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Personality Disorders and Psychiatric Comorbidity among Persons with Gender Identity Disorder

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The present study aims at surveying the rate of prevalence of comorbid psychiatric and personality disorders among the patients who suffer from Gender Identity Disorder (GID). The research sample includes 108 participants from the city of Gorgan in northern Iran (62 people who converted from male-to-female and 46 individuals converted from female-to-male) who have GID (ones who underwent surgical procedures to change their sex) This was conducted through adoption of Millon Clinical Multiaxial Inventory (MCMI-III) and Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) Axis I Disorders (SCID-I). Analysis of results indicated that the most frequent personality disorders were Depressive personality disorder and Obsessive-Compulsive Personality Disorder. Furthermore, the maximum prevalence rates of comorbid psychiatric disorders were seen as Post Traumatic Stress Disorder (PTSD), Major Depression Disorder (MDD), Specific Phobia (SP), Body Dysmorphic Disorder (BDD), and Obsessive-Compulsive Disorder (OCD). Similarly, there was a significant difference between the two groups of conversions: male-to-female and female-to-male transsexualism in terms of rate of personality disorder prevalence. Axis I and II disorders were highly prevalent among patients with GID.

Keywords: Comorbidity, Gender Identity Disorder, Personality Disorder, SCID-I, MCMI-III

The term gender identity, meaning a person's relative sense of his/her own masculine or feminine identity was first used by John Money in 1965 to refer to the subjective experience of gender (Mijolla, 2005). Later on Robert Stoller introduced it into psychoanalytic literature. He used gender to refer to ideas and experiences of masculinity, femininity and gender identity to general sense of masculinity and femininity. According to him, failure to interrupt the maternal symbiosis with boys may result in transsexualism (Stoller, 1968). The psychoanalytic theories explain this disorder differently. The developmental model of Mahler, Pearson and Ovesey (1974) emphasized that transsexualism in males originates from unresolved separation anxiety during the separation-individuation phase. We should bear in mind that traditionally in explaining the femininity in men, classical psychoanalytic theorists have emphasized the decisive role of fear of castration and of powerful identification with mother (Fenichel, 1972).

The Term Transsexualism in its current usage refers to those individuals who have persistent desire for living in the social role of the opposite sex, and wish to undergo sex reassignment surgery (Cohen-Kettenis & Pfafflin, 2003). As a psychiatric diagnosis, Transsexualism was named as a disorder for the first time in DSM-III in 1980. Then in DSM-IV, it was substituted by Gender Identity Disorder (Heath, 2006), that often corresponds with behavioral and anxiety problems in addition to higher rate of comorbid psychiatric disorders (Korte et al., 2008). DSM5 has renamed the problem and calls it Gender Dysphoria (American Psychological Association, 2013).

The rate of gender identity disorder is, however, low : 1:30,000 per males and 1:100,000

per females (Kring, Davison, Neale, & Johnson, 2007). The referral cases of GID disorder among boys are greater than GID among girls (Bradley & Zucker, 1997). This disorder causes inconvenience and psychological pain in the person and his/her friends and family, and inflicts serious damage to occupational, educational, social, marital performances and interpersonal relationships (Westheimer & Lopater, 2005). Teenagers, with GID disorder, may often feel lonely and rejected and due to the low possibility of having satisfactory sexual relationship; they feel dissatisfied in their relationship with their peers. Most of the teens with GID disorder have a belief that they are actually of the opposite sex or are susceptible to be the opposite gender (Zucker & Bradley, 1995). Many patients with GID are socially isolated, and this may lead to weakness of self-esteem, hatred of school and seclusion from their coevals (American Psychiatric Association, 2000).

GID disorders may be accompanied by other disorders. Although, some of these patients have a record of a major psychiatric disorders such as schizophrenia and/or major mood disorders, most of them lack such background. In these patients, some types of Axis II Personality Disorder are seen, particularly Borderline Personality Disorder (BPD); however, no personality disorder seems to be specific to GID. Personality disorder is a factor that provides ground for other psychiatric disorders and it interferes with therapeutic results of Axis I Syndromes (Sadock, Kaplan, & Sadock, 2007). Comorbidity of personality disorders are related to more severe syndromes and more adverse therapeutic results for Axis I disorders (Kring et al., 2007). When dealing with Axis I disorders, clinical specialists should consider personality backgrounds. Often an interaction can be observed between interpersonal conflicts and psychiatric disorders. Psychological disorder may revive interpersonal conflicts or intensify them or create new conflicts. On the other hand, the existing conflicts may stimulate or intensify the course of a psychiatric disorder (Othmer & Othmer, 2001). The synchronous occurrence of Gender Identity Disorder with other psychological traumas may result from social consequences (like seclusion by coevals, isolation and low self-esteem) during performing sexual behavior incongruent with their body (Money & Russo, 1979).

Some researchers have looked at transgenderism as a Narcissistic Personality Disorder, where the self has been profoundly impaired (Chiland, 2000). Personality disorder among males with GID is more pervasive than in females with the given disorder (Green & Blanchard, 2000) and since tolerance of anxiety among such patients is at low level, so it is possible for them to express syndrome in pathology of personality, anxiety, depression and drug abuse (Zucker & Bradley, 1995). It has been indicated that 92% of males and 58% of females have received other psychiatric diagnoses rather than sexual dissatisfaction where most of the abnormalities corresponded to personality disorders in both groups (Levine, 1980). Others reported that Axis I disorders (Depressive disorder, Bipolar and Schizophrenia) and Axis II disorders (Schizoid and Borderline personality disorders) were highly prevalent among GID patients (Cole, O'Boyle, Emory, & Meyer III, 1997). Similarly, thinking of committing suicide might be observed among teenagers with GID disorder, especially when they became isolated from their coevals and families (Zucker & Bradley, 1995). Hepp, Kraemer, Schnyder, Miller, and Delsignore (2005) showed that Axis I and II Disorders had been pervasive among patients with GID disorder. Obsessive and narcissistic personality models have been demonstrated in conjunction with GID (Dadfar, Dadffar, & Yeke-yazdan, 2009). Asgri, Saberi, Rezayi, and Dolatshahi (2007) reported in the GID patients the maximum frequency of comorbid psychiatric disorders comprised of paranoid thoughts and other pervasive disorders including Phobia and Somatization, respectively.

These subjects are less studied in Iran, owing to the exclusion of family and society. Also, it is difficult to contact and assess these patients. Hence, research on this community in our country is both difficult and inadequate. The following questions were raised in this context: 1) What is the rate of prevalence of comorbid Axis

l psychiatric disorders among GID patients? 2) How much is personality disorder prevalent in GID patients? 3) Is there any difference between the rate of personality disorders prevalent in male-to-female and female-to-male groups? 4) Is there any difference between male-to-female group and female-to-male group in terms of prevalence of comorbid psychiatric disorders?

Method

Participants:

The age range of the research sample is 15-40 years from which 101 individuals (93.5%) were single and seven (6.5%) were married. Samples were selected by available sampling method and statistical population of this study included all patients with GID disorder in Iran, who have referred to Rehabilitation Organization and Forensic department to determine their transgenderism and have received GID diagnosis based on criteria of DSM-IV-TR. The sample consisted of 108 participants (62 male-to-female and 46 female-to-male) with GID, who were examined by SCID-I based on DSM-IV and MCMI-III for assessing Axis I and II disorders respectively.

Tools Used:

Structured clinical interview for Axis I disorders (SCID): This is a semi structured clinical interview format, which diagnoses a broad range of psychiatric disorders based on DSM-IV. This clinical interview is appropriate for 18+ adults and with a little alteration can also be employed for teenagers. SCID-I is usually performed in a 45-90 minute session, which varies depending upon the complexity of the background, the skill and the experience of the interviewer as well as the ability of the patient in expressing his/her problem. (First, Spitzer, Gibbon, & Williams, 1997). In addition, the diagnostic agreement for most diagnoses was above 0.60.

Millon Clinical Multiaxial Inventory (MCMI-III): The 3rd edition of this inventory (Millon, Millon, Davis & Grossman, 2006) includes 175 true and false questions and has become a standard self assessment inventory evaluating a broad range of information regarding the character, emotional adaptation and the clients' perception of the test. The mentioned questionnaire is designed for 18+ adults who have the ability of reading at least to the level of first grade high school. MCMI-III is specifically designed to help diagnose the Axis II disorders and its completion takes 20-30 minutes. This questionnaire is to be employed with psychiatric populations and is not supposed to be used for normal individuals and those who just have a trivial disorder (Groth-Marnat, 2009). Also, test reliability using Cronbach's alpha coefficient was 0.824.

Statistical Analysis:

The data analysis of the present survey was conducted through descriptive and inferential indices. Statistical, frequency and frequency percentage indexes were employed in the descriptive statistic. In the inferential statistics, the data was analyzed through Chi-Square c2 and Fisher's Exact Test.

Results

Descriptive data analysis and demographic characteristics are shown in Table 1.

Table1. Demographic characteristics and descriptive data

	M to F		F to M	
	n	%	n	%
Education				
Average	19	30.6	15	33.6
Diploma	27	43.5	21	45.7
Associate Degree	7	11.3	3	6.5
Bachelor Degree	7	11.3	7	15.2
MA	2	3.2	0	0
Marriage				
Unmarried	57	91.9	44	95.7
Married	v	8.1	2	4.3
Age				
15-20	2	3.2	3	6.5
21-25	29	46.8	19	41.3
26-30	27	43.5	19	41.3
31-35	2	3.2	2	4.3
36-40	2	3.2	3	6.5
Total	62	57.4	46	42.6

Diagnoses of Axis I and II are shown in Tables 2 and 3. With respect to Table-2, it is seen that from the total sample (108 participants) 22 (20.4%) individuals were having Depressive Personality Disorder, 2 (1.9%) had Paranoia Personality Disorder, 7 (6.5%) had Histrionic Disorder, 13 (12.0%) had Obsessive-Compulsive Personality Disorder, 5 (4.6%) had Narcissistic Personality Disorder, 3 (2.8%) had Dependent Personality Disorder, 6 (5.6%) had Schizotypal Personality Disorder, 2 (1.9%) had Passive-aggressive Personality Disorder, and the rest 25 (23.1%) had Personality Disorders NOS, which has not been mentioned anywhere else. Furthermore, 23 (21.3%) lacked any type of personality disorders. The maximum frequency obtained were NOS, depressive and obsessive-compulsive personality disorders, respectively. There were histrionic and schizotypal personality disorders with lower frequency.

Table 2. DSM Axis II diagnoses of gender identity disorder patients (N=108)

	MTF(n=62)		FTM(n=46)		Total(N=108)		Fisher's Exact	
	n	%	n	%	n	%	$\chi 2$	P
Personality disorders							20.483	<.006**α
Depressive	17	27.4	5	10.9	22	20.4		
Paranoid	2	3.2	0	0	2	1.9		
Histrionic	4	6.5	3	6.5	7	6.5		
Obsessive-Compulsive	1	1.6	12	26.1	13	12.0		
Narcissistic	2	3.2	3	6.5	5	4.6		
Dependent	2	3.2	1	3.2	3	2.8		
Schizotypal	4	6.5	2	4.3	6	5.6		
Passive-aggressive	2	3.2	0	0	2	1.9		
NOS	15	24.2	10	21.7	25	23.1		
NOT	13	21.0	10	21.7	23	21.3		

**P <.01; α p value are from Fisher's exact test

With respect to Table-2, the analysis indicated that 12 cells had expected frequency of less than 5; thus, Fisher's exact test was chosen for analysis of significance. Given the results of Fisher's Exact Test (P<.006; c2=20.483), there is a significant difference between both groups of male-to-female and female-to-male in terms of prevalence of personality disorders.

As it was observed in Table-3, the maximum frequencies of comorbid psychiatric disorders included Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), specific phobia, Body dysmorphic disorder, Obsessive Compulsive Disorder (OCD), bipolar type I disorder and social phobia respectively.

Table 3 shows that 16 cells of this table have the expected frequency of less than 5; therefore, Fisher's Exact Test for significance was chosen for analysis. Given that Exact significance (P<.884; c2=10.812), it is concluded that there was no significant difference between the two groups of male-to-female and female-to-male in terms of prevalence of comorbid psychiatric disorders.

Discussion

With respect to the obtained results it can be concluded that Axis I disorders (comorbid psychiatric disorders) are highly prevalent among GID patients. The results of the present study are in compliance with the results of earlier research, which reported that children with GID are exposed to the increasing risk of comorbidity problems (Wallien, Swaab, & Cohen-Kettenis, 2007), and existence of depression as an influential factor in the record of GID patients who committed suicide (Clements-Nolle, Marx, & Katz, 2006). Research also reported that Axis I and II disorders had been prevalent in GID patients (Cole et al., 1997; Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Hepp et al., 2005; Levine, 1980; Meyer, Jacobson, Edgerton,

Table 3. DSM Axis I diagnoses of gender identity disorder patients (N=108)

	MTF (n=62)		FTM (n=46)		Total (N=108)		Fisher's Exact	
	n	%	n	%	N	%	$\chi 2$	P
Comorbid disorders							10.812	<.884**α
Bipolar-I	5	8.1	3	6.5	8	7.4		
Bipolar-II	2	3.2	1	2.2	3	2.8		
Dysthymia	1	1.6	3	6.5	4	3.7		
OCD	5	8.1	4	8.7	9	8.3		
PTSD	9	14.5	8	17.4	17	15.7		
MDD	10	16.1	5	10.9	15	13.9		
Social phobia	5	8.1	2	4.3	7	6.5		
Specific phobia	7	11.3	5	10.9	12	11.1		
GAD	3	4.8	2	4.3	5	4.6		
Body dysmorphic	5	8.1	6	13.0	11	10.2		
Alcohol dependence	1	1.6	0	0	1	0.9		
Schizoaffective	2	3.2	0	0	2	1.9		
Hypochondriasis	2	3.2	2	4.3	4	3.7		
Paranoid	0	0	1	2.2	1	0.9		
Somatization	2	3.2	0	0	2	1.9		
Anorexia nervosa	0	0	2	4.3	2	1.9		
No Axis I diagnosis	3	4.8	2	4.3	5	4.6		
Total	62	100.0	46	100.0	108	100.0		

**P<.01; α p value are from Fisher's exact test

& Canter, 1960). Post Traumatic Stress Disorder (PTSD) had been the most prevalent among GID patients, which may be explained by the findings on SCID-I. The GID patients reported experiences including being sexually abused in childhood, exposure to severe stressful life events (death of one of the parents), and rejection by their family and coevals. The coexistence of other psychiatric disorders may also increase individual vulnerability against PTSD disorder morbidity (Sadock, Kaplan, & Sadock, 2007). It is worth mentioning that retrospective reports also related some factors such as instability of paternal family (Naisheath, Mechanic, & Resick, 2000), and physical or sexual abuses of patients in childhood to the increase in the possibility of occurrence of PTSD (Breslau, Chilcoat, Kessler, & Davis, 1999).

Also, the rate of prevalence of Major Depressive Disorder (MDD) is highly frequent in GID patients. The GID patients continue their life thinking that they are in a wrong body, this makes them disappointed and depressed forever (Seligman, Walker, & Rosenhan 2007). Sometimes, it may be due to the distance between the individual from his/her very idealistic goals and failure in achieving such objectives (Sadock, Kaplan, & Sadock, 2007).

However, the results of this study are not in line with the results of Gualerzi et al. (2008) who found that GID is an independent clinical state, and not necessarily related to comorbidity of psychiatric disorders.

The rate of prevalence of NOS, depressive, obsessive-compulsive, and histrionic personality disorders were most frequent in the sample of the present study, which conforms with the results of some earlier studies (e.g., Bodlund, Kullgren, Sundbom, & Höjerback, 1993; Hepp et al., 2005; Madeddu, Prunas, & Hartmann, 2009; Meyer et al., 1960). One such study further found high prevalence of borderline personality disorder also among GID patients (Campo, Nijman, Merckelbach, & Evers, 2003).

However, the results of the present research are not in line with the results of the study done by Seikowski, Gollek, Harth, & Reinhardt (2008) who

did not find personality disorders in GID patients.

There is also significant difference in the prevalence of personality disorders between male-to-female and female-to-male groups. The results of present research are in compliance with the results of the study conducted by De Cuypere, Jannes, & Rubens (1995) in which, male-to-female and female-to-male groups are different from each other in terms of prevalence rate of personality disorders and psychological performance.

There is no significant difference between male-to-female and female-to-male groups in terms of being afflicted with comorbidity of psychiatric disorders. The prevalence rate of comorbid psychiatric disorders is the same in both groups. The results of the current study are in conformance with the results of research done by Gomez-Gil et al. (2009), who indicated that comorbidity of psychiatric disorders, including adaptation disorder and specific phobia, are the same in male-to-female and female-to-male groups.

Conclusions and Limitations

It may be concluded that most patients with Gender Identity Disorder had an additional disorder in Axis I and Axis II. The major limitation of the study is that the sample size was not very large. Since, in the cultural and familial values context of Iran it is very difficult to reach these patients. If studies with larger group of participants along with a control group are conducted, the findings would be further enriched.

References

American Psychological Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th)*. Washington, DC: Author.

American Psychological Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.)*. Washington, DC: Author.

Asgri, M., Saberi, M., Rezayi, O., & Dolatshahi, B. (2007). The prevalence psychopathology in gender identity disorder. *Scientific Journal of Forensic Medicine,13*, 181-186.

Bodlund. O., Kullgren, G., Sundbom, E., & Hojerback, T. (1993). Personality traits and disorders among transsexuals. *Acta Psychiatrica Scandinavica, 88*(5), 322-327.

Bradley, S. J., & Zucker, K. J. (1997). Gender identity disorder: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 872-880.

Breslau, N., Chilcoat, H. D., Kessler, R. C., & Davis, G. C. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma: Results from the Detroit Area Survey of Trauma. *Journal of American Psychiatry, 156*, 902-907

Campo, J., Nijman, H., Merckelbach, H. L., & Evers, C. (2003). Psychiatric comorbidity of gender identity disorders. *Journal of American Psychiatry, 160,* 1332-1336.

Chiland, C. (2000). The psychoanalyst and the transsexual patient. *The International Journal of Psycho-analysis, 81*, 21-35.

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal Homosex, 51*, 53-69.

Cohen-Kettenis, P. T., & Pfafflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence*. California: Sage Publications.

Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer III, W. J. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26*(1), 13-26.

De Cuypere, G., Jannes, C., & Rubens, R. (1995). Psychosocial functioning of transsexuals in Belgium. *Acta Psychiatrica Scandinavica, 91*(3), 180-184.

Dadffar, M., Dadffar, F., & Yeke-yazdan,. R. (2009). Survey personality pattern in gender identity disorder. *Scientific Journal of Forensic Medicine, 15*, 96-99.

De Cuypere, G., Janes, C., & Rubens, R. (1995). Psychosocial functioning of transsexuals in Belgium. *Acta Psychiatrica Scandinavica, 91,* 180-184.

Fenichel, O. (1972). *The psychoanalytic theory of neurosis*. New York: W.W. Norton.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (2012). *Structured Clinical Interview for DSM-IV® Axis I Disorders (SCID-I), Clinician Version*, Administration Booklet: American Psychiatric Pub.

Gómez-Gil, E., Trilla, A., Salamero, M., Godás, T., & Valdés, M. (2009). Sociodemographic, clinical, and psychiatric characteristics of transsexuals from Spain. *Archives of Sexual Behavior, 38*(3), 378-392.

Green, R., & Blanchard, R. (2000). *Gender identity disorders. Comprehensive textbook of psychiatry*,

7th ed. Baltimore: Williams and Wilkins, 646-662.

Gualerzi, C., Crespi, G., Angelini, M., Moko, L., Rolle, C., Manieri, V.,Villari, F. Bogetto, F. & Fontana, D. (2008). Gender identity disorder and psychiatric comorbidity: a descriptive study. *Sexologies, 17,* 80-81.

Heath, R. A. (2006). *The handbook of transsexuality: changing gender to match mindset*. Greenwood: Praeger Publishers.

Hepp, U., Kramer, B., Schnyder, N., & Delsignore, M. (2005). Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research, 58*, 259-261.

Korte, A., Goecker, D., Krude, H., Lehmkuhl, U., Dipl, M., Gruters-Kieslich, A., Beier, K. M., & Phil, M. (2008). *Gender identity disorders in childhood and adolescence.* Deutsches Arzteblatt International, 105, 834-841.

Kring, A. M., Davison, G. C., Neale, M. J., & Johnson, S. L. (2007). *Abnormal Psychology. United States of America*: Wiley, J. & Sons.

Levine, S. B. (1980). Psychiatric diagnosis of patients requesting sex reassignment. *Journal of Sex & Marital Therapy, 6*, 73-164.

Madeddu, F., Prunas, A., & Hartmann, D. (2009). Prevalence of Axis II disorders in a sample of clients undertaking psychiatric evaluation for sex reassignment surgery. *Psychiatric Quarterly, 80*(4), 261-267.

Marnat-Groth, G. (2009). *Handbook of psychological assessment*. New York: John Wiley & Sons.

Meyer, E., Jacobson, W. E., Edgerton, M. T., & Canter, A. (1960). Motivational patterns in patients seeking elective plastic surgery: I. Women who seek rhinoplasty. *Psychosomatic Medicine, 22*(3), 193-201.

Mijolla, A. (2005). *International dictionary of psychoanalysis.* USA: Thomson Gale.

Millon, T.; Millon, C.; Davis, R.; Grossman, S. (2006). *MCMI-III Manual (Third ed.)*. Minneapolis, MN: Pearson Education, Inc.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity role in childhood. *Journal of Pediatric Psychology, 4,* 29-41.

Nishith, P., Mechanic, M. B., & Resick, P. A. (2000). Prior interpersonal trauma: The contribution to current PTSD symptoms in female rape victims. *Journal of Nervous & Mental Disea Ease, 188,* 496-504.

Othmer, E., & Othmer, S. (2001). *The clinical interview using DSM-IV-TR: Fundamentals (Volume 1), the difficult patient (Volume 2)*. Washington: American Psychiatric Press.

Person, E., & Ovesey, L. (1974). The transsexual syndrome in males: II. Secondary transsexualism. *American Journal of Psychotherapy, 28*(2), 174-193.

Sadock, B. J., Kaplan, H. I., & Sadock, V. A. (2007). Kaplan & Sadock's synopsis of psychiatry: behavioral sciences/clinical psychiatry. Lippincott Williams & Wilkins.

Seikowski, K., Gollek, S., Harth, W., & Reinhardt, M. (2008). Borderline personality disorder and transsexualism. *Psychiatrische Praxis, 35*, 135-141.

Seligman, M., Walker, E., & Rosenhan, D. (2007). *Abnormal psychology*. New York: W. W. Norton.

Stoller, R. J. (1968). *Sex and Gender: On the Development of Masculinity and Femininity.* New York. Science House.

Wallien, M. S., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(10), 1307-1314.

Westheimer, C. R., & Lopater, S. (2005). *Human sexuality: A psychosocial perspective.* Baltimore: Lippincott Williams & Wilkins.

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents.* New York: Guilford Press.

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