A Structural Equation Model for Age at Clinical Presentation in Nonhomosexual Male Gender Dysphorics

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Nonhomosexual male gender dysphorics often make their first requests for clinical assessment when they are in or approaching middle age. This study investigated how well patients' explanations for the timing of these requests fit the objective data. Subjects were 194 outpatients presenting for the first time at a gender identity clinic. Their common explanations for the timing of their requests were incorporated into a formal path model, which was tested using Bentler's structural equations program. The model provided an acceptable fit to the data. The more times a patient has been married and the more children he has fathered, the older he is likely to be when first presenting for clinical attention. This outcome is consistent with the claims of patients that they would have come to a gender clinic sooner if they had not been restrained by commitments to wives and children.

KEY WORDS: gender dysphoria; path analysis; sex reassignment surgery; structural equation modeling; transsexualism.

INTRODUCTION

The term gender dysphoria refers to discontent with one's biological sex, the desire to possess the body of the opposite sex, and also to be regarded by others as a member of the opposite sex. Nonhomosexual gender dysphorics are men sexually attracted to women, to both sexes, or to neither sex. Previous research indicates that these three groups are similar with regard to psychosocial variables relevant to the present study (e.g., hetero-

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sexual experience) and further suggests that all three are probably just variant forms of the same underlying disorder (Blanchard, 1985, 1988, 1989a, 1989b).

Nonhomosexual male gender dysphorics typically present for clinical assessment in their mid-30s, and patients requesting their first consultation after the age of 50 or 60 are not rare. These patients give various reasons for the timing of their requests. A few older individuals state that, although prodromes of their disorder (e.g., cross-dressing) had appeared in early childhood, the conscious wish to be a woman only crystallized a few years before. That explanation does not, however, apply to all older patients, most of whom state that their desires to be female date back to puberty or earlier childhood.

Many patients explain long lags between early (self-reported) cross-gender feelings and much later help-seeking behavior in terms of conflict between their transsexual wishes, on the one hand, and incompatible goals and desires, on the other. One frequently cited source of conflict is marriage. Patients often report that they delayed inquiring into sex reassignment because of emotional attachment to their wives or guilt at the thought of divorcing them. Perhaps even more common are patients’ assertions that they put off consulting a gender identity clinic because of their love for, or sense of obligation toward, their dependent children. It should be noted that patients’ own accounts of the effects of parenthood on their subsequent behavior differ sharply from the notion that children precipitate transsexual strivings in vulnerable men by reactivating their own childhood traumas (Person and Ovesey, 1974; Wise and Meyer, 1980).

The purpose of this study was to investigate whether patients’ own explanations for late help-seeking behavior account for the observed data well enough to be plausible. The answer to that question has various implications: The credibility that we accord self-reports of this type can affect our clinical evaluation of individual patients as well as our general conception of nonhomosexual gender dysphoria—as a disorder that typically starts late, grows slowly, or both, versus one that commonly progresses to clinically uncomfortable levels quite early, but often fails to trigger help-seeking behavior because of psychological or social conflicts.

Patients’ collective reasons for seeking gender clinic referrals at older ages—particularly the more common reasons regarding age of onset, marriage, and parenthood—may be conceived as a multivariate model for explaining the observed variability in age at clinical presentation. The specific objective of this study was to investigate how well this multivariate model—or rather, my formalized and expanded version of it—fits the empirical data. The formal model included the variables cited by patients plus a fourth—sexual attraction to physically mature women (gynephilia)—that