

# Clinical Features of Outpatients of Nagasaki University Hospital Gender Clinic

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The concept of gender identity disorder has developed rapidly since the 1950s. Recently, gender identity disorder has drawn attention in the medical field as well as in society. To elucidate issues associated with individuals with gender identity disorder, we examined the demographic background, and medical and social problems in outpatients of the Gender Clinic of the Neuropsychiatry Department at Nagasaki University Hospital from January 1, 2003 to February 28, 2005. Of 27 individuals observed during this period, 3 were diagnosed with gender dysphoric syndrome, and the remaining 24 were diagnosed with gender identity disorder according to the ICD-10. Patients of female to male (FtM) and of male to female (MtF) were 15 and 9, respectively. Women in their twenties comprised 50% of the study subjects and about 30% of the study subjects were from outside Nagasaki prefecture. The subjects showed an active attitude to receiving therapy for solving their problems. Many subjects had disclosed their problems to family members and friends on the occasion of important life events such as graduation from high school or a birthday. Feelings of gender dysphoria were frequently experienced from infancy, and in MtF these feelings were occasionally first experienced in adolescence. Obstacles to social adjustment were more frequently observed in MtF than in FtM. The results of the present study suggest the need for early diagnosis and early intervention to immediately reduce unnecessary suffering and to increase the likelihood of improving quality of life.

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## Introduction

In July 1996, the Ethics Committee of Saitama Medical School recommended approval of surgical treatment for gender identity disorder (GID). In May 1997, the Japanese Society of Psychiatry and Neurology published the Guideline for Diagnosis and Treatment of GID (hereafter referred to as the Guideline). Subsequently, the situation surrounding GID has continued to change rapidly.

The Japanese Society of Psychiatry and Neurology created a special committee on gender identity disorders in order to establish the Guideline (Version 1). The former chairman of the Department of Neuropsychiatry, Nagasaki University Graduate School of Biomedical Sciences became a member of this committee in 1997 and contributed to the publication of the Guideline (Version 2)<sup>1</sup> in 2002. As a result, the department has had the opportunity to observe GID cases in clinical settings from an early stage.

In the present research, we first examine the historical background

of the concept of gender, then describe approaches to and the current state of outpatient services for GID at Nagasaki University Hospital. Finally, we review problems associated with these services and discuss prospects for the future.

## Gender Identity Disorder

A concept similar to GID appeared around the time Hirschfeld described transvestism<sup>2</sup> in 1910. However, individuals whose sexual identity and behavior did not match their biological sex were considered en masse to be sexually deviant, a concept that included homosexuality and fetishism. In 1936, Ellis<sup>3</sup> referred to the phenomenon of cross-dressing as "eonism." The concept of eonism maintains that cross-dressing is one of the means for confirming that one has behavior patterns and psychological characteristics of the opposite sex and is conceptually analogous to GID. In 1952, Hamburger

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performed the first male to female sex change operation. In 1954, Benjamin<sup>4</sup> introduced the concept of transsexualism and was the first to point out that the therapist should facilitate agreement between physical sex and psychological sex.

In 1955, Money<sup>5</sup> used the term "gender role" in psychosexual research on a boy who lost his penis due to injury to represent the non-biological, psychosocial elements of gender as opposed to biological sex. In 1965, the Johns Hopkins Gender Identity Clinic was established and in 1968 Stoller<sup>6</sup> expressed the fundamental awareness of one's sex as "core gender identity." These concepts have been integrated into the current concept of gender, which consists of the following three components:

- (1) Gender identity: the sameness, unity, and persistence of one's individuality as a male, female or amphoteric.<sup>7</sup>
- (2) Gender role: sexual behavior patterns prescribed by society.
- (3) Sexual orientation: the sex that is the object of one's sexual interest or arousal.

According to Yamauchi,<sup>8</sup> GID is a state in which one is biologically normal, although, clearly aware that his or her body is of opposite sex.

In 1978, GID officially appeared in the International Classification of Diseases (ICD-9) published by the World Health Organization (WHO). Though GID was listed along with subcategories such as homosexuality, transvestism, and pedophilia under the sexual deviations and disorders category, only the diagnosis of transsexualism was indicated. The ICD-10,<sup>9,10</sup> published in 1992, lists categories named "disorders of sexual preference" and "psychological and behavioral disorders associated with sexual development and orientation" along with "gender identity disorder." Transsexualism is listed as a subcategory of GID. Additionally, all of the following basic symptoms are required for diagnosis: (1) persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex; (2) strong persistent cross-gender identification; and (3) preference for cross-sex roles. In addition, diagnosis of the disorder was systemized in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association) diagnostic system and was included in the DSM-III-R (1987) and DSM-IV (1994). While the required basic symptoms are almost identical to those in the ICD-10, some differences have been noted regarding diagnostic ranking. For example, in the DSM-IV,<sup>11</sup> GID is cited along with sexual dysfunctions and paraphilias.

Distinct from these diagnostic systems, there is the extensive concept of gender dysphoria syndrome, which includes the concept of GID. Gynandromorphs and individuals with gender dysphoria are included in this syndrome. Therefore, it is difficult to establish a differential diagnosis between gender dysphoria syndrome and GID.

## Materials and Methods

### *Current state of the gender clinic*

As of April 1, 2005, four psychiatrists at the Nagasaki University Hospital Gender Clinic see new outpatients every Tuesday and

Thursday. The present treatment course is in accordance with the Guideline and consists of two stages. The first stage involves psychotherapy and the second stage consists of psychotherapy and hormone therapy.

The first stage includes a definitive diagnosis and collection of detailed information on the patient's life history and present illness. A psychological assessment, consisting of concurrent physical examinations and laboratory tests, is also performed. Physicians inquire about situations the individual faced in the past and the life he or she would like to lead in the future.

After the completion of the first stage, the patient undergoes an interview with another psychiatrist and a meeting is held to determine whether the patient should proceed to treatment in the second stage. A decision is made after thorough discussion with reference to the latest medical information on the patient. Subsequent hormone therapy in the second stage is performed in cooperation with the Department of Obstetrics and Gynecology.

The present service is limited to the first and second stages as the third stage, sex reassignment surgery (SRS), is currently not available at Nagasaki University Hospital. This is explained to patients prior to commencing treatment, the initiation of which is planned only after the patient provides their consent.

If psychiatric disorders other than the problem of GID are manifest in patients prior to acceptance into the treatment course, their treatment is prioritized. Drug treatment is performed in accordance with patient's symptoms, such as insomnia, depression, anxiety, and dissociation.

### *Subjects*

The Department of Neuropsychiatry began an outpatient service for GID in 2001 and began to function as a gender clinic from January 2003. For the present research, we reviewed the 27 cases seen by the Gender Clinic of the Neuropsychiatry Department at Nagasaki University from January 1, 2003 to February 28, 2005. After excluding 3 patients diagnosed with gender dysphoria syndrome, the remaining 24 patients diagnosed with GID were selected as subjects of the present study.

## Results

### *Diagnosis*

All 24 cases of GID were diagnosed with transsexualism according to the ICD-10; 15 cases were female to male (FtM) and 9 were male to female (MtF).

### *Age*

Age at initial diagnosis ranged from 17 to 50 years. Age at initial diagnosis in men was distributed relatively uniformly, while in women 80% were in their twenties (Table 1).

**Table 1.** Characteristics of 24 outpatients with gender identity disorder at Nagasaki University Hospital Gender Clinic

Variable	Male (n=9)		Female (n=15)		Total (n=24)	
	n	%	n	%	N	%
Age at initial diagnosis (years)						
15-19	3	33.3	2	13.3	5	20.8
20-24	2	22.2	8	53.3	10	41.7
25-29	1	11.1	4	26.7	5	20.8
30-34	1	11.1	1	6.7	2	8.3
35-39	0	0	0	0	0	0
40-44	1	11.1	0	0	1	4.2
45-49	0	0	0	0	0	0
50-54	1	11.1	0	0	1	4.2
Residence						
Nagasaki city	2	22.2	6	40.0	8	33.3
Nagasaki prefecture, outside Nagasaki city	6	66.7	3	20.0	9	37.5
Outside Nagasaki prefecture	1	11.1	6	40.0	7	29.2
Living with family						
Yes	6	66.7	5	33.3	11	45.8
No, living alone	3	33.3	10	66.7	13	54.2
Occupation						
Company employee <sup>a</sup>	3	33.3	8	53.3	11	45.8
Self-employed	0	0	1	6.7	1	4.2
Student	0	0	4	26.7	4	16.7
Unemployed	6	66.7	2	13.3	8	33.3
Education						
Junior high school graduate <sup>b</sup>	3	22.2	2	13.3	5	20.9
High school graduate <sup>c</sup>	5	55.6	7	46.7	12	50.0
University/College graduate <sup>d</sup>	1	11.1	5	33.3	6	25.0
Not reported	0	0	1	6.7	1	4.2
Reason for visiting our department						
Referred by other hospital/department	6	66.7	7	46.7	13	54.2
Information from books	2	22.2	5	33.3	7	29.2
Information from the Internet	1	11.1	2	13.3	3	12.5
Information from lectures	0	0	1	6.7	1	4.2

<sup>a</sup>One male and one female were working at their fathers' firm. Two females had welfare-related jobs.

<sup>b</sup>Includes one female high school pupil and two (one male and one female) high school dropouts.

<sup>c</sup>Includes two female college students.

<sup>d</sup>Includes one female graduate student.

### Residence

Of the 27 subjects, 8 (33.3%) were living in Nagasaki city, 9 (37.5%) were living outside Nagasaki city but in Nagasaki prefecture, and 7 (29.2%) were living outside Nagasaki prefecture (Table 1). Most of those from outside Nagasaki prefecture were living in areas such as Saga and Fukuoka prefectures, which are relatively close to Nagasaki city.

### Living with family

Eleven (45.8%) cases were living with their family and 13 were living alone. A difference was observed between MtF and FtM patients in terms of the proportion of cases living with their family; 6 (66.7%) MtF patients were living with their families, while 5 (33.3%) FtM patients were living with their families (Table 1). Two MtF cases had not disclosed their troubles regarding GID to their families. Only one MtF case had been married, but was already divorced at initial diagnosis.

### Occupation

The frequency of unemployment was significantly ( $p=0.013$ ,

Fisher's exact test) higher in MtF (66.7% or 6/9) than in FtM (13.3% or 2/15). Among those who had occupation, none except few enunciated the problems they currently faced to others in the workplace. Subjects indicated that they felt compelled to assume the role of their biological sex in the workplace.

### Education

The highest level of education was high school graduation for more than 60% of all cases. The proportion of cases indicating high school as the highest level of education was higher in MtF (88.9% or 8/9) than in FtM (46.7-53.3% or 7/15-8/15), though this difference was not significant ( $p=0.069$ , Fisher's exact test). Variation in the proportion in FtM was the result of one case whose highest education level was not reported (Table 1).

### Reason for visiting our department

More than half of all cases (13 cases or 54.2%) were referred to our department by another hospital or department (e.g. psychiatry, obstetrics, or gynecology). Others visited us independently on the basis of information collected from books (7 cases or 29.2%), the Internet (3 cases or 12.5%), or lectures (1 case or 4.2%).

### *Case history and family history*

No specific physical ailments or psychiatric treatment history were noted. However, one case was the victim of sexual abuse and another was the victim of attempted sexual violence. Two other cases were victims of violence from relatives when they were drinking.

The parents of 4 cases were divorced or separated. One MtF case had a sibling who visited a psychiatric department because of alcoholism.

### *Disclosure*

Eighteen (75%) cases had disclosed their problems to family members, such as parents, siblings, spouses and grandparents, or to other individuals, such as friends and partners. Disclosure occurred at various times, but in many cases it coincided with important life events such as graduation from high school or college, a homecoming or a birthday. The time of disclosure also coincided with the time when they were living almost alone.

### *Time of first recognition of gender dysphoria*

The time when the cases began to feel that their sex was wrong (gender dysphoria) was frequently in their infancy. In 16 (66.7%) cases, feelings of gender dysphoria began in the lower grades of elementary school. As expected, the first recognition of gender dysphoria tended to be somewhat later in men, and frequently occurred when they were junior high school or high school students.

The time at which cases began copying and wearing the clothing of the opposite sex was frequently prior to puberty in women, while it tended to be later in men. In particular, almost all female cases indicated that they hated wearing skirts from childhood.

Furthermore, while playing children's games most of the women assumed cross-sex roles in make-believe and preferred games traditionally played by boys (e.g. pretending to be a superhero). In contrast, variation was observed in men, but notable responses indicated that they were unable to assume cross-sex roles even if they wanted to, and that they felt they should not do so.

### *Object of affection*

Eleven (45.8%) cases that had partners included 2 men and 9 women. Women's partners were all female. Almost all of them reported that their partner understood GID, and some of them came to the clinic with their partner. Four women had previously associated with men and 3 of these women had experienced sexual relations with those men. Of the 2 men who associated with women, one was unmarried and the other was divorced. The latter had sexual relations with his ex-wife and had two children with her.

### *Past treatment*

Two men and 2 women had a history of purchasing hormones through the Internet and other similar sources or had a history of

receiving hormone therapy alone at medical facility similar to an obstetrics or gynecology department.

At initial diagnosis, 2 FtM cases had already undergone mastectomy at a medical facility handling plastic surgery in Japan.

### *Treatment required*

Twenty-one (87.5%) cases expressed a desire to undergo the third treatment stage, SRS. Of these, 1 case wished to undergo SRS but not hormone therapy. An apparent gap was observed between desires and reality; there was difficulty in obtaining the consent from the family in addition to personal problems, such as the cost of surgery, the risk of surgery, anxiety about adverse effects, and age.

### *Accompanying psychiatric symptoms*

Accompanying psychiatric symptoms included depression, anxiety, insomnia, obsession, dissociation, eating disorder, school refusal, social withdrawal, self-mutilation and suicide attempt. Self-mutilation and suicide attempt were noted in 3 (12.5%) cases; 2 MtF and 1 FtM. Self-mutilation varied from wrist cutting to self-inflicted injury to the sexual organs. Seven (29.2%) cases, however, presented no accompanying psychiatric symptoms. The manifestation of accompanying psychiatric disorders varied among cases (persistent, acute and transient, and acute and recurrent).

## **Discussion**

The prevalence of disease is one of the basic indices for use in clinical practice as well as for public health. Although no epidemiological data based on population studies are available for GID, some medical institutions have reported the prevalence of GID as estimated from their outpatients. The ratio of men to women reported in Japan was as follows: 31.1/68.9 or 1/2.2 in Sapporo,<sup>12</sup> 38/54 or 1/1.4 in Takatsuki, Osaka (including other diagnoses by the gender clinic),<sup>13</sup> 40.3/59.7 or 1/1.5 in Moriguchi, Osaka<sup>14</sup> and 39.7/60.3 or 1/1.5 in Okayama.<sup>15</sup> These showed fairly good agreement with our estimate of 9/15 or 1/1.7. However, estimates from abroad differ widely from those mentioned above: 9/1<sup>16</sup> and 6.6/1<sup>17</sup> in Toronto, 2.3/1 in Berlin,<sup>18</sup> 2.8/1 in Amsterdam,<sup>19</sup> and 1/5.5 in Krakow, Poland.<sup>20</sup> Although elucidating the factors resulting in such discrepancy is extremely difficult, they would be helpful in understanding, at least in part, the etiology of GID.

Although controversial, GID is classified into primary and secondary types.<sup>21</sup> Primary gender dysphoria mostly occurs in early childhood or early adolescence; however, it is sometimes seen in late adolescence or adulthood. These individuals usually have a relatively strong sense that their gender is different from their physical sex. Secondary gender dysphoria occurs somewhat later in life, and sometimes occurs when one approaches maturity or old age. Initial symptoms usually appear as transvestism. Gender is sometimes not fixed and changeable in individuals with secondary gender dysphoria.

FtMs are relatively homogenous and are usually primary type, while symptoms are more variable in MtFs in whom secondary gender dysphoria is frequently seen. A similar tendency was observed in the present study. There were 3 women in the present study who had experienced sexual relations with men. One of the reasons for such behavior might be that they expected to have a change in their perceptions and thoughts, although they all described the experience as distressing.

Although marginally significant ( $p=0.055$ , Fisher's exact test), the present study showed a correlation between the frequency of living with family and that of unemployment; of 16 employed subjects, 5 (31.3%) were living with their family, while 6 (75.0%) out of 8 unemployed were living with their family. Thus, the higher frequency of living with family observed for men was related to a higher frequency of unemployment in men than in women. In fact, the frequency of those living with family was similar among employed men and women (1/3 and 4/13, respectively); among unemployed men and women the frequency was 5/6 and 1/2, respectively. Furthermore, the present study showed that women are more likely to have a partner than men, a tendency similar to that reported by Takamatsu et al.<sup>22</sup> These results suggest that adaptation to society is more difficult for men than for women because of stigma and a lack of understanding among those around them.

Gender identity disorder is thought of as difficult to diagnose in clinical settings, and it has been suggested that the current DSM diagnosis system will lead to the significant characteristics of gender identity disorders being overlooking.<sup>23</sup> With respect to the diagnosis of gender identity disorder, differentiation from gender dysphoria syndrome is particularly difficult for the following reasons.

First, self-consciousness of gender depends on an individual's subjective description and no objective index is available for measuring this. Therefore, with respect to various aspects such as life history and lifestyle, information should be collected from not only the individual, but also the individual's family and partner.

Second, the concept of gender is not invariable or fixed but is changeable over time, even in the same individual. In addition, feelings of discomfort, aversion to one's own sex, and the level of treatment required also vary among individuals. Therefore, even individuals facing problems associated with GID are occasionally unable to understand each other.

Third, patients consulting gender clinics exhibit symptoms, which are regarded as peripheral symptoms accompanying gender dysphoria. Some instances require differentiation among mental disorders such as dissociative disorder, personality disorder,<sup>24,25</sup> and eating disorder.<sup>26</sup> In the present study, one of the 3 cases with gender dysphoria syndrome was troubled by strong dissociative symptoms and received additional treatment for dissociative disorder.

Since gender dysphoria can develop in childhood, even in normal individuals, diagnosis of childhood GID is somewhat difficult.<sup>27,28</sup> Early intervention may affect the later life of child patients; hence, strict diagnosis should be made with the greatest care. Since our gender clinic has not seen any childhood GID cases to date, we should prepare ourselves for the education of children and their parents.<sup>29</sup>

Problems facing those with GID are closely related to legal issues, such as the change of one's name or sex. An objection has been made to the conditions required for changing one's sex according to the "Law concerning special rules regarding sex status of a person with gender identity disorder" enacted on July 16, 2003, and attention is being paid to future trends. In clinical practice, we noted patients who would have problems when they have to identify themselves for marriage, employment or school.

Although the Guideline has been revised, there are occasionally individuals in clinical settings who do not conform to it. There are also individuals who already used hormones or underwent mastectomy prior to initial consultation. Treatment-related desires varied as well; therefore some individuals were unsure of which treatment to proceed with. Such instances are expected to increase in the near future. Thus, the establishment of some uniformity between cases not satisfying the Guideline and the treatment system is needed.

Furthermore, the medical facilities that can currently perform SRS are extremely limited in Japan. During the course of therapy, 1 MtF chose to undergo SRS overseas. This is a major problem for physicians as well as patients. The authors seek to foster an environment that provides sufficient treatment for satisfying patients' needs.

## Future Prospects

In October 2004, one case was reported in Nagasaki prefecture, in which a family register was changed according to the "Law concerning special rules regarding sex status of a person with gender identity disorder"; such cases approved in Japan now exceed 50. The number of psychiatry departments providing outpatient treatment for GID is gradually increasing in the Kyushu region. However, at present, no medical facilities in this region can perform SRS. In addition, no organized self-help groups for GID currently exist in either Nagasaki or Saga prefecture. However, the spread of mass media and the Internet seems to be helping to reduce the information gap between urban and rural areas, although obvious differences still remain.

In light of the findings discussed here, medicine is not keeping pace with the rapidly advancing social conditions and legal issues involving GID. In the future, diagnosis will be more critical in determining the appropriate treatment for gender dysphoria syndrome. Studies of the peripheral symptoms of gender dysphoria, and biological evaluations of GID and gender dysphoria syndrome should be encouraged.

In conclusion, early diagnosis and early intervention are necessary to immediately reduce unnecessary suffering, to increase the likelihood of improving the quality of life, and to reduce the stigma of this disorder. Therefore, an environment should be fostered in which sufficient treatment for satisfying patients' needs is provided.

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