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Dysfunctional core beliefs, perceived parenting behavior and psychopathology in gender identity disorder: A comparison of male-to-female, female-to-male transsexual and nontranssexual control subjects

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ABSTRACT

Background: Research into the association between Gender Identity Disorder (GID) and psychological disturbances as well as on its relation with parenting experiences yielded mixed results, with different patterns for Male-to-Female (MF) and Female-to-Male (FM) transsexual subjects. We investigated vulnerability markers of maladjustment and their possible origins in MF and FM transsexuals by examining maladaptive core beliefs and parenting behaviors thought to be specifically related to them.
Methods: Dysfunctional core beliefs, parenting experiences and psychiatric symptoms were assessed by the Young Schema Questionnaire indexing 19 Early Maladaptive Schemas (EMS), the Young Parenting Inventory and the Symptom Checklist-90-R, respectively, in 30 MF, 17 FM transsexual and 114 control subjects (43 males, 114 females).
Results: Subjects with GID demonstrated a level of psychiatric distress comparable to that of controls. They did display elevated scores, however, on multiple EMSs compared to nontranssexual subjects, indicating feelings of isolation, emotional deprivation and an urge to meet others' needs, with MF transsexuals conceptualizing themselves also as more vulnerable and deficient than controls. Parenting experiences of transsexual subjects were characterised by increased maternal dominance, emotional abuse and neglect compared to controls, with males being exposed to a disengaged maternal style and more paternal emotional neglect and criticism. Both MF and FM transsexuals were made felt that in areas of achievement they will inevitably fail.
Conclusions: There is no evidence of elevated levels of psychiatric symptoms in GID, but potential predisposing factors, particularly in MF transsexuals, are present; these may originate from the more intense rejection they experience.

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1. Introduction

Gender identity disorder (GID), or transsexualism, is characterised by strong cross-gender identification together with a feeling of discomfort with one's own anatomical sex and the gender role associated with that sex (Cohen-Kettenis & Gooren, 1999). Its estimated prevalence varies from 1:12,900 to 1:35,000 for MFs, and from 1:33,000 to 1:100,000 for FMs (De Cuypere et al., 2007, Gómez-Gil, Vidal-Hagemeuer, & Salamero, 2009; O'Gorman, 1982). Since it first appeared as a nosological entity, it has been a focus of debate whether GID is a manifestation of severe psychiatric morbidity, associated with mental disturbance or a diagnostic entity in its own right (Kórász & Simon, 2008).

Studies into this question yielded mixed results. GID was found to be associated with distress and higher prevalence of certain Axis I and II disorders (Bodlund, Kullgren, Sundbom, & Höjerback, 1993; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005). Some studies, however, suggest that instead of being preconditions for the development of GID, psychiatric problems may be the consequences of persistent psychological difficulties due to the incongruence of biological sex and gender identity on the one hand and the social rejection on the other. With respect to psychopathology, and pathological personality traits, transsexuals seem to be comparable to controls (Haraldsen & Dahl, 2000; Kersting et al., 2003).

Another area of inquiry is the role of parental influences in the etiology of GID. Prior studies found that fathers of transsexuals, in particular those of MFs, were more hostile and rejecting (Sípová & Brzek, 1983) than those of controls. In

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addition, they were less dominant (Rekers, Mead, Rosen, & Brigham, 1983; Sípová & Brzek, 1983). Regarding mothers, whilst some reported an intrusive parenting control (Marantz & Coates, 1991; Tsoi, 1990), others did not find difference (Parker & Barr, 1982; Rekers et al., 1983). It is important to note, however, that transsexuals cannot be treated as a homogenous group. Specifically, several researchers identified differences between the psychological and social adjustment of MF and FM transsexuals, which may account for some of the contradictions. FMs exhibit fewer symptoms of mental distress; more stable relationships both pre- and post-surgery; and have more realistic expectations of sex-reassignment surgery (SRS) than MFs (De Cuypere, Jannes, & Rubens, 1995; Landén, Wålinder, & Lundström, 1998). In addition, FMs have marriage less often prior SRS, are more likely to have sexual relationships according to their gender identity present at younger age (Gómez-Gil et al., 2009). These findings suggest that FM transsexuals are socially and psychologically better adjusted than MFs, albeit there are some contradicting results, indicating no difference in psychiatric comorbidity (Cole, O'Boyle, Emory, & Meyer, 1997; Hepp et al., 2005) or even lower psychological functioning in FMs (Bodlund et al., 1993; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005). To date, little attention has been paid to the differences between male and female transsexuals inpersonality traits or those elements of self-concept which may underlie the phenomenological differences. The few available studies showed that both groups displayed sex-roles and characteristics congruent with their gender identity; nonetheless, MFs tended to show more extreme cross-gender identification (Cole et al., 1997; Fleming, Jenkins, & Bugarin, 1980; Herman-Jeglinska, Grabowska, & Dulko, 2002; Lippa, 2001). Though FMs rate themselves higher than control females in self-ascribed masculinity (Herman-Jeglinska et al., 2002; Lippa, 2001), they also score higher on feminity scales (Herman-Jeglinska et al., 2002). Thus, while FM transsexuals incorporate some of their former sex-roles into their new role as males, MFs try to adhere perfectly to the sex-role stereotypically attributed to the opposite sex (Herman-Jeglinska et al., 2002), which in itself, can cause severe psychological distress. It remains unexplored whether MF and FM transsexuals also differ in their core beliefs or schemas guiding their conceptualizations of themselves and relations to others. Differences in Early Maladaptive Schemas (EMSs), identified by Young, Klosko, and Weishaar (2003) seem to be especially relevant. EMSs are pervasive, dysfunctional patterns of cognitions, memories and emotions regarding oneself and one's relationships with others. Given that EMSs are associated with poor social and psychological functioning (Ball & Cecero, 2001; Leung, Waller, & Thomas, 1999) and the differences between MF and FM transsexuals in adjustment, one can hypothesize that MF and FM transsexuals differ in their EMSs. In addition, since adverse parenting plays a role in psychopathology and disturbed internal representations of the self in general, and contributes to EMSs (Harris & Curtin, 2002; Sheffield, Waller, Emanuelli, Murray, & Meyer, 2005) as well as to the development of atypical gender identity in particular, it can be hypothesized that the 2 groups differ in their recalled child-rearing patterns. To our knowledge, only a few studies explored the differences between adult MF and FM transsexuals in this respect. They found that FMs experience less parental (especially maternal) care as children than nontranssexual females or MF transsexuals (Cohen-Kettenis and Arrindell, 1990; Tsoi, 1990). Overall, similar to MF transsexuals, who receive less paternal care than nontranssexual males or FMs (Tsoi, 1990), FMs may not have a desirable same-sex role-model. However, findings that cross-gender boys are regarded more negatively by fathers, while mothers are more acceptable, also predict the same results (Feinman, 1981; Martin, 1990; Sandnabba & Ahlberg, 1999).

The goal of our study was: 1/to characterize MF and FM transsexuals in psychopathology, core conceptualizations of the self and the world, and parenting experiences via comparing them to controls of the same and the opposite sex; and 2/to delineate differences of MF and FM transsexuals in these three areas. Based on prior research we hypothesized a level of psychopathology either similar (FMs) or slightly lower (MFs) than normal in our sample of transsexual subjects. We also expected MFs to score higher than controls and FM transsexuals on certain EMSs, especially on those related to their sex-role identification. Furthermore, we assumed that the 2 groups would differ in recalled parental behaviors that underlie EMSs. Specifically, we expected that the differences would be the most pronounced in recalled parental behaviors which either foster identification with the cross-sex parent or occur as a reaction to atypical gender development.

2. Methods

2.1. Participants

A total 204 subjects (47 transsexuals, 157 healthy controls) were included in the study. The transsexual sample comprised 30 MF (biological males diagnosed with GID) and 17 FM transsexual subjects (biological females diagnosed with GID) according to DSM-IV criteria (American Psychiatric Association, 1994) at the Semmelweis University, Department of Psychiatry and Psychotherapy, Budapest, Hungary. The diagnostic status was assessed by a trained clinical psychiatrist (first author), specialised in the assessment of GID. Participants included in the study were drawn from a larger sample of 84 patients who contacted the Department between 2003 and 2009 to request formal recommendation from mental health professionals for SRS, and were willing to participate in this investigation. Participation in the study was voluntary, with no incentives offered. All subjects involved have already had real-life experience in the desired role, either as full time men (FM) or full time women (MF) by the time of the assessment. The healthy control sample consisted of 157 volunteers (43 male, 114 female), mainly staff members and students recruited from the Semmelweis University of Medicine and the Eötvös Loránd University, and their acquaintances. None of them had history of psychiatric illness, neither had they ever felt need for psychiatric treatment.

All participants were Caucasian. All subjects gave written informed consent to participate in the study prior assessment and their permission to use the data for research purposes. The design was approved by the local research ethics committee.

2.2. Measures

2.2.1. Background information and symptom assessment

Subjects were administered a short questionnaire to obtain basic background information, history of SRS and cross-gender behavior. In order to systematically assess the level of current psychopathology, the Hungarian version of the Symptom Checklist-90-R (SCL-90-R, Derogatis, 1977) was used. The SCL-90-R is a widely used 90-items self-report questionnaire of psychiatric distress with 9 subscales plus additional items covering a wide range of psychopathological symptoms that are rated for severity with regard to the week prior assessment. Its psychometric utility has been established, with high internal consistency (Cronbach alphas ranging from 0.73 to 0.96 for the 9 subscales of the Hungarian version) and predictive value for a separation of clinical and normal samples, as well as adequate diagnostic accuracy in detecting overall psychopathology (Unoka, Rozsa, Fabian, Mervo, & Simon, 2004).

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