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Desire for Non-Mutilative Disability in a Nonhomosexual, Male-to-Female Transsexual

Nathan J. Kolla · Kenneth J. Zucker

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Abstract In adults, the desire for a healthy limb amputation has been reported in both the lay press and the scientific literature. While the etiology of this condition is currently unknown, prevailing theories have tended to conceptualize the phenomenon as paraphilic in origin. In this report, we present the case of a 25-year-old, nonhomosexual male-to-female transsexual who manifested an intense desire to be afflicted with a nonmutilative neurological disability (multiple sclerosis). The patient categorically denied sexual attraction towards the thought of being an amputee or physically disabled. Hypotheses are proposed for the development of this condition with special emphasis accorded to the significance of the preferred target disability.

Keywords Transsexualism · Gender identity disorder · Disability · Multiple sclerosis · Apotemnophilia

Introduction

Nonpsychotic individuals who desire amputation of their healthy limbs have been well documented in the literature (Johnston & Elliott, 2002). In contrast, little has been written on the subject of people wishing to be physically disabled in other ways. At present, it is unclear whether able-bodied persons who deliberately disable themselves through self-inflicted damage are phenomenologically related to individuals uniquely fascinated with physical disability but who have no intention of self-harming. Alternatively, a taxonomy distinguishing among those known colloquially as *devotees*, *pretenders*, and *wannabes* has been proposed (Storrs, 1996). Whereas devotees in this nomenclature comprise non-disabled persons harboring sexual attraction toward individuals with disabilities, pretenders and wannabes include individuals who either feign disability or have a genuine wish to be disabled.

Bruno (1997) outlined the case of a heterosexual, female devotee/pretender who developed an attraction towards men with impairments in mobility. Although the patient initiated sexual encounters with physically disabled males, she claimed that the thought of being in the company of these disabled men was more arousing than actual intercourse. She eventually resorted to renting wheelchairs, admitting that she took pleasure in the sympathetic glances she received from others while using them in public. Despite craving affirmation as a physically disabled person from others with *bona fide* impairments, this individual unequivocally denied wanting to be disabled herself.

First (2005) reported on results from semi-structured telephone interviews with 52 subjects self-identifying as wanting to have limb amputations. First found that the most common reason cited by his participants for wanting an amputation was to restore their perceived true identities as amputees (63% of the sample). Fifteen percent identified sexual arousal or excitement as the primary reason for desiring amputation, while 52% considered it a secondary motivation; however, the vast majority (87%) of participants acknowledged feeling sexually attracted toward other amputees. Among the entire sample, one individual had undergone

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N. J. Kolla (✉)
Law and Mental Health Program, Centre for Addiction and Mental Health, 250 College Street, Toronto, ON M5T 1R8, Canada
e-mail: nathan.kolla@utoronto.ca

K. J. Zucker
Gender Identity Service, Child, Youth, and Family Program, Centre for Addiction and Mental Health, Toronto, ON, Canada

male-to-female sex reassignment surgery; an additional six participants acknowledged that they had considered sex reassignment surgery at some point in their lives. The desire for self-demand amputation ostensibly lacking any sexual arousal as a motivator has also been described (Wakefield, Frank, & Meyers, 1977).

Several case reports suggest that devotees, pretenders, and wannabes may be over-represented among transsexuals and people with transvestic fetishism (Berger, Lehrmann, Larson, Alverno, & Tsao, 2005; London, 1952; London & Caprio, 1950; Money, Jobaris, & Furth, 1977; Money & Simcoe, 1986; Woody, 1973). These accounts have been limited to patients preoccupied with limb amputation. However, transsexualism has also been linked to other forms of self-mutilation, such as self-castration (Money & De Priest, 1976) and successful limb amputation (Berger et al., 2005; Ollason, 1996). To the best of our knowledge, there has never been a report in the literature of a devotee/pretender/wannabe drawn to nonmutilative forms of disability. In this case report, we describe a nonhomosexual male-to-female transsexual who both pretended to be disabled and conveyed her wish to be afflicted with a neurological condition.

Case Report[1]

Andrea, a 25-year-old, nonhomosexual male-to-female transsexual, was seen in psychiatric consultation by NK after being referred by her family physician for treatment of refractory depression. Andrea had an extensive psychiatric history, including multiple hospitalizations beginning at the age of 13 for suicidal behavior and depressive episodes. Although Andrea was initially thought to have an underlying bipolar condition, this diagnosis was subsequently revised by her inpatient psychiatric team to major depressive disorder with comorbid borderline personality disorder (BPD). Andrea had also been diagnosed with bulimia nervosa in adolescence but had neither binged nor purged in several years. Her medical history was significant for asthma and Menière's disease. In addition to weekly estrogen injections, she was taking bupropion SR, spironolactone, betahistine, and salbutamol.

Compared with earlier periods in her life, Andrea ostensibly appeared to be functioning at a higher level when she first presented. For example, she owned her own home, had enjoyed stable employment for the past 7 years in her field, and was recently married to a non-transgendered, homosexual woman. As her wife had been living in a different country when they first met on an Internet dating site, they had been involved in a long-distance relationship for over 2 years before getting married. During the courtship period, Andrea and her future wife had alternated visiting one another in their respective cities. Andrea was very vague on details involving their sexual relationship. In spite of Andrea's current depressive symptoms, she described feeling stable the past 2 years.

At the age of 17, Andrea was referred by her psychiatrist to the Child and Adolescent Gender Identity Clinic at our hospital for endorsing chronic feelings of not being male and wishing to be a woman. At the time of the referral, the patient presented as an outwardly appearing biological male. Although Andrea remembered thinking as early as age six that there was something wrong with her, she did not understand the significance of these thoughts until she came to the realization at 16 that she did not identify as a male. She subsequently shared this information with her mother, who exhibited little surprise at Andrea's revelation. Andrea indicated that she had cross-dressed as a young child. Her mother worked as a tailor at home and Andrea would secretly try on women's clothing. When she was seven, her father caught her in girls' clothes and became very upset with her. Andrea denied dressing up in women's clothes, using make-up, or engaging in any overtly feminine behavior during her teenage years. She began transitioning to a female at the age of 18 when she received electrolysis and started taking estrogen supplements prescribed by her family physician. She asserted that she was fairly satisfied with her physical appearance at present and had no desire to pursue genital reassignment surgery.

Andrea's parents divorced when she was 11 years old. In general, she claimed to remember very little of her upbringing. Andrea described herself as a loner with few friends. She reported being especially uncomfortable around boys during her youth. She disliked sports and avoided physical education class whenever possible due to frequent teasing about being overweight. She remembers wishing she could have a more feminine body habitus. Andrea indicated that her mother suffered from dissociative identity disorder (multiple personality disorder) and was frequently hospitalized, although this diagnosis had never actually been corroborated by the patient's mother. After Andrea's parents divorced, she saw very little of her father on account of his work schedule. Andrea resided with her mother and stepfather until she was 14 and attempted suicide twice. She later moved into a group home for 2 years before moving out on her own.

Andrea started dating at the age of 17. Her first relationship, mainly platonic, was with a girl whom she courted for 6 months. She later met a man living in a different city through the Internet; physical intimacy with this partner was limited to kissing and petting. Her next relationship was with a woman when she was 20. Andrea reported feeling more of an attraction toward women than men. She was currently dating another nonhomosexual male-to-female transsexual

[1] Verbal informed consent was provided by the patient for publication of her case in a scholarly journal.

despite her recent change in marital status; however, they are not sexually involved. She did not elaborate on whether her wife was aware of this relationship.

The patient presented for the current assessment using forearm crutches to help walk. When asked why she required crutches, she indicated that she needed them for "psychological reasons." Andrea declined to explain these reasons despite gentle coaxing; however, when she arrived for her second visit in a manual wheelchair, she confided that she felt her depressive symptoms were the result of her *not* having multiple sclerosis (MS). The extent of Andrea's restricted insight into her need for using crutches and wheelchairs was revealed when she explained that they allowed her to pretend she had a neurological condition, despite being unable to explain the appeal of being afflicted with MS. Andrea endorsed no psychotic symptoms and explicitly acknowledged that she knew she did not suffer from MS. Importantly, she denied feigning typical symptoms of MS, such as visual disturbance, bladder incontinence, or parasthesias for primary or secondary gain. Similarly, she denied ever having intentionally led a healthcare practitioner to believe that she had MS. While the patient remembered wanting to have had MS since childhood, she could not recall a formative experience or knowing anyone with the condition. Nonetheless, she had begun to seek out individuals with MS for companionship in recent years despite feelings of envy when around them. Andrea emphatically denied sexual arousal towards others with MS or arousal at the thought of being afflicted with the condition. Similarly, she rebuffed any notion of becoming sexually aroused by fantasies of limb amputation, a paraphilia known as apotemnophilia (Money et al., 1977). The patient denied wanting to have other illnesses.

Although the patient linked her current depressive symptomatology to lack of this neurological condition, she remained pessimistic about the usefulness of a psychological or pharmacological intervention. Andrea did report, however, that she was seeing a psychotherapist well versed in the area of "body integrity identity disorder," who she found helpful. Body integrity identity disorder has been described as a state of profound dissatisfaction with one's body to the point where amputation of one or more limbs is desired. It has been proposed as an alternative to apotemnophilia, as sexual arousal is not thought to be a common motivator (First, 2005). Andrea ultimately accepted recommendations for psychopharmacological treatment and agreed to follow-up with her therapist.

Psychological Testing

As part of Andrea's assessment in late adolescence, she was administered a psychological testing protocol. Because at that time Andrea was living in the male gender role, her male name at the time of testing will be used.

Andrew presented as a soft-spoken, anxious young man. In terms of physical appearance, he had straight, long, blonde hair, falling to about his shoulders. He wore loose fitting sweatpants and sweatshirt and appeared somewhat unkempt. Andrew appeared to be more comfortable when given clear and unambiguous tasks, such as the WAIS-III, than with projective tests. He seemed fairly confident during the cognitive testing, but was very reluctant to guess on any questions for which he did not have an immediate answer. Andrew was also comfortable in completing self-report questionnaires, slowly and methodically completing the multiple-choice questions, but spending a considerable amount of time on the few questions that required a written answer.

Andrew was most anxious when asked to complete the House–Tree–Person test (Buck, 1948). With considerable encouragement, Andrew was able to draw a house, but then refused to draw a tree or a person, simply stating, "I can't do it." His anxiety was even more prominent on the Rorschach test, where he stared at each card for a considerable amount of time and then was often unable to provide any response at all. He began to perspire noticeably, despite several breaks and reassurance on the part of the examiner. No attempt was made to institute the inquiry portion of the Rorschach as Andrew became completely uncommunicative at that point. Because of the paucity of responses on the Rorschach, no attempt was made to interpret the protocol.

On the WAIS-III, a standardized test of intellectual ability, Andrew obtained a Verbal IQ (111) at the low end of the High Average range (77th percentile), a Performance IQ (102) in the Average range (55th percentile), and a Full-Scale IQ (107) at the high end of the Average range (68th percentile).

Because Andrew did not live with his parents at the time of assessment and was no longer in school, the Child Behavior Checklist and the Teacher's Report Form (which are usually part of our protocol) were not available. Andrew, however, completed the Youth Self-Report Form (Achenbach & Edelbrock, 1986), which, like the CBCL and TRF, addresses a variety of potential behavioral problems in youth. Andrew identified 40 items as characteristic of his behavior, which summed to 64 and fell in the clinical range (>90th percentile). Two narrow-band scales were elevated: Anxious/Depressed and Attention Problems. One other narrow-band, Withdrawn, fell in the borderline clinical range. The Internalizing T score fell well within the clinical range and was substantially higher than the Externalizing T score, which fell well below the clinical range.

Andrew also completed a battery of self-report questionnaires pertaining to sexual orientation and gender identity. Regarding sexual orientation in fantasy over the past 6 months using the Erotic Response and Orientation Scale (Storms, 1980), Andrew reported both heterosexual and homosexual feelings, with a mild predominance of the latter. On a 1–5 point scale, his mean heterosexual score was 2.87

and his mean homosexual score was 3.50. Regarding sexual orientation in behavior since the age of 13 years using a modified Sexual History Questionnaire (Langevin, 1983), Andrew reported both heterosexual and homosexual experiences. On a 1–5 point scale, his mean heterosexual score was again 2.87 and his mean homosexual score was 3.50. He had not experienced heterosexual intercourse or, with males, either insertive or receptive anal intercourse. On a slightly modified version of Blanchard's (1985) Cross-Gender Fetishism Scale, Andrew did not report any indication of transvestic fetishism, which was consistent with his self-report during the clinical interview. At the time of this assessment, then, Andrew appeared to have a bisexual sexual orientation in both fantasy and in behavior. Given that Andrew (now Andrea) was married to a lesbian woman and was also concurrently "dating" a male-to-female transsexual, it would appear that Andrea's current sexual orientation was clearly nonhomosexual (in relation to birth sex).

On an 8-item Gender Dysphoria/Identification Questionnaire (Zucker & Bradley, 1984), Andrew reported strong feelings of gender dysphoria over the past 6 months, including the desire to have an "operation to change your body into a girl's." In terms of his recollections (from the ages "0 to 12 years") about his childhood sex-typed behavior and feelings (Zucker et al., 2006), Andrew reported moderate levels of cross-gender behavior with co-occurring gender dysphoria. For example, he recalled that he played with boys and girls equally but that his best or closest friend was "usually" a girl. He characterized his favorite toys and games as "neither 'masculine' or 'feminine'." He indicated that he "usually" admired girls or women seen on TV or in the movies. Role playing and dress-up play were reported to be equally divided between male and female choices. He reported that, as a child, he felt "very feminine" and "much less masculine" compared with other boys his age. He reported no participation in sports with other boys. He recalled a reputation as a "sissy" to have occurred "some of the time." He recalled that he "never felt good about being a boy." He reported that he had a desire to be a girl "almost always," but on another item indicated that he "never" verbalized this desire to others. He reported that he felt emotionally closer to his mother than to his father and that he "always" felt that his mother cared about him but "rarely" that his father cared about him.

Discussion

Our case report describes the disability feigning behavior of a nonhomosexual male-to-female transsexual who attributed her depressive symptoms to an unfulfilled desire of having MS, a potentially disabling and progressive neurological disease. Although our patient rejected the suggestion of an underlying sexual motivation for her wish to be disabled, sexual arousal is thought to be an important motivation among persons seeking self-demand amputation.

While Money (1993) has suggested that apotemnophilia shares commonalities with Munchausen's syndrome or factitious disorder, these diagnoses were not applicable to our patient. First, individuals with factitious disorders rarely, if ever, acknowledge that they are intentionally producing their symptoms. Second, they typically lack insight into their need to appear disabled (Abbey, 2002). Andrea exhibited at least partial insight into her need to appear as someone with a neurological impairment; for example, she recognized that assuming this persona helped lessen her symptoms of depression. With regard to the former point, Andrea was entirely forthcoming with her health care providers about her practice of feigning mobility impairments. According to Bruno (1997), if the psychological make-up of devotees, pretenders, wannabes, and persons with factitious disability disorders can be formulated on the basis of a disability satisfying unfulfilled needs for love and attention, then an awareness of wanting to seem or become disabled and physically giving the impression of being disabled comprise two factors that help differentiate these groups. Although patients with factitious disabilities, pretenders, and successful wannabes all appear to be disabled, the awareness of wanting to be disabled is only present in the latter two groups. A self-described pretender and wannabe, Andrea articulated her longing to be disabled, while she simultaneously assumed the outward appearance of an individual with physical impairment.

That the craving for limb amputation can be considered a *de facto* paraphilia, even among individuals claiming that identity issues form the core of this desire, has been suggested as being especially relevant for nonhomosexual male-to-female transsexuals (Lawrence, 2006). Whereas homosexual male-to-female transsexuals, nonhomosexual male-to-female transsexuals, and persons desiring limb amputation all typically express marked dissatisfaction with their embodiment and will often simulate the desired identity utilizing clothing or assistive devices, there are proposed similarities common only to the latter two categories. These can be summarized as follows: (1) both derive from a related paraphilia (e.g., in the case of nonhomosexual male-to-female transsexuals, the corresponding disorder is hypothesized to be autogynephilia or sexual arousal at the thought of being perceived as female [Blanchard, 1989], whereas apotemnophilia may be more central to individuals seeking self-demand amputation); (2) simulation of target embodiment or identity associated with sexual arousal; (3) sexual attraction to those with the desired embodiment; (4) increased prevalence of other paraphilias; and (5) rejection of paraphilia-related theories as explanatory models for the two conditions (Lawrence, 2006).

Andrea was attracted to women and had taken steps to transition to a woman; moreover, she reported feeling envious of others with MS and wanted to become or at least appear to be a person with MS. These observations suggest that Andrea may have experienced erotic target location errors in relation to the categories of person she admired, loved, or felt some attraction toward (e.g., women and individuals with MS). Blanchard (1991) conceptualized erotic target location errors as an individual's development of erotic images of himself that included characteristics of the desired object or a sexual orientation to non-essential elements of the desired object or both. Although Freund and Blanchard (1993) illustrated the concept of erotic target location errors using the example of pedophiles who fantasized about being children and subsequently dressed up like them, they postulated that erotic target location errors, including fetishes for clothing linked to the desired object, erotic fantasies of being the desired object, and unrelenting wishes to change one's body into a replica of the desired object, could develop toward any class of sexual object. Lawrence (2006) has posited that individuals who desire limb amputation similarly manifest erotic target location errors by wanting to change their bodies to the salient erotic target. The hypothesis that both Andrea's transsexualism and her desire to resemble a person a person with a nonmutilative, albeit visible, disability could reflect erotic target location errors is not only a parsimonious explanation of the patient's symptoms but is also conceptually related to the coexistence of putative erotic target location errors involving mutilative disabilities in male-to-female nonhomosexual transsexuals.

Despite Lawrence's (2006) claim that the desire for limb amputation is unambiguously paraphilic in the context of an erotic target location error, there are accounts of apotemnophilia that do not necessarily depict self-demand amputation as being synonymous with a circumscribed arousal to thoughts or images of being an amputee. Everaerd (1983) described the case of Mr. A, a 65-year-old homosexual male, who endorsed an intense desire for leg amputation dating back to age 10. In Everaerd's report, Mr. A explained that "just as a transsexual is not happy with his own body but longs to have the body of another sex, in the same way I am not happy with my present body, but long for a peg-leg" (p. 286). Although Mr. A endorsed acrotomophilia (e.g., sexual attraction to amputees), he clarified that sexual arousal was secondary to the happiness which becoming an amputee would afford him. Lawrence (2006), nonetheless, challenged the notion that sexual motivation can be secondary to issues of identity among nonhomosexual male-to-female transsexuals. Lawrence argued that since a person's sexuality or erotic–romantic orientation and identity are inextricably linked, distinguishing between sexually driven and identity-driven motives is unhelpful. Lawrence further proposed that the presence of an erotic target location error could also explain the desire for limb amputation in persons without gender identity disorders. However, it is unclear whether Lawrence believes that the motivation for limb amputation in homosexual male-to-female transsexuals, assuming such a phenomenon exists, can be similarly formulated. As Lawrence points out, most devotees and acrotomophiles are males who are sexually attracted to females (Dixon, 1983; Furth & Smith, 2000; Riddle, 1989).

As outlined in our case report, Andrea confessed to being relatively sexually inexperienced. Given her deliberate evasiveness surrounding details of her sexual relationship with her wife, it is unknown whether they had ever had intercourse. Among the many handicaps associated with MS is hypoactive sexual behavior in the context of diminished sexual interests, particularly among males (Schmidt, Hofmann, Niederwieser, Kapfhammer, & Bonelli, 2005). Male-to-female transsexualism has also been characterized as being a hyposexual condition (Person & Ovesey, 1974a, b; Pomeroy, 1969). Others similarly report infrequent masturbation in male-to-female transsexuals receiving estrogen therapy (Kwan, Van Maasdam, & Davidson, 1985; Lawrence, 2005). There is evidence to suggest that younger patients with MS tend to endorse more depressive symptoms than their older counterparts (Kneebone, Dunmore, & Evans, 2003) and have more unstable relationships (Buchanan, Wang, & Tai-Seale, 2003). Although currently settled with her wife, Andrea's prior relationships were tenuous. Through her initial encounters with MS patients, it is possible that Andrea readily identified with the related features and associated symptoms of the illness. When coupled with the observation that MS is largely a condition of young, Caucasian women (Ebers, 2008), this perceived similarity may have led to a desire to assume the role of an MS patient.

An adequate formulation of Andrea's wish to be disabled must also consider the contribution of her personality structure, including borderline personality traits. Murray (1985) has proposed that male transsexuals form a subset of the wider borderline construct, although subsequent research investigating this claim remains scant. While Andrea had been previously diagnosed with BPD, there was not sufficient evidence to justify diagnosing BPD as an active condition when she was seen in consultation by the first author. However, it is not uncommon for BPD to remit. Natural history studies show that about 39% of all individuals with BPD no longer fulfill diagnosable criteria for it after 2 years of follow-up (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006). It is, therefore, possible that Andrea previously fulfilled criteria for the disorder but had remitted by the time the first author assessed her. Nonetheless, Andrea clearly continued to display features of the disorder. For example, her mental status during the psychiatric assessment was such that she appeared to be dissociating when asked about past episodes of functional impairment. By her own admission, many of Andrea's

previous relationships were short-lived and involved people she contacted via the Internet and whom she had never met in person. Her reluctance to answer questions concerning her wife precluded the first author from being able to gain a clear sense of the nature of their relationship. It was similarly difficult to discern whether the patient's wife sanctioned or even knew about Andrew's extramarital involvements. Absent any corroboration by the patient's wife about the quality of their marriage, it is reasonable to surmise that Andrea may have misrepresented the stability of this relationship. Andrea's unwillingness to talk about this ostensibly positive aspect of her life when she elaborated on other well-developed facets (e.g., career) supports this hypothesis. Perhaps the most prominent borderline trait endorsed by this patient was her identity disturbance and unstable self-image as a disabled individual. Andrea did not uniformly assume the persona of an individual with a physical disability. When around others with confirmed MS, for example, she did not pretend to have the disorder. This inconsistency suggests that Andrea may have harbored insecure self-image representations of herself as disabled, as her disability feigning behavior appeared to be context-dependent. Wilkinson-Ryan and Westen (2000) have documented that patients with BPD report identity issues characterized as "role absorption," a process by which individuals over-identify with a group to the point where this label subsumes their complete identity. Framing Andrea's preoccupation with MS in the context of role absorption thus underscores the likelihood of borderline character pathology operating to perpetuate this individual's distress.

A limitation of this report is that Andrea's denials of transvestic fetishism, abasiophilia (e.g., attraction to individuals with impaired mobility), or arousal to feigned disability were not probed in great depth. There are reasons one might be skeptical about the accuracy of her denials. For example, Blanchard, Racansky, and Steiner (1986) showed that nonhomosexual cross-dressing males, including some with gender dysphoria, who denied sexual arousal with cross-dressing did, in fact, demonstrate sexual arousal when tested using penile plethysmography. Among the possibilities raised by the authors to help explain this phenomenon was that study participants were consciously misleading examiners about the level of their arousal or conversely that they were genuinely unaware of any erotic arousal. A two-factor model of socially desirable responding has been advanced that distinguishes between responding based on self-deception, where a respondent truly believes his or her self-report, and impression management, which involves conscious manipulation on the part of the respondent (Paulhus, 1984). Impression management is felt to more likely in situations involving public disclosure. Thus, we cannot rule out the possibility that Andrea may have willfully misinformed the clinician about any potential paraphilic behaviors in an effort perhaps to legitimize her request of gaining help for her depression. However, in the absence of any phallometric data indicating sexual arousal to some form of disability, there is minimal evidence to support this hypothesis.

When a transsexual person expresses a desire to be afflicted with (or appear to be afflicted with) a nonmutilative disability, clinicians should consider whether the patient may regard the sympathy and consideration he or she might receive as a visibly disabled person as compensating for, or creating an alternative to, the disrespect, discrimination, and abuse that he or she might experience (or worry about experiencing) as a visibly transsexual person. Clinicians should also be mindful of possible characterological pathology.

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