REVRENE
NORTHEAST NETWORK NURSING JOURNAL
ISSN ON LINE 2175-6783

Original Article

DISORDERS OF IDENTITY AND SEXUAL BEHAVIOR: AN EPIDEMIOLOGICAL APPROACH

TRANSTORNOS DE IDENTIDADE E DE COMPORTAMENTO SEXUAL: UMA ABORDAGEM EPIDEMIOLÓGICA

TRASTORNOS DE IDENTIDAD Y COMPORTAMIENTO SEXUAL: UN ENFOQUE EPIDEMIOLÓGICO

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The research aimed to characterize patients affected by Identity Disorders and Sexual Behavior and identify their occurrence by sex, as well as the patient's origin, diagnosis and length of stay, type of admission and discharge and funding source for services rendered. This is a retrospective study conducted in a psychiatric clinic in the Midwest Miner. The sample consisted of 2715 patients, predominantly male (1518- 55.9%), age range 21-30 years (917- 33.7%), the origin of hospitalization for Psychosocial Care Centers (1123 - 41.3%), the diagnosis of "Other Disorders of sexual preference" (2567- 94.5%), the residence time of 1 to 30 days (1770-65.2%), the high medical (1818-66,9%), the first admissions (1775-65.3%) and Health System as the main funder (2004 to 73.1%). It was evident that the disorders are more common in young men and it was realized how little knowledge of health professionals about these disorders.
Descriptors: Sexual Behavior; Hospitalization; Mental Disorders; Psychiatric Nursing.

A pesquisa teve como objetivo caracterizar os pacientes acometidos por Transtornos de Identidade e de Comportamento Sexual e identificar sua ocorrência por sexo, bem como a procedência do paciente, diagnóstico e tempo de internação, tipo de alta e internação e fonte financiadora dos serviços prestados. Trata-se de estudo retrospectivo realizado em uma clínica psiquiátrica do Centro Oeste Mineiro. A amostra foi composta por 2715 pacientes, predominante do sexo masculino (1518-55,9%); a faixa etária de 21 a 30 anos (917-33,7%); a procedência para internação dos Centros de Atenção Psicossocial (1123-41,3%), os diagnósticos de "Outros Transtornos de preferência sexual" (2567-94,5%); o tempo de permanência de 1 a 30 dias (1770-65,2%); as altas médicas (1818-66,9%); as primeiras internações (1775-65,3%) e o Sistema Único de Saúde como principal financiador (2.004-73,1%). Evidenciou-se que os transtornos são mais comuns nos homens jovens e percebeu-se o pouco conhecimento dos profissionais de saúde sobre estes transtornos.
Descritores: Comportamento Sexual; Hospitalização; Distúrbios Mentais; Enfermagem Psiquiátrica.

El objetivo fue caracterizar pacientes afectados por trastornos de identidad y comportamiento sexual y determinar su incidencia por sexo, así como la procedencia, el diagnóstico y la duración de la estancia, tipo de ingreso y de alta y fuente de financiamiento para los servicios prestados. Es retrospectivo, realizado en una clínica psiquiátrica del Centro Oeste minero, Brasil. La muestra constituida por 2.715 pacientes varones en su mayoría (1518-55,9%), con edades entre 21 y 30 años (917-33,7%). La origen para hospitalización de los Centros de Atención Psicosocial (1123-41,3%), el diagnóstico de "Otros trastornos de la preferencia sexual" (2567-94,5%), el tiempo en el hospital de 30 días (1770-65,2%), alta médica (1818-66,9%), primera hospitalización (1775-65,3%) y el Sistema Único de Salud como pagador (2004-73,1%). Los trastornos son más comunes en hombres jóvenes y se percibió poco conocimiento de los profesionales acerca de estos trastornos.
Descriptores: Conducta Sexual; Hospitalización; Disturbios Mentales; Enfermería Psiquiátrica.

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INTRODUCTION

The approach to the subject of the research focusing on Identity and Sexual Behavior Disorders (TICS) originated in Mental Health classes from the Residency Program, of Universidade Federal de São João Del Rei, and the previous experience of the authors with TICS within the context of mental health. Due to the classes the group became interested in the theme to be investigated.

The identity and sexual behavior disorders, or "paraphilias" are defined by unconventional sexual interest. They are characterized by sexual arousal reactions triggered in the body of the individual in the presence of unusual stimuli, and by frequent recurrence of this pattern of abnormal sexual behavior[1].

The abnormal sexual behavior is culturally relative, however, one can define as abnormal the behavior that is intense enough to somehow cause "clinical distress" and interfere negatively in the social or work activities of the individual and / or the people around them[2].

According to the Diagnostic and Statistical Manual of Mental Disorder-IV (DSM-IV), published by the American Psychiatric Association, the following disorders are classified as paraphilias: Exhibitionism, Fetishism, Voyeurism, Pedophilia, Masochism, Sadism and Transvestic Fetishism. The DSM-IV also brings a class of "not specified paraphilia" which includes disorders such as necrophilia, bestiality and gender identity disorders[3].

In this context it is important to highlight the definition of gender identity disorder, and exclude homosexuality as a disorder. The gender identity disorders are characterized by strong and persistent cross-gender identification, that is, the desire to be the other sex, temporarily or permanently, and also discomfort with their own sex and the feeling of inadequacy of their role in a certain gender[4].

A large study[5] developed in Brazil, which evaluated the unconventional sexual behavior of more than 7,000 individuals, found that about 41% of individuals have already practiced at least once in their life, sexual acts such as: group sex, threesome, incestuous relationships, exhibitionism, voyeurism and others. Furthermore, nearly 10% of respondents practiced until two forms of unconventional sex, being voyeurism and fetishism the most common sexual disorders in Brazil.

There are several studies and many current discussions that attempt to unravel the TICS as well as the cause and behavior of these disorders. Scientific advances, the greater acceptance in society and treatment as a whole, focused on redefining sexuality, have favored the research related to these disorders. However, in contrast, the subject has still been little discussed among the population and health professionals[6].

In this study, the research practice will be guided by the need to consider the implications of this theme, which makes it essential to study the matter and thus, it will enable knowledge to health professionals and anyone interested in the theme.

In this context, the aim of this study was to characterize patients affected by TICS and identify their occurrence by age and sex, as well as the patient's origin, diagnosis and length of stay, type of admission and discharge and funding source for services rendered to the patient.

METHOD

This is a descriptive, exploratory and documentary research with retrospective character. A descriptive research has as its main objective to describe the characteristics of the object of study, or relate it to variables. An exploratory research elaborates issues of a problem and is based on the formulation of hypotheses, with the aim of improving knowledge about the concept studied. A documentary research uses as source material

that did not receive an analytic treatment, as the documents kept in the archives of public and private institutions, newspapers, photographs, notary documents, or documents that have been previously analyzed such as company reports, research reports, statistical tables. The retrospective character is due to the fact that the study is prepared based on past records and followed until the present moment[7].

The study was conducted at São Bento Menni (CSBM), a philanthropic psychiatric hospital of medium size, with total capacity of 120 beds, located in Divinópolis-MG. It is considered a reference center of the Unified Health System (SUS) for psychiatric hospitalizations in the Midwest region of Minas Gerais, it serves on average 85% of SUS patients suffering from chronic and acute mental disorders, both for psychiatric treatment as well as on an outpatient basis, being patients mainly from the neighboring cities of Divinópolis[8].

The CSBM develops, through its National hospital admission (SIH), registration, monitoring and archiving of information regarding admissions through medical records, stored on your Statistics and Medical Archive Sector (SAME). Therefore, it created an electronic system for data collection and recording of admissions from the year 1995, and it records all data about hospitalizations since 1980, the year of its opening, presented in manuscript format in its SAME.

Thus, the necessary information was collected in the database of SIH/CSBM, focusing on the data collected, we built a new database with information about patients affected by TICS, with emphasis on the following variables: sex, age, patient's origin, length of stay, type of discharge, hospital diagnosis and funding source. The admission diagnoses found in the research are coded and classified according to the 10th edition of the International Classification of Diseases (ICD-10). For purposes of discussion, the settings in this publication will also be used.

One adopted the following inclusion criteria: patients admitted to the CSBM in the period from October 20, 1980 (date of opening of the clinic) to 31 December 2005 (year of submission of the project to the Committee for Ethics in Research), with CSBM stay longer than 24 hours and who were followed since admission, discharge or transfer. Data were analyzed using descriptive statistics. The study was processed after approval of the Ethics Committee on Research of the Universidade de São Paulo with opinion No. 0649/2006, and it was developed from March to June, 2012. As the focus of the study was the information referring to admissions already available in the database SIH / CSBM, there was no type of contact with patients. It is noteworthy that the study followed all norms of Resolution 196/1996 of the National Health Council and the ethical principles of research.

RESULTS

During the study period 24,161 patients admitted to the CSBM, 2715 were affected by TICS, which represents a rate of 11.2%. After analyzing the data on the epidemiological profile of patients with TICS, there was a predominance of males in 1518 (55.9%) over females with 1197 (44.1%).

As to age, the most affected were found between 21 and 30 years old (from 917 to 33.8%), followed by age group 31-40 years old (620 to 22.8%). The other age groups were presented with the following percentages: 10 to 20 years old (137-5%), 41-50 years old (555 to 20.4%), 51-60 years old (371 to 3.7%) from 61 to 70 years old (69 to 2.5%) and older than 70 years old (from 70 to 2.8%)

The admission diagnoses presented in greater numbers in this study was the "Other Disorders of sexual preference" with 2567 (94.5%) cases. The Exhibitionism was the second most common diagnosis in the study, with 85 (3.1%) cases, followed by pedophilia with 23 (0.8%) diagnoses among more than 2700 patients evaluated. Two

other admission diagnoses were found in the study "Bivalent Transvestism", 21 (0.7%) and "Transsexualism" 19 (0.6%).

With regard to other clinical variables, Table 1 shows the results.

Table 1 - Characterization of patients with TICS admitted to the CSBM, according to clinical variables. Divinópolis, MG, Brazil, 1980-2005

Variable	**Frequency (n %)**
1-Origin	
Private Doctor's Office	612 (22,5)
Psychosocial Care Centers	1123 (41,3)
Family	703 (25,9)
Others	276 (10,1)
2nd. Length of Stay in CSBM	
1 to 30 days	1770 (65,2)
31 to 60 days	783 (28,8)
61 to 90 days	109 (4,0)
> 90 days	53 (1,9)
3. Type of Discharge	
Hospital medical discharge	1818 (66,9)
Asked for discharge	562 (20,6)
Administrative discharge	16 (0,6)
Discharge due to abandonment / evasion	314 (11,5)
Clinic transfer	4 (0,1)
Death	1 (0,03)
4. Type of Stay	
Hospitalizations	1775 (65,4)
Readmissions	940 (34,6)
5. Source of Hospitalization Funding	
Unified Health System	2004 (73,8)
Private	55 (2,0)
Health Insurances	650 (23,9)
Free	6 (0,2)

Source: Database SIH / CSBM

Regarding the origin of the patients to the hospital, it can be observed that 1123 (41.3%) were coming from the Centers of Psychosocial Care (CAPS), followed by 613 (22.5%) from private doctors.

As for the time of admission, most patients remained 1-30 days, totaling 1770 (65.2%) of admissions, followed by the residence time of 31 to 60 days (from 783 to 28.8%).

The type of discharge which occurred more frequently in sexual disorders were the hospital medical discharges with 1818 (66.9%) cases, followed by asked for discharges with 562 (20.6%). One highlights the occurrence of a death by suicide (0.03%).

Regarding the type of admissions in 1775 (65.3%) were first hospitalizations and 940 (34.6%) were cases of readmissions. The source of funding in most admissions was

SUS, with 2,004 individuals representing 73.1% of the patients treated at CSBM.

DISCUSSION

In line with this research a study[5] conducted in 18 Brazilian cities, with 7022, individuals also showed that unconventional sexual behavior is more frequent in males, out of the 3791 men evaluated 1,895 (50%) have already practiced some unconventional sexual behavior. In the case of women, out of the 3231 evaluated only 969 (30%) have practiced it.

It is important to consider that the attributes given to gender differences can be seen as factors that influence unconventional sexual behavior, which involves the biological, social and cultural dimensions. Referring to the biological dimension, one highlights the hormonal differences between the sexes, which provides higher libido due to testosterone in men, when compared to the action of estrogen in women. With regard to social factors, usually since their childhood the boys are encouraged to be explorers, sexualized and independent, while girls are driven to be sweet and fragile and preserve themselves sexually. In the cultural aspect one observes that there is a greater liability to the eroticization of men by external means, through worship and exposure of the female's body and sexual organs.

As to age, the most affected were found between 21 and 30 years old, followed by the age group of 31 to 40 years old. A study about unconventional sexual behavior between individuals of different ages showed a higher incidence among individuals from 30 to 40 years old, which appeared to be compatible with decreased sexual activity[5]. It is important to highlight the establishment of misdiagnosis and late diagnosis as factors that may be associated with the most affected age.

It is noteworthy that the diagnosis "Other disorders of sexual preference" most found in the study, according to the ICD-10 is defined as various other forms of sexual preference and behavior. This classification includes paraphilias such as bestiality, necrophilia and feeling up, being exemplified respectively by sex with animals, corpses and the act of rubbing against another person in public[9]. The high incidence of diagnosis "Other disorders of sexual preference" can be explained by the difficulty of health professionals in closing an accurate diagnosis, classifying various disorders in that less specific category. Thus all the disorders that comprise this group require studying and they are rarely mentioned in large surveys.

When analyzing the paraphilias more specifically, in the case of necrophilia, the literature associates it with other pathologies such as severe psychiatric problems and mental deficit. Furthermore, the use of alcohol as a trigger for practicing such acts is also described[10]. Little is known also about zoophilia. A study with around 7000 individuals developed in Brazil[5], identified 181 people who had already had sex with animals.

Exhibitionism is characterized by a desire to expose genitals in public. Results of another study indicate exhibitionism as the third most common diagnosis of paraphilia in women with an incidence rate of around 30%, being the number of cases of this disorder in women close to the number of cases in men and they are related to history of sexual abuse[11]. Although exhibitionism is the second most common diagnosis in this study, the percentage in relation to total diagnoses was small compared to other studies. This fact may be related to the difficulty of definition and characterization of this pathology on the part of health professionals.

Pedophilia, according to the CID-10, is defined as the sexual preference for children. In this study the diagnosis of

pedophilia had a low frequency among more than 2700 patients. Other studies, however, argue that pedophilia is the most common paraphilia. Furthermore, it is described the highest incidence of this disorder in men and starting mainly during adolescence[12].

Pedophilia is perhaps the most known and discussed TICS. Not by the pathological aspect, but for the vision of society on the carriers of this disorder, which are judged as monsters, rapists and criminals. It is important to highlight, therefore, that when these individuals abuse minors, although criminals, should also be treated as patients, suffering from a serious disorder and who need treatment.

Some authors associate the onset of pedophilia to abuses suffered in childhood and/or relationship problems with parents during the first years of life. They also report the influence of testosterone to develop the disorder, which may be one explanation for the higher number of male pedophiles[12].

Regarding the disorders "Bivalent Transvestism" and "Transsexualism", their carriers are called both "transvestites" without distinctions, but there is a clear distinction between them[13]. The CID-10 states that Bivalent Transvestitism is the wearing of clothes of the opposite sex to meet temporarily the desire to belong to the other sex, not accompanied by sexual arousal. Transsexualism is characterized by a strong desire to be the other sex, with the presence of a feeling of discomfort in belonging to their gender. It is also accompanied by the willingness to undergo surgery and hormone treatments to bring change their body as much as possible into the desired gender[9].

Regarding transvestitism, there was no consensus as to its etiology and little has been studied about its incidence, but many studies correlate the disturbance to the low socioeconomic and educational level, drug use, prostitution, sexually transmitted diseases, and the incidence of other psychiatric comorbidities[13]. It is likely that the difficulty of social integration of these individuals, due to prejudice, maximize the health risk factors mentioned above, triggering a cascade effect from economic difficulties resulting from poor education.

As to transsexualism, most studies discuss the surgeries for changing the individual into the opposite sex. However, a survey conducted in Spain estimated the incidence of this disorder in 1 for every 21,031 men and 1 in every 48,096 women[14].

Although the causes of transsexualism are not clearly elucidated, some researchers such as Gomes, Esteva and Bergero, relate their beginning to another preexisting disorder, the gender identity disorder in children[15]. The gender identity disorder in children appears before puberty and usually in early childhood. It is characterized by the desire to be the other sex, besides suffering for belonging to a particular gender with intense concern about the clothes and activities of the opposite sex. A literature review conducted in Spain concluded that about 90% of transsexuals from that country showed the first symptoms in childhood[15]. On the other hand, some studies claim that only 5-20% of gender identity disorders in childhood become transsexuals[16]. In both cases, transsexualism and bivalent transvestism, the low incidence rates are probably related to the fact that patients do not look for treatment.

Regarding the origin of the patients to the hospital, it can be observed that most came from the Centers for Psychosocial Care (CAPS), this finding is against the Brazilian Psychiatric Reform[17] which considers the CAPS strategic devices because they allow the organization of a network to substitute psychiatric hospitals. From the high numbers of hospitalizations coming from CAPS, one realizes that these institutions have not fulfilled the functions for which they were created, acting only as a complementary service to the hospital.

The hospitalizations and the long length of stay in the hospital of patients suffering from TICS reflect inconsistency

with the new paradigm of Mental Health's approach, which prioritizes the model of community care instead of hospital centralization. The CAPS, which act as restructuring of attention in Mental Health, should be prepared to attend with priority this population of users with severe and persistent mental disorders in their territorial area, and it should be a day care service oriented according to territoriality[17] . The approach proposed by the Mental Health policy focusing on CAPS gives the patient a rehabilitation process that aims at social rehabilitation and strengthening of family bonds, and on the other hand, generates less cost to health services because the patient can be treated without leaving their home environment.

However it is known that in the present moment, it is noticeable the need for joints that aim at conversation between public health and mental health, as well as reordering of CAPs and the construction of a health network that aims innovated ways of thinking and acting due to the health-illness mental process, thus allowing a network of spaces favorable to hosting and creating territorial linkages[18].

The discharges occurred, mostly by medical criteria, indicate a good adherence to the treatment established, and this reflects in a unique opportunity for adequate pharmacotherapy and psychotherapy stability of the individuals[19]. Because of the kinds of discharge presented, it is noteworthy the occurrence of a death by suicide, which shows clearly the level of disturbance and mental suffering that the individual with TICS presents.

When analyzing the type of admissions one observed that, in most cases, they occur for the first time, but the number of readmissions occurred are considerable, and they are usually related to the unpreparedness of the patients or their family about the care to be performed at home, such as the difficulty in administering medications, changes in lifestyle, among others[20].

In this context it is necessary that discharges are preceded by guidance on the aspects inherent to the treatment and maintenance of stability to be provided by the CAPS. It is of utmost importance at this moment, the role of the professional nurse as a health educator to both the user and the family, intrinsic support to an effective healing process of the patient.

The high cost of mental disorders to SUS was verified by analysis of the funding source, the high rates of hospitalizations financed by SUS suggest a need to expand the network of mental health services to assist people with mental disorders thus preventing the segregation and institutionalization of patients. Thus, it is evident the necessity and importance of investing more resources in the network of primary health care together with the CAPs, thus providing a more effective treatment, which promotes better quality of life for patients and reducing costs related with the treatment of mental illnesses.

FINAL CONSIDERATIONS

Based on the results found, we can say that the large number of patients affected by TICS and the consequent psychosocial deterioration caused by this disorder point to the urgent need for further discussion on the issue among the population and health professionals, as well as the establishment of public health policies aimed at coping with these disorders.

One verified the need for further studies that address the issue of TICS by gender because there is a lack of information on the social, biological and cultural factors in relation to abnormal sexual behavior in both sexes.

One realized the need to develop tools that enable early detection of the first signs and symptoms of TICS, thus enabling a better definition and approach of the age group when the disorder starts, because most of the information about the diseases existing currently refer to episodes of seeking treatment by the patients.

It is important to emphasize the necessity to achieve better integration of CAPS with the Primary Care Units (Health Clinics and Family Health Team) and Secondary Care (Hospitals and Polyclinics), in order to strengthen the network substitutive of the psychiatric hospital. Thus, one enables a more effective treatment, which prevents institutionalization, gives a better quality of life for patients and reduces costs to SUS.

There was a predominance of more than 90% of diagnoses made as "Other disorders of sexual preference," which, according to CID-10, encompasses more than one disorder, and is therefore not clearly defined. One can infer that the study shows that health professionals also have difficulties in giving accurate diagnoses when it comes to this type of disorder. It is prudent, therefore, to promote training and continuing education for professional diagnosticians. Another important point to note is concerning the few epidemiological studies involving the sexual disorders and the lack of more precise literature definitions of the less common disorders.

With regard to hospital admissions it is important to reaffirm that, based on the current policy of Mental Health, the hospitalizations should not occur, a fact that would favor the deinstitutionalization and social integration of the patients. According to the Psychiatric Reform the CAPS, observing the principle of territoriality, should be one of the main forms of access of the users to attention network, resolving largely the needs of the individuals. However, it is observed that this logic has not happened since the CAPS presented itself as one of the main services who directed patients to CSBM.

Regarding hospital discharges it becomes pertinent to mention that, although most of them occur smoothly and by medical management, such mental disorders generate immeasurable suffering to these patients, a situation that can be represented by the suicide of a patient hospitalized, which reflects the need for improved therapeutic approach and wakefulness of these patients. It is also noticed a high rate of readmissions occurred, which reinforces that therapy needs to be rethought as new forms of discharge plan to guide self-care and family care, which presents itself as the main part in this event and in the promotion of social reintegration.

It is hoped that the results of this study contribute to the advancement of knowledge of health professionals, for patients and families, enabling a critical view that is necessary to face these disorders in the pathological sphere, unlike its current approach is in the moral sphere.

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Received: June. 6th 2012
Accepted: Nov. 11th 2012