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**ORIGINAL ARTICLE**

# Affect Control in Patients with Gender Dysphoria Disorder Visiting Legal Medicine Center in Southwest of Iran

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**ABSTRACT**
*Background: Emotions play an important role in personality development, social relationships and the formation of identity. Aim: The current study was conducted to investigate affect control in patients with gender Dysphoria in the southwest of Iran. Material& Methods: This is a descriptive study. The statistical population included all patients with gender Dysphoria visiting the General Directorate of Legal Medicine in Fars Province in the southwest of Iran from 2005 until 2015. The research sample was comprised of 66 subjects selected with convenience sampling method. Demographic and affect control questionnaires were used for data collection. The independent t-test, Mann-Whitney U test, Pearson correlation coefficient, eta-squared, and SPSS 22 were employed for data analysis. The significance level was considered to be p<0.05. Results: The results indicated no significant difference between operated and not-operated individuals, except in positive affect between operated and not-operated men (p<0.05). There was a correlation between affect control and the educational attainment in operated group; whereas, this correlation was between affect control with educational attainment and job in the not-operated group(p<0.05).Conclusions: According to the findings, it can be concluded that there was no difference in the affect control of operated and not-operated individuals with gender dysphoria disorder; whereas, there was a correlation between the demographic variables such as job and educational attainment with affect control in these individuals.*
***Keywords;*** *Affect control, Gender Identity Disorder (GID), Transsexualism, Iran, Shiraz*

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## INTRODUCTION

Gender dysphoria disorder is one of the most important aspects of human identity [1]. It refers to an individual's feeling and perception of being a man or woman along with the entire thoughts, feelings and behaviours pertaining to sexual satisfaction [2]. It is normally consistent with an individual's anatomic gender [3].
Gender identity is generally formed through the learning process [4], in which factors such as parental attitudes, current culture, external genitals, and genetic are involved [5]. The child is educated about sexual roles and is encouraged to reinforce gender-related behaviours [1, 4]. However, gender identity sometimes takes on a path that is not consistent with an individual's biological gender registered in the birth certificate. In such circumstances, it is stated that the individual has gender dysphoria [6]. One of the disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is gender dysphoria [3]. The common characteristic which people with gender dysphoria share is a strong and compatible desire to live and to be accepted as a member of the opposite sex [7]. The emotional component of gender dysphoria is called sexual boredom [8].

People with gender dysphoria disorder are a social segment with stressful lives due to familial pressures and limitations, as well as cultural and social prejudices [9], and are prone to multiple conflicts. Therefore, it is expected that such conflicts cause them to harm themselves or even others in different ways such as depression, anxiety, anger, suicide, and craving for drugs [10]. They are faced with many problems, inducing them to feel everything out of control and incapable of self-affect-control in different familial and social situations [10].

Emotions constitute an important and essential part of human life, insofar as it is hard to imagine life without them. Emotional characteristic and changes, formation of emotional relationships, and the perception and interpretation of others' emotions play an important role in the development and organization of personality, moral evolution, and social relationships, and the formation of identity and concept of self [11]. All humans experience excitements and emotions in their lives. It is totally normal that they express different emotions while encountering various situations. Severely negative emotions not only are abnormal and non-constructive, but also bring destructive and harmful effects [12]. Emotional extremism and negligence would make people difficult, aggressive, angry, resentful, and anxious, which uncontrollably and gravely threaten their mental and emotional health [13].

Affect control skill means learning how to recognize, express, and control recognition skill in various situations [14]. This skill has various effects on different aspects of life, interpersonal interactions, and mental and physical health [15].

Dinner (1994) emphasized that the most common aspects describing emotional experiences are positive and negative emotions. Positive affects express a level of pleasant engagement that includes a range of positive emotions such as desire, honour, powerfulness, and interest. On the contrary, negative affects refer to a level of unpleasant engagement that includes a range of negative emotions such as feeling of guilt, embarrassment, restlessness, and distress [16]. Historically, the relationship between depression and anxiety, as two main constituents of negative affect, has drawn notably theoretical and clinical attention [17] .To our knowledge, few studies have been conducted on affect control in general among patients with gender dysphoria disorder.

Many studies have reported a high prevalence of emotional problems and anxiety disorder among people with gender dysphoria in comparison with the entire population [18-24]. Hilens *et al*. (2014) reported this prevalence as 13-25% in Belgium and the Netherlands and 35-40% in Germany and Norway [20]. In another study, Gomez-Gale *et al* (2012) showed that heterosexual patients, who attended the gender identity unit of the clinic, reported social distress, anxiety and depression [25]. Garnowski and Griach (2006) also stated that people with difficulty in showing their emotions would experience more depression, anxiety and negative effects in comparison to others [26]. Blanchard *et al*. (1983) carried out a study to measure the degree of anger and physical aggression among homosexual, heterosexual, and transsexual men. They concluded that homosexuals showed less anger and physical aggression than heterosexuals, and transsexuals had the lowest scores in aggression scale [27]. Glado and Bali [28] stated that homosexual men were less physically aggressive than heterosexual men.

Considering all of the above-mentioned cases and given the fact that gender dysphoria is among the disorders causing severe damages to occupational, educational, and social performances and interpersonal relationships [29], such circumstances influence an individuals' personality and behavioural system, and eventually social adaptability [30], and confuse them. On the other hand, emotional bonds is one of the most problematic area for people with gender dysphoria disorder [31]. This is because incapability in affect control would influence many aspects of life, along with physical and mental health, communications, and life quality of such people in different societies [32]. Due to the lack of such study in Iran, this investigation was designed and carried out to compare affect control in people with gender dissatisfaction visiting the Legal Medicine Centre in the southwest of Iran.

## MATERIALS AND METHODS

This study was conducted to investigate affect control in patients with gender dysphoria disorder in 2015. For this purpose, the necessary authorizations were issued by the General Directorate of Legal Medicine in Fars Province. The target population was comprised of two groups. The first group included the patients with gender dysphoria disorder who visited the General Directorate of Legal Medicine in Fars Province for transgender surgery authorization. Then they were introduced to licensed psychiatrists and psychologies for psychiatric evaluations. The definitive diagnosis of gender dysphoria disorder was based on DSM-IV criteria. The second group included the patients with gender dysphoria disorder who had undergone a transgender surgery since two to ten years ago. Before the surgery, these patients had been definitely diagnosed with gender dysphoria disorder by a psychologist and a psychiatrist confirmed based on DSM-IV (1994) and ICD-10 (1988) in the General Directorate of Legal Medicine in Fars.

The statistical population included all operated and not-operated patients with sexual identity disorder (80 subjects in total). According to the Morgan table, the sample size was calculated to be 66 individuals who were selected within four months from eligible volunteers among the research population using convenience sampling and visiting the General Directorate of Legal Medicine in Fars Province, as well as the licensed psychiatry and psychology offices. Patients were orally provided with the necessary instructions on honest cooperation and how to fill the questionnaires. In addition, Helsinki Accords on medical research were adhered. Emphasizing the confidentiality of respondents' information, it was attempted to increase their trust and tendency towards cooperation [33]. After obtaining patients' cooperation and their informed consent, a questionnaire was given to each of them. Then the questionnaires were gathered after completion. In such restricting circumstances, it was not possible to select the same number of male and female respondents; therefore, the researcher had to rely only on those who were willing to cooperate.

Table1. Descriptive Statistics of Affect control in 2 groups[1]

| | GID people (operated) | GID people (not operated) |
|---|---|---|
| | $\bar{x} \pm \sigma$ | $\bar{x} \pm \sigma$ |
| Affect control | 3.3861±.53513 | 3.4756±.59343 |
| Anger | 3.5670±.71806 | 3.6316±.83471 |
| Depressed mood | 3.2143±.53668 | 3.1283±.58304 |
| Anxiety | 3.3929±.68717 | 3.3927±.74210 |
| Positive Affect | 3.3736±.80697 | 3.6761±.71294 |

The inclusion criteria were patients with definitive diagnosis of gender dysphoria disorder based on DSM-IV-TR, tendency towards cooperation, and complete medical record. The exclusion criteria were patients with no confirmed definitive diagnosis of sexual identity disorder by the Commission of Psychiatry, psychotic, mood, and other disorders, incomplete medical records, no interest for cooperation, and changed address.

The research instruments included demographic inventory (age, gender, educational attainment, and employment status) as well as the affect control questionnaire.

The latter is a self-assessment tool used to evaluate the level of affect control. It consists of 42 questions with 4 subscales namely anger, depressed mood, anxiety, and positive affect. The responses were scored on a seven-point scale from 1 "Strongly Disagree" to 7 "Strongly Agree."

The questions 4, 9, 12, 16, 17, 18, 21, 22, 27, 30, 31 and 38 were inversely scored. Eight, eight, thirteen, and eight items were related to anger, depressed mood, anxiety, positive effect, respectively [34]. The internal and re-test validity of the test were 94% and 78% for overall test score, 72% and 73% for anger, 91% and 76% for depressed mood, 89% and 77% for anxiety, and 84% and 64% for positive effect, respectively [35]. Moreover, the reliability coefficient and Cronbach's alpha were estimated to be 84% for affect control, 53% for anger, and 60% for positive affect by Dehesh (2009).

## STATISTICAL ANALYSIS

Data were analysed using the descriptive statistical methods (frequency, frequency percentage, mean, and standard deviation), analytical statistics (independent t-test, Mann-Whitney U, Pearson correlation coefficient, and eta-squared), and SPSS 22. In this study, Cronbach's alpha was equal to 0.81, and the significance level ($p<0.05$) was considered to be the discrepancy among variables.

## RESULTS

In general, 66 patients (28 operated versus 38 not-operated) were included in the study. The average ages of operated and not-operated groups were 24.46±4.43 and 24.84±3.6 years, respectively. In terms of gender, 31 and 35 subjects were male and female, respectively. In the operated group, the highest educational and occupational frequencies were diploma with 13 subjects (46.4%) and self-employed with 17 subjects (60.7%), respectively. In the not-operated group, the highest educational and occupational frequencies were degrees prior to diploma with 21 subjects (55.3%) and unemployed with 19 subjects (50%), respectively.

In this study, there was no significant difference in the affect control between the operated and not-operated groups, except in the amount of positive affect in operated and not-operated men. The statistic was equal to -2.117, and significance level was 0.042 ($p<0.05$) (Table 2 and 3).

[1] .Descriptive Statistics of Affect control by Each Group GID people (operated) GID people (not operated)

Table2. The Independent t-Test for Affect control and Subscales

| | | T-test | d.f | Sig. | Mean difference |
|---|---|---|---|---|---|
| Male | Affect control | -1.551 | 33 | .13 | -.28354 |
| | Anger | -1.405 | 33 | .17 | -.34722 |
| | Anxiety | -.897 | 33 | .38 | -.21921 |
| | Positive Affect | -2.117 | 33 | .04 | -.48718 |
| Female | Anger | .633 | 29 | .53 | .20298 |
| | Anxiety | 1.109 | 29 | .28 | .30440 |
| | Positive Affect | -.432 | 29 | .67 | -.13846 |
| Total | Anxiety | .001 | 64 | .99 | .00014 |
| | Positive Affect | -1.611 | 64 | .11 | -.30249 |

Table 3: Man-Whitney U Test for Affect control and its Subscales in the Two Groups

| | | Mann-Whitney U | Sig. | Mean Ranks (operated) | Mean Ranks (operated) |
|---|---|---|---|---|---|
| Male | Depressed mood | 148.500 | .88 | 17.75 | 18.26 |
| Female | Affect control | 96.000 | .70 | 16.90 | 15.57 |
| | Depressed mood | 92.000 | .58 | 17.30 | 15.38 |
| Total | Affect control | 499.500 | .67 | 34.66 | 32.64 |
| | Anger | 515.000 | .82 | 32.89 | 33.95 |
| | Depressed mood | 519.500 | .87 | 33.95 | 33.17 |

Furthermore, in the operated group, there was a correlation between affect control and the educational attainment (0.352); whereas, affect control was correlated with the educational attainment (0.462) and job (0.318) in the other group. There was no correlation between affect control and other demographic variables in the two groups (Table 4).

Table4. Correlation of affect control with demographic variables

| | | Age[1] | Gender[2] | Education[2] | Job[2] |
|---|---|---|---|---|---|
| Affect control | GID people (operated) | -.247 | .168 | .352 | .188 |
| | GID people (not operated) | .015 | .197 | .462 | .318 |
| 1. Pierson's Correlation Coefficient<br>2. Eta | | | | | |

## DISCUSSION

The findings of the current study suggest no significant between-group difference in affect control. In addition, no correlation was found between affect control and gender in the two groups. To explain, it can be said that given the type and nature of gender dysphoria disorder, the transsexual surgery only influences the body and appearance of such individuals. On the other hand, since the affect control is a psychological subject, a conflict has always existed between emotions and biological gender in them before surgery. Their strong tendency to convey masculine or feminine moods implies their need to be accepted as one with the emotions of opposite gender. It means that they have normal feelings and reactions of a man or woman, and thus no tangible post-surgery difference is observed in them in terms of affect control. This is consistent with the study conducted by Maramanti [37].

The research findings, indicating a correlation between affect control and education (0.352) in the operated group, can be explained by the fact that the operated group has more control over their affects. This is because they are mentally more relaxed and no longer concerned about the operation, leading to deeper self-satisfaction despite all problems. It means that developing a capability in reviewing and reconstructing the severity and orientation of an emotion in selves and others enables them to internally moderate and cope with negative effects and direct them towards adjustment. Since emotional recognition gives them analysis and control capabilities, they perform better in dealing with life problems and adjusting with environment and others. In general, they can take a step towards success in different aspects of life, and also can organize their professional life better in accordance with their interests, or at least to have a job to make a living. However, having a good job requires higher education and greater experiences, which are what they usually lack and thus choose self-employment.

To explain the finding, indicating a correlation between affect control with education (0.462) and job (0.318) in the not-operated group, it can be stated that the latter group usually tend to jobs which are not common for their biological gender, due to their existing concern about the operation. This tendency is strongly resisted by the society because family and society still have a negative attitude towards the patients with gender dissatisfaction, considering them to be perverts and not patients and expecting them to take on roles that are common for their genders. These patients are usually under pressure and blamed

for showing behaviours of opposite sex. This may eventually result in rejection by family. On the other hand, such individuals have low educational level, lack emotional unawareness, and are incapable of processing their feelings cognitively and thus are not usually able to identify, perceive or describe their emotions. They are also rarely capable of adapting to stressful circumstances and controlling their affects. In addition, as they fail in their objectives, aggressiveness and anger are expected from them due to the high stress, and misapprehension of their internal and psychological states by others and society.
When patients with gender dysphoria cannot speak out their negative effects, the psychological component of affect-expression and psychological distress systems such as depression, anxiety and anger would be stimulated and represented more in form of as self-mutilation and suicide. In addition, low emotional capacity inhibits them from having positive mood and adequate level in dealing with others. This challenges adaptability to others. Thus, such individuals are most often schizoid, socially marginal, and unemployed. Although, a completely similar study was not found in the literature, these findings are consistent with studies conducted by Azdel [38], Clements [39], Tong [40] and Askari [41] on depression, anxiety, anger, and suicide in this group of patients.

## CONCLUSION

Given the fact that the patients with gender dysphoria disorder are a special group with particular conditions and requirements, affect control skills influence different aspects of their lives (employment, education, interpersonal interactions, and physical health). It can be concluded that emotional excess and negligence result in inconsistency, aggression, anger, depression and anxiety in these people, which uncontrollably and gravely threaten their mental and emotional health.

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