"Gender Dysphoria in Adults with Autism Spectrum Disorder."

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INTRODUCTION: Per the American Psychiatric Association (APA), gender dysphoria is the mismatch between an individual's assigned physical gender, and the gender with which they/she/he identifies. In particular, this mismatch may lead to significant distress for an individual. This feeling of distress may present in a variety of ways - anxiety, fear, depression, discomfort.[3]

Per the Diagnostic and Statistical Manual of Mental Disorders (DSM5), there must be a difference in an expressed vs assigned gender, along with significant distress. This discomfort must be present for at least six months, and requires two of the following: marked incongruence between experienced gender and sex characteristics; a strong desire to rid one's undesired sex characteristics; strong desire of another gender's sex characteristics; a strong desire to be the other gender and be treated as the other gender; the belief that an individual has typical feelings of another gender. Population identifiers include, but are not limited to: gender-nonconforming, transgender, transsexual, genderqueer, non-binary.[1] This diagnosis can be seen within a variety of populations; interestingly, there is growing evidence suggesting ASD or autistic traits are over-represented in non-gender-conforming groups. Current literature suggests that there may be an overrepresentation of gender dysphoria in individuals with ASD, compared to the general population.[2] This is important to identify, due to the fact that specific presentations common to ASD, such as literalness and diminished theory of mind, may impede individuals from receiving proper support.

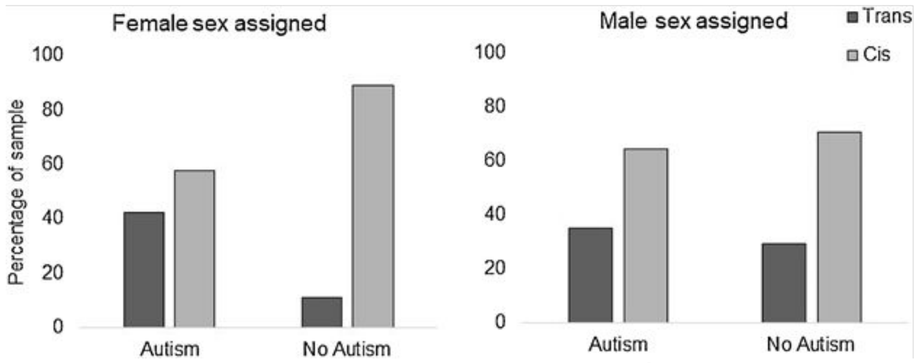

Figure 1: female vs male gender identify and ASD[3]

CASE PRESENTATION: This report describes the case of a 51-year-old, assigned female at birth, with past psychiatric history of PTSD, DID, and Borderline Personality disorder. Upon admission, they mentioned previously being misdiagnosed with Bipolar disorder and Schizophrenia. Patient presented to an involuntary unit of a standalone psychiatric hospital for further evaluation and treatment of persistent irritability, chronic delusions, and severe PTSD.

On initial evaluation, the patient's appearance was disheveled and their head was shaved. They wore sunglasses inside, as well as an oversized sweatshirt with the hood on. They used earplugs to limit their exposure to loud voices and sounds on the unit, and exhibited abnormal prosody of speech, with frequent tangential thought process. The patient appeared to have poor social-emotional reciprocity, as evidenced by difficulty engaging in back to forth conversation. They endorsed a long history of peers and health care providers not truly understanding them. It was also stated that others do not understand their inability to adapt to situations, and expressed significant distress with inability to understand what others are thinking, suggesting poor theory of mind. Patient often used movie quotes to communicate and express their emotions. In addition, they expressed multiple personas, which could be interpreted as a presentation for multiple personalities. However, as patient's episodes of dissociation were observed, they appeared to be more in line with the history of PTSD. This, along with psychological testing, later ruled out DID.

Overall, patient endorsed these symptoms as being present since early childhood. With all the aforementioned symptoms present throughout multiple encounters, the treatment team became highly suspicious that Autism Spectrum Disorder (ASD) could be the patients' primary diagnosis. Extensive psychological testing was performed, in order to confirm this working diagnosis; analysis from the psychological testing agreed with a diagnosis of ASD. When the patient was informed of this diagnosis, they accepted and appeared to be relieved, stating they were finally able to explain why their behaviors did not fit others "socially acceptable normal."

Over the course of their hospitalization, the treatment team noticed the patient referring to themselves as "us and we". As this was explored further, the patient stated they did not like using "he/she/him/her" to describe themselves. They mentioned not feeling as though these terms described them, as they did not fit into a specific category. The patient expressed others trying to put them into a demographic their entire life, such as lesbian or straight, but has always "seen myself as just on object." As patient became older, they felt pressured to define themselves as lesbian and they attempted to identify themselves as such. Over the years, they began to grow distressed, secondary to this identifier. The patient admited that their struggle with gender identity had been a significant stressor throughout their life, and the only time they have been able to accept themselves is when they identified as non-binary.

DISCUSSION: Over the past 20 years, the prevalence of ASD has been on the rise. In 2000, data suggested that the prevalence was 1 in 150. Since then, this number has significantly increased, with the prevalence being 1 in 59; the most recent data shows the prevalence of ASD to even be 1 in 54. It is suggested that the increase in prevalence is due to increased awareness and changes to the diagnostic criteria of ASD.[5] In association with the increased prevalence of ASD, there is emerging literature suggesting a correlation with comorbid gender dysphoria.

Per graph, individuals diagnosed with autism were more likely to identify as transgender compared to individuals without autism. This could be seen for both assigned genders, but the effect of ASD on increasing the likelihood of identifying as transgender is especially evident for individuals assigned female gender at birth. This evidence, along with other research, continues to affirm the possibility for increased prevalence of gender dysphoria within ASD populations.

All in all, if a patient is diagnosed or suspected to have ASD, they should also be screened for gender dysphoria, as part of a routine psychiatric assessment. These underdiagnosed, comorbid conditions may cause patients harm if unnoticed; this is evidenced by increased rates of depression/anxiety in ASD individuals with gender mismatch.[4]

CONCLUSION: The patient presented had multiple previous misdiagnoses, likely due to their true underlying diagnosis of Autism Spectrum Disorder, with comorbid gender dysphoria. As the literature is beginning to show a positive correlation between these two diagnoses, further research and case studies will need to be performed in order to aid health care providers in establishing accurate assessments and develop appropriate treatment plans. Further work-up in the case of either co-morbid condition may be indicated as research continues to point that these two disorders frequently coexist.

Figure 2: Photo illustration by Natalie Matthews-Ramo/Slate. Image by Thinkstock.

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