Sociodemographic Characteristics and Psychological Adjustment Among Transsexuals in Spain

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Abstract This study examined the sociodemographic characteristics and the psychological adjustment of transsexuals in Andalusia (Spain), and also analyzed the differences between female-to-male (FtM) and male-to-female (MtF) transsexuals. The sample included 197 transsexuals (101 MtF and 96 FtM) selected from those who visited the Transsexual and Gender Identity Unit at the Carlos Haya Hospital in Malaga between 2011 and 2012. Our analyses indicated that MtF transsexuals were more likely to have lower educational levels, live alone, haveworked less frequently throughout their lifetime, and have engaged in prostitution. For FtM transsexuals, there were more frequent references to the mother's psychiatric history and more social avoidance and distress. Multivariate analysis showed that the number of personality dysfunctional traits and unemployment status were associated with depression in the entire sample. The following three conclusions can be made: there are significant differences between MtF and FtM transsexuals (mainly related to sociodemographic variables), depression was high in both groups, and a remarkable percentage of transsexuals have attempted suicide (22.8 %) or have had suicidal thoughts (52.3 %).

Keywords Transsexualism · Gender dysphoria · Sociodemographic characteristics · Psychosocial adjustment · Transgender

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Introduction

Various studies, from many countries, have examined the prevalence, sociodemographics, and psychiatric morbidity in transsexuals (e.g., Cole, O'Boyle, Emory, & Meyer, 1997; De Cuypere, Janes, & Rubens, 1995; De Cuypere et al., 2007; Haraldsen & Dahl, 2000; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005; Herman-Jeglin´ska, Grawoska, & Dulko, 2002; Heylens et al., 2014; Hoshiai et al., 2010; Lande´n, Wa˚linder, & Lundstro¨m, 1998; Olsson & Möller, 2003; Tsoi, 1990, 1992; Van Kesteren, Gooren, & Megens, 1996). The prevalence of transsexualism varies by country (Bakker, van Kesteren, Gooren, & Bezemer, 1993; Tsoi, 1988), and differences have even been found within the same country (De Cuypere et al., 2007). Similarly, studies comparing MtF and FtM transsexuals also produce varied results. Some studies have found no significant differences in psychiatric morbidity or in sociodemographic variables, leading to the conclusion that MtF and FtM are similar in prevalence of comorbid psychopathology (Cole et al., 1997; Haraldsen & Dahl, 2000). Others, however, have found significant differences in educational level, employment, etc. (Herman-Jeglin´ska et al., 2002; Tsoi, 1992).

There is a risk that transsexuals may be stigmatized, experiencethestressofbelongingtoaminoritygroup, and/ordevelop psychosocial adjustment and mental health problems (e.g., lack of safe environments, victimization at school, etc.). In addition, the process of sex reassignment may also produce stress (Go´mez-Gil, Trilla, Salamero, Goda´s, & Valde´s, 2009). The gender reassignment may be problematic if the symptomatology was not taken into account during the process as it may cause significant distress and due to untreated psychological and psychiatric disorders the procedure may be complicated (Fraser, 2009; Lev, 2009). However, The Standards of Care for the Health of Transsexual, Transgender, and Non-Gender Conforming People, 7th Version (The World Professional

Association for Transgender Health, 2011) doesnot recommend pathologizing different gender identities or gender expressions that result from diversity.

Several studies have found that transsexuals have more associated psychological problems, such as depression, negative self-image, anxiety, dissociative disorders, personality disorders, and suicidal behavior than non-transsexuals (Hepp et al., 2005; Heylens et al., 2014; Kerstring et al., 2003). However, other studies have not found increased psychopathology in transsexuals compared to the non-transsexual population (Cole et al., 1997; Hoshiai et al., 2010). Discrepancies in the results may be attributed to methodological differences or to social and cultural environmental factors (Bodlund & Armelius, 1994; Haraldsen & Dahl, 2000).

Studieswithina population that defines itself as transgender suggest an elevated rate of suicidal behavior, with a lifetime suicidal ideation in more than half of the reported population (Bradford, Reisner, Honnold,& Xavier 2013; Moody& Smith, 2013; Xavier, Honnold, & Bradford, 2007) and approximately a third having attempted suicide (Bradford etal., 2013; Clements-Nolle, Marx, & Katz, 2006; Goldblum et al., 2012; Grossman& D'Augelli, 2007; Kenagy, 2005; Moody & Smith, 2013). Although research within a clinical transsexual population is scarce, some studies have found high rates of suicidal behavior. For example, Lande´n, Wa˚linder, and Lundstro¨m (1998) found that 19.3 % had attempted suicide during their lifetime. More recently, Hoshiai et al. (2010) found that 74.8 % had suicidal ideation and 33.1 % self-mutilating behavior during their lifetime. In an extensive follow-up study in Sweden, suicide attempts and suicide deaths were more likely in the transsexual population after sex reassignment surgery than in the control group (Dhejne et al., 2011).

Research on the prevalence of personality disorders in transsexuals has rendered different ratios ranging from 3 to 66 %, which is probably related to methodological issues and different characteristics of the samples (Bodlund, Kullgren, Sundbom, & Höjerback, 1993; Cole et al., 1997; Duisˇin et al., 2014; Haraldsen & Dahl, 2000; Hepp et al., 2005; Heylens et al., 2014; Hoshiai et al., 2010; Madeddu, Prunas, & Hartmann, 2009). Several studies have found the majority of personality disorders within cluster B (Bodlund et al., 1993; Cole et al., 1997; Haraldsen & Dahl, 2000; Hepp et al., 2005; Madeddu et al., 2009), althougha recent multicenter study found the most prevalent personality disorders within cluster C (Heylens et al., 2014). Several studies have found that transsexuals are more often diagnosed and have more personality disorder traits than the non-transsexual population (Bodlund et al., 1993; Duisˇin et al., 2014). Nevertheless, the results are ambiguous; for example, in Miach, Berah, Butcher, and Rouse (2000), there was no evidence to suggest that transsexualism was associated with severe personality disorders. Furthermore, most studies have foundnodifferencesbetweenpersonalitydisordersamong MtF and FtM transsexuals (Hepp et al., 2005; Heylens et al., 2014; Madeddu et al., 2009).

In studies regarding depression, different results have been found, with a range of current major depression between 1.4 and 17.4 % (Cole et al., 1997; Go´mez-Gil et al., 2009; Haraldsen & Dahl, 2000; Hepp et al., 2005; Hoshiai et al., 2010; Lobato et al., 2007). To our knowledge, there are few studies regarding factors related to depression in transsexuals, although a review article indicated various contributory factors: discrimination, nondisclosure, lack of social support, therapies (hormones and surgery), sociodemographic, and socioeconomic factors (young age, single status, unemployment, etc.), substance abuse, and access to services (Rotondi, 2012).

Regarding the care of transsexuals in Spain, public health care is not homogenized among the 17 autonomous regions. In 1999, Andalusia was the first autonomous region to create a specific unit within the public health system, located at the Carlos Haya Hospital of Malaga. The unit has a multidisciplinary team that includes psychologists, endocrinologists, plastic surgeons, and other specialists. To date, 1370 people have sought care at the unit. Although the unit sees Andalusia residents, it also attends to people from other regions that lack a specialized unit or from regions with a unit that does not offer all the specialties needed to fully carry out the process of sex reassignment (Esteva de Antonio et al., 2012). In Spain, there is still little information onsociodemographics and psychiatric morbidity (Bergero Miguel et al., 2001; Esteva de Antonio et al., 2001; Go´mez-Gil et al., 2009). Despite its clinical importance, thereare few studiesonsocial andpsychological adjustment for this group and even fewer studies using standardized diagnostic instruments. Likewise, there are few studies that make an analysis of the factors associated with depressive symptoms.

This is the first study that the Transsexuality and Gender Identity Unit (TGIU) at the Carlos Haya Hospital in Malaga has conducted on social and psychological adjustment difficulties. The objective of this study was to analyze sociodemographic factors, clinical aspects, and differences between MtF and FtM transsexuals who are seeking sex reassignment.

Method

Participants

The sample included a total of 197 transsexuals (M = 28.0 years, SD = 9.9). Of these, 101 were MtF (51.3 %, M = 29.2 years, SD = 11.8) and 96 were FtM (48.7 %, M = 26.7 years, SD = 7.3). The sample was selected from patients attending the TGIU who met the Transsexualism criteria for the ICD-10 (F64.0) standards and did not meet any of the exclusion criteria for sex reassignment set by the unit. Presenting with a

psychotic disorder or a severe personality disorder was an exclusion criterion to follow the process, and these patients were excluded from the TGIU treatment. Approximately 7.8 % of patients who request treatment were excluded at the TGIU. Only one of the eligible patients refused to participate in the study. The participants had requested hormonal and/or surgical treatment or had a psychological consultation at the TGIU between 2011 and 2012 and provided informed consent for the study.

Results

Sociodemographic Characteristics

The sociodemographic results are summarized in Table 1. Of the nine sociodemographic variables analyzed, there were no

working in the past (never) (*OR* 2.87; *CI* 1.12-7.32; $p = .020$).

Discussion

Sociodemographic Characteristics

In general, with regard to sociodemographic variables, MtF transsexuals presented certain characteristics that may reveal some major difficulties of social integration than FtM transsexuals. There was a lower level of education in MtF transsexuals compared with FtM. These data were consistent with the results reported in other studies (Go´mez-Gil etal., 2006; Tsoi, 1992). Other research, however, found no significant differences between MtF and FtM transsexuals (De Cuypere et al., 2007) or observed the opposite, i.e., higher educational levels in MtF transsexuals (Herman-Jeglin´ska et al., 2002). An explanation of this result could be victimization at school: non-conforming men face more harassment from their peers than non-conforming women, and non-conforming women perceive their schools as safer compared with non-conforming men (Kosciw, Greytak, & Diaz, 2009). In another study in the TGIU (with a group of patients partially overlapping this sample), the MtF transsexuals reported a higher level of violence in schools compared with FtM, while there were no differences in other contexts violence such as home and neighborhood (Bergero-Miguel et al., 2014). Most MtF transsexuals in Andalusia like those in Singapore (Tsoi, 1992) and elsewhere in Spain (Gomez-Giletal., 2006), butunlikethosein Belgium(De Cuypereetal., 2007), are homosexual in orientation. As such, they are more likelytobeovertlyfemininеduringchildhoodandadolescence and are therefore more likely to experience the gender-based

Table 3 Psychopathological aspects

	MtF (n = 101)		FtM (n = 96)		v^2	*p*
	n	%	n	%		
SCID-II PQ						
Avoidant	23	22.8	36	37.5	5.09	.024
Dependent	6	5.9	10	10.4	1.32	ns
Obsessive–compulsive	54	53.5	49	51	\1	ns
Passive-aggressive	33	32.7	30	31.2	.05	ns
Depressive	19	18.8	30	31.2	4.07	.044
Paranoid	44	43.6	36	37.5	\1	ns
Schizotypal	30	29.7	26	27.1	\1	ns
Schizoid	10	9.9	9	9.4	\1	ns
Histrionic	15	14.8	6	6.3	3.82	.051
Narcissistic	50	49.5	26	27.1	10.44	.001
Borderline	41	40.6	39	40.6	\1	ns
Antisocial	14	13.9	20	20.8	1.67	ns
Depression						
BDI (M/SD)	11.6	10.0	11.0	10.3	\1	ns
Depressed ([21)	17	16.8	15	15.6	\1	ns
Social anxiety						
SAD (M/SD)	7.5	7.2	10.0	9.0	−1.56	ns
SAD ([15)	20	19.8	31	32.3	4.00	.045
Social anxiety (SAD)	27	26.7	37	38.5	3.13	.077
Social avoidance (SAD)	15	14.9	23	24	2.62	ns
FNE (M/SD)	13.7	7.7	15.3	8.8	−1.31	ns
FNE ([21)	25	24.8	32	33.3	1.76	ns
MINI (N = 193, MtF = 99, FtM = 94)						
Posttraumatic stress	2	2	6	6.4	2.31	ns
Anorexia nervosa	1	1	1	1.1	\1	ns
Bulimia nervosa	5	5.1	2	2.1	\1	ns
Antisocial personality disorder	1	1	8	8.5	6.1	.016

MtF male-to-female transsexual, *FtM* female-to-male transsexual, *M* mean, *SD* standard deviation, *BDI* Beck Depression Inventory, *SCID II* Structured Clinical Interview for DSM- IV Axis II Personality Questionnaire, *SAD (total)* Social Avoidance and Distress, *SAD (AS)* Social Avoidance and Distress, social anxiety scale, *SAD (ES)* Social Avoidance and Distress, social avoidance scale, *FNE* Fear of Negative Evaluation

Table 4 Binary logistic regression using as dependent variable the BDI score[11

BDI[a]	OR adjusted	CI	*p*
Self-harm lifetime	2.54	.95–6.78	.063
Numbers of personality disorders traits (SCID II-PQ)	1.44	1.24–1.67	\.OO1
Sad ([15)	2.02	.92–4.44	.080
Employment status (unemployed)	1.86	.91–3.81	.090
Working in the past (never)	2.87	1.12–7.33	.027

BDI Beck Depression Inventory, *SCIDII-PQ* Structured Clinical Interview for DSM- IV Axis II Personality Questionnaire, *SAD* Social Avoidance and Distress

[a] Cox and Snell's $R^2 = .28$

victimization and harassment and that may make them leave school or have difficulties in school. Lower social individualism has been associated with homosexual orientation in transsexuals and might explain these differences found between countries (Lawrence, 2010b).

Regarding marital status, significant differences were found in this population. Ourresult supports literature showing that FtM transsexuals are more likely to live as couples and maintain more stable relationships than MtF transsexuals (De Cuypere et al., 1995; Dixen, Maddever, Van Maasdam, & Edwards, 1984; Gómez-Gil et al., 2009; Verschoor & Poortinga, 1988). It is likelythattheexplanationofthefactismultifacetedandrelated to the differences in social acceptance and sociodemographic and personality characteristics.

Wefoundnosignificantdifferencesintermsofemployment status; however, there were differences related to past work: FtM transsexuals were more likely to have worked in the past. More than one-third of the sample felt that they experienced discrimination while looking for work. These experiences were consistent with studies that reported that transsexuals suffer frequent job losses and problems in social relationships, among otherdisadvantages(Michel, Ansseau, Legros, Pitchot, & Mormont, 2002).

A higher percentage of MtF transsexuals in this sample practiced prostitution. This finding aligns with those reported by Dixen et al. (1984), who found that 16.9 % of MtF transsexuals had practiced prostitution. Prostitution has been linked to poverty, poor family financial resources, little or no family support, difficulty finding work, a low educational level (Hwahng & Nuttbrock, 2007), and homosexual orientation (Lawrence, 2010a).

Mental Health

Transsexuals often consult mental health professionals before going to the TGIU. In this sample, 48.4 % received psychotherapy. There were no significant differences for this variable, which is consistent with the findings from other studies which also found no significant differences between MtF and FtM with respect to previous psychiatric treatment (De Cuypere et al., 1995; Dixen et al., 1984; Landen et al., 1998). Violent acts are experienced frequently by transgenders (Kim et al., 2006) and the LGB population (Kosciw et al., 2009; Toomey, Ryan, Diaz, Card, & Russell, 2010), and has been associated with social intolerance (Bergero-Miguel et al., 2008; Grossman & D'Augelli, 2006), even at an early age (Carver, Yunger, & Perry, 2003).

Importantly, a high proportion of transsexuals from both groups had suicidal thoughts and attempted tocommitsuicide in comparison with the non-transsexual population (Gabilondo et al., 2007). Although we found nosignificant differences, there was a trend towards more suicidal thoughts in FtM transsexuals. There was no difference in past suicide attempts, which contradicts data from international studies that found that MtF experienced more suicide attempts (Dixen et al., 1984; Landen et al., 1998). The transsexual population is at high risk of attempting suicide during their lifetime.

Personality Disorder Traits, Depression, Social Anxiety, and the MINI

The results of the personality disorder traits were similar to those found in the study by Bodlund et al. (1993). This study used the same instrument and observed higher rates of personality disorder traits in transsexuals compared with a control group in 8 of the 12 traits analyzed. Comparing our results with another study that was using a large population of students aged from16to18 years(Maggini,Ampollini,Marchesi, Gariboldi, & Cloninger, 2000), more features of personality disorder traits in transsexuals were observed, mainly in obsessive–compulsive and paranoid, butno differences were noticed in histrionic and dependent traits. However, comparing personality traits in transsexuals with studies conducted by others using clinical psychiatric samples (obsessive–compulsive disorder, substance dependence, etc.), the percentage ofpersonality disorder traits is generally higher in clinical populations than in transsexuals (Ahmed, Kingston, DiGiuseppe, Bradford, & Seto, 2012; Bricolo, Gomma, Bertani, & Serpelloni, 2002; Huh et al., 2013). The differences between transsexuals and control population could be explained by the high levels of depression and social integration difficulties that transsexuals experienced in their lives.

Comparing the SAD and FNE scores with samples from other studies (Bobes et al., 1999; Garc´ıa-López et al., 2001), the mean scores were similar or even lower than in non-transsexual populations. There were more participants who exceeded the cut-off point on the SAD in FtM transsexuals (32.3 %) than in MtF (19.8 %), which was inconsistent with a study conducted in Catalonia (Gómez-Gil et al., 2009), where there were no significant differences between groups in the diagnosis of social phobia. Another recent study from our group found an association between social phobia and current cannabis use in transsexuals (Guzman-Parra et al., 2014).

The prevalence ofother psychiatric disorders (PTSD, anorexia nervosa, bulimia, and antisocial personality disorder) was lowand coincides with others studies (Go´mez-Gil et al., 2009; Heylens et al., 2014). The FtM transsexual group presented an increased antisocial personality disorder which may be related to gender roles (Castro, Carbonell, & Anestis, 2012). Regarding eating disorders, other studies have speculated that transsexuals might represent a population at risk of having eating disorders (Vocks, Stahn, Loenser, & Legenbauer, 2009). Although the sample was too small to draw conclusions, the current prevalence of anorexia and bulimia would be higher in the transsexual population compared to the general population (.21 and .81, respectively) (Qian et al., 2013).

This study showed a significant prevalence of depressive symptoms in both groups. The mean score on the BDI test was higherin the transsexualsamplecomparedwith a sample(M = 5.93) of Spanish non-transsexual men and women (Sa´enz & Va´zquez, 1998). However, in the study by Kim et al. (2006), the BDI score (M = 21.4) in transsexuals was considerably higher than in this study. Regarding the predictor variables of depression in transsexuals, the results were in line with studies conducted on non-transsexuals in which depression was related to interpersonal difficulties, unemployment or unpaid work and other mental health comorbidities (Bello´n et al., 2011). However, other variables such as employment discrimination, substance abuse or fear of negative evaluation (FNE[21) were not significantly related to depressive symptoms.

Limitations

There were some general issues limiting this study. Primarily, in the absence of a non-transsexual population control group, it is impossible to draw conclusions as to whether there were differences in psychopathology and psychosocial adjustment compared to the transsexual population. Secondly, there may be undiagnosed disorders affecting this population that were not detected by this design. Thirdly, the sample was not representative of the entire transsexual population as not all members of this population sought treatment atthe Unit. Wedonot know how many transsexuals in our community underwent the diagnostic evaluation process or conducted this process through private centers. In fourth place, this study was cross-sectional and not prospective. It would be desirable to monitor these data over a period of time to identify possible changes and to assess the effects of treatment on sociodemographic and psychopathological variables. In fifth place, the high percentage of patients (7.9 %) that were finally excluded from the treatment unit might underestimate the presence of psychopathology in the sample. Finally, the study did not take into account social desirability bias, which could affect the data because the motivation to participate in the reassignment process is strong.

Conclusions

The results confirmed differences in sociodemographic variables between MtF and FtM transsexuals. FtM transsexuals displayed, in some variables, better adjustment in sociodemographic variables. Although there have been many institutional and legal advances in Spain, the data from this study suggests that there are still many obstacles for adequate social and psychological adjustment. With regard to psychopathology, the FtM group presented a greater tendency towards avoidance behavior (high scores for social avoidance and avoidant personality characteristics). Transsexuals are at high risk for suicidal behavior and depression, so the emphasis on suicidal and depression prevention is important. Future lines of research that address protective and resilience factors are important.

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