differences between our male and female transsexuals, especially concerning their psychological functioning and the impact of the degree of which they are socially accepted. The sociocultural influence is explored by comparing our data with the data from the above-mentioned study in the Netherlands.

#### Material and methods

Since 1986 a psychological and psychiatric evaluation for SRS has been carried out with 65 consecutive applicants at our Gender Identity Clinic (University Hospital of Gent). Thirty-five individuals met the DSM-III-R diagnosis for transsexuality (302.50) and were admitted to the programme for sex reassignment therapy. They included 22 male-to-female and 13 female-to-male patients.

The obvious differences between the male and female group (consecutive sample) led us to compare them on a number of items. The data for this comparison were obtained at the beginning of the hormonal treatment, through the Amsterdam Biographic Questionnaire (ABQ), which is the standard screening at the Gender Foundation in Amsterdam. As all patients belonged to the Dutch-speaking Belgian community, the use of the ABQ yielded no problem. Thorough psychiatric evaluations by the first author offered supplementary data as well as psychiatric diagnoses. A psychologist checked the concomitant mental disorder and the Axis II diagnosis independently.

Table 1. Sexual preference of male transsexuals mentioned in the literature (11)

	Homosexual	Heterosexual	Asexual
Hirschfeld (1922)	35%	35%	15%
Hamburger (1953)	65%	22%	
Randall (1959)	25%	55%	
Walinder (1967)	53%	20%	27%
Blanchard (1987)	42%	58%	

Source: Blanchard (11).

The profiles of the M-F transsexuals and of the F-M transsexuals were established by comparing familial, socioeconomic characteristics (items 1 to 5), cross-gender behaviour including referral age (items 6 until 9), sexual history (items 10 to 12), mental distress in the past (admissions to psychiatric clinics, suicidal attempts, abuse of alcohol, medication and drugs (items 13 to 15) and psychiatric diagnosis (item 18). Furthermore, we compared our population with their Dutch counterparts (12) who had been subjected to the same Amsterdam Biographic Questionnaire.

The differences between the male and the female population and between both nationalities were statistically analysed by chi-square test. In the case of  $2 \times 2$  tables, when frequencies were too low to reach the requirements of this test, the exact Fisher (EF) test was applied. The significance level was taken at  $P = 0.05$ .

#### Results and discussion

The results of the frequencies, and the comparison with the results by Verschoor & Poortinga (12) are listed in Tables 2 and 3.

Our M-F/F-M ratio (1.7:1) is relatively low in comparison with the other western European countries, where the average ratio is 3:1. In a recent prevalence study in the Netherlands (13), a tendency of a lower sex ratio of 2.5:1 was confirmed. Although our sample is too small to be conclusive, it must be stated that the ratio we found was consistent throughout the whole period of the study.

The family situations of our M-F and F-M transsexuals show striking differences. Unlike the male transsexuals, most of whom had lived as male subjects in accordance with social expectations before requesting SRS, no female transsexuals were married or divorced, or had had children. Significant differences were found, respectively  $P < 0.01$  (EF) for married or divorced and  $P < 0.05$  for transsexuals with children. In Western countries (in contrast with Singapore - 14) this "flight into marriage" is known for male transsexuals as well as for female ones (1, 7, 8, 15). Also the study by Verschoor & Poortinga (12) shows a significant difference between the two groups ( $P < 0.001$ ).

The social integration, which was taken to be expressed by being employed or in education, was better for the female applicants. This agrees with the Dutch data, although statistical significance was not reached.

Our results do not offer conclusive proof that the male transsexuals had a lower degree of education than the female ones, although the frequencies suggested it. The educational level of the father varied significantly ( $P < 0.05$ ), which agreed with the higher

Table 2. Comparison of MF transsexuals and FM transsexuals concerning their psychosocial functioning, their cross-gender behaviour and mental comorbidity

	M-F n=22	%	F-M n=13	%	P
1. Married or divorced <i>in Netherlands</i>	10	45 27.5	0	0 0	<0.01 EF
2. Children	8	36.4	0	0	<0.05 EF
3. Employment in job or enrolled in study <i>in Netherlands</i>	12	54.5 57.6	11	84.6 74.5	NS
4. Educational level					
basic+lower secondary	15	68.2	5	38.3	} NS
higher secondary	5	22.7	6	46.2	
higher education or university	2	9.1	2	15.4	
5. Educational level of parents					
a. father					} <0.05
basic+lower secondary	17	77.3	6	46.2	
higher secondary	4	18.2	2	15.4	
higher ed+university	1	4.5	5	38.5	
b. mother					} NS
basic+lower secondary	19	86.4	8	61.5	
higher secondary	3	13.6	3	23.1	
higher education+university	0	0	2	15.4	
6. Cross-gender identity awareness before age 6 <i>in Netherlands</i>	7	31.8 54.1	8	61.5 76.8	NS
7. Preference during childhood					
for cross-gender toys <i>in Netherlands</i>	11	50 75.3	11	84.6 90.9	NS
for cross-gender play and games <i>in Netherlands</i>	11	50 76.1	11	84.6 95.1	NS
for playmates of opposite sex <i>in Netherlands</i>	8	36.4 77.3	11	84.6 92.3	<0.05
8. Applying for SRS before age 30 years <i>in Netherlands</i>	7	31.8 51.2	11	84.6 72.7	<0.01
9. Cross-dressing all the time <i>in Netherlands</i>	10	45.5 45.2	13	100 75.0	<0.001 EF
10. Sexual preference					
same biological sex	10	45.5	11	84.6	NS
bisexual	4	18.2	0	0	} <0.01
heterosexual	6	27.3	0	0	
asexual	2	9.1	2	15.4	NS
11. Sexual fantasy					
cross-gender self-experience <i>in Netherlands</i>	17	77.3 92.1	11	84.6 95.9	NS
imagined partner of some biological sex <i>in Netherlands</i>	13	59.1 76.4	11 7	84.6 91.8	NS
12. Stable relationship <i>in Netherlands</i>	6	27.3 21.1	7	53.8 48.0	NS
13. Previous psychiatric treatment <i>in Netherlands</i>	10	45.1 21.4	5	38.5 33.3	NS
14. Previous abuse of alcohol and/or drugs <i>in Netherlands</i>	11	50.0 11.3	8	61.5 3.8	NS
15. At least one suicide attempt <i>in Netherlands</i>	12	54.5 19.3	6	46.2 18.6	NS
16. DSM-III-R pathology					
Axis 1 concomitant mental disorder	5	22.7	0	0	NS
Axis 2	16	70.3	3	23.1	<0.05 EF
Axis 3	3	13.6	2	15.4	NS

socioeconomic level we observed in our female population. Hoenig & Kenna (16) found that, in England and Wales, most transsexuals, and more specifically males, were of working-class origin, from "environments where the gender roles tend to be much more rigid and well defined". The lower educational level

of male applicants for SRS is also mentioned by Tsoi (10). One explanation for this difference is that the gender dysphoric male with a higher education level puts professional success and social integration first, and finds other solutions than SRS for his gender dysphoria. A further explanation may be that, for

some unknown reason, we have a particular selection of the male and/or female transsexual population.

Unlike the study in the Netherlands, we did not find any significant difference between the female and the male transsexuals regarding the age of becoming aware of their cross-gender identity. The female transsexuals manifested their cross-gender identity during childhood through cross-gender behaviour (a preference for playmates of the opposite sex) more expressly ( $P < 0.05$ ). We also observed that the female transsexuals applied for SRS at a much younger age than the males ( $P < 0.01$ ) and that, at the time of their application, they were cross-dressing without interruption ( $P < 0.001$ ). Our results about the low frequency of cross-gender behaviour in childhood of the male transsexuals are remarkable. Only 36% of the male population had playmates of the opposite sex during childhood, which implies a significant difference with the results of Verschoor & Poortinga (12) ( $P < 0.001$ ). The remaining 64% reported that they had preferred to play on their own or that they had had no opportunity to meet girls.

We would suggest that, in the educational process, cross-gender behaviour, as the expression of the cross-gender identity, is more likely to be repressed than the awareness of the cross-gender identity. The same hypothesis applies to our finding that, even when they decide to have SRS, the hesitation of the male transsexuals to manifest themselves as females is striking. Indeed, while for a female transsexual it is easier to take up the male gender role without being stigmatized than it is for the male transsexual to take up the female role, the decision to manifest himself in female clothes has a different dimension. Female wear still bears the connotation of femininity, while male fashion has tended to become "unisex" and has thus acquired feminine properties.

When for reasons of statistical simplification we regard the bisexual orientation as a heterosexual preference, our results of 45% male transsexuals with homosexual preference and 45% with heterosexual preference are in line with the percentages mentioned in the literature (Table 1). This is quite different from the nearly exclusively homosexual behaviour of the female transsexuals. This trend can also be inferred from the analysis of their sexual fantasy.

The percentage of transsexuals who are involved in a stable relationship is smaller in the males than in the females, but not significantly so. This suggests that it is as difficult for the male transsexual as it is for his partner to maintain the relationship. As male transsexuals tend to be handicapped in their feminine physical appearance (their height, large hands, facial hair, pronounced Adam's apple), it is difficult

for the couple to obtain the approval from the outside world, and this in turn makes it more difficult to achieve a stable relationship.

With regard to previous psychiatric treatment, substance abuse and suicide attempts, our results agree with those of Verschoor & Poortinga (12) in finding no significant difference between male and female transsexuals. However, they demonstrate a significant difference between the transsexuals in the Netherlands and our population (Table 3). This indicates an impact of sociocultural determinants, besides and apart from the psychological factors, the unease about the body and the difficulties about passing to the opposite sex and gender role.

Until the late 16th century, the Netherlands and Belgium had a common political and cultural history. Subsequently, and as a consequence of the division of Europe between Catholicism and Protestantism, differences in culture evolved between the northern part (the Netherlands) and the southern part (Belgium). Although at present the majority of the inhabitants of Belgium (i.e., the Flemish) speak the same language as in the north (i.e., Dutch), substantial cultural divergences have developed based on the different political structures. Even with the supranational framework of present-day Europe, these divergences are reflected in different approaches to personal and ethical issues. Although a precise description of this broadly cultural difference is impossible, it can be made tangible by some historical facts. In the seventeenth century, the United Provinces formed a haven of tolerance and hosted Descartes and Locke, who wrote his *Epistola de Tolerantia* in the Netherlands in 1685, while from the University of Louvain Cornelius Jansenius disseminated his ideas over western Europe. The open-mindedness and tolerance that were typical for the Republic of the United Provinces have eventually created a climate that allowed the Calvinistic Uni-

Table 3. Comparison of Belgian and Dutch transsexuals concerning their mental distress in the past

	De Cuyper et al. (present study)		Verschoor & Poortinga (12)		P
		%		%	
Previous psychiatric treatment					
M-F	10/22	45	30/140	21	<0.05
F-M	5/13	38	15/45	33	NS
Previous abuse of alcohol and/of drugs					
M-F	11/22	50	18/159	11	<0.001
F-M	8/13	61	2/53	4	<0.001
At least one suicide attempt					
M-F	12/22	54	27/140	19	<0.001
F-M	6/13	46	8/43	19	NS

versity in Amsterdam to found a Chair of Transsexuology in 1989. While in the north transsexuals were given the opportunity to become accepted in society from the 1970s onwards, it was not until 1986 that our university established an integrated and multidisciplinary approach to transsexualism that allowed for the social and ethical acceptance of transsexuals.

As far as the frequencies of most items are concerned, our study population of male and female transsexuals is quite similar to the population described by Verschoor & Poortinga (12). It is on cultural historical grounds that the high incidence of psychiatric consultation, of alcohol and drug abuse and of suicide attempts in male as well as in female applicants for SRS in our study can be interpreted as the result of psychiatrization of gender problems because of social nonacceptance. Most international studies report also a slightly higher incidence of suicidal attempts and psychiatric history than is found by Verschoor & Poortinga (7, 8, 11, 12).

The clinical assessments by the psychiatrist and by the psychologist according to the DSM-III-R criteria reveal a difference between male and female transsexuals: on Axis I 5 male transsexuals (23%) showed symptoms of clinical depression or addiction (a nonsignificant difference), 16 male transsexuals (70%) were diagnosed with a personality disorder on Axis II (mostly borderline personalities) versus only 3 females (23%), including 2 passive-aggressive and 1 borderline personality ( $P < 0.05$ ). Moreover, 3 male transsexuals received the V 40.000 code in Axis II for their borderline intellectual functioning, versus no females. These data again highlight the difference between male and female transsexuals and demonstrate that the criteria used to evaluate their mental functioning by checking the previous psychiatric treatments, alcohol and substance abuse and suicidal attempts, can only be conclusive about the difficulties in coping with their gender dysphoria. But the development of psychopathology is a different criterion and presumable has a more complex relation with the uneasiness experienced by the gender-dysphoric individual.

### Conclusion

In a consecutive group of applicants for SRS meeting the criteria for diagnosis of transsexualism, M-F transsexuals differ from F-M transsexuals in several areas such as social conduct (marriage, children), socioeconomic level of the family of origin (educational level of the father), age of applying for SRS and of manifesting the cross-gender identity, sexual preference and psychopathology. The female-to-male

transsexual population is definitely more homogeneous. It is striking that the highly educated, young, mentally healthy male-to-female transsexual is absent from our population. Is it only the mentally disturbed male transsexuals who opt for SRS as a relief for their gender-dysphoric feelings?

Although it is generally accepted that it is much more difficult for the male gender dysphoric to pass to the opposite gender than it is for his female counterpart, the gender dysphoric woman also struggles hard and looks for immediate solutions in alcohol, drugs, suicide attempts or psychiatric help. In any case the tolerant climate can be beneficial for both. Finally, if it is already so difficult for the female-to-male transsexual, is it not obvious that the inspired male gender dysphoric looks for other solutions than sex reassignment surgery?

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