Care of Children

Psychiatry Perspective

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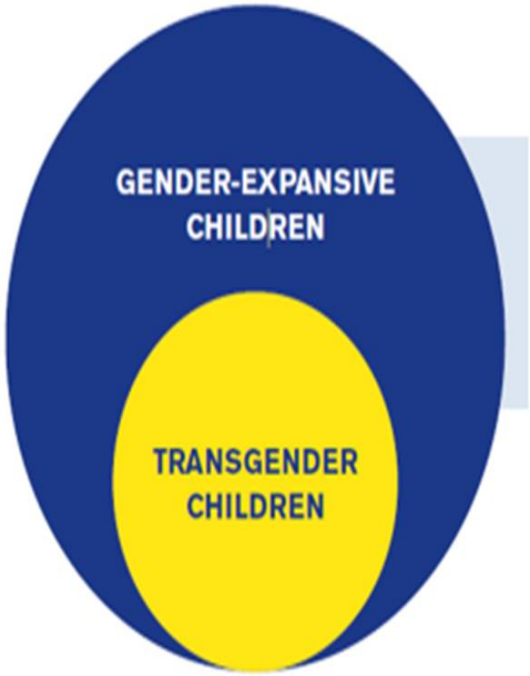
Case 1.

- The pre-pubertal child
- Wait and watch approach
- Vigilance for early signs of puberty and exacerbation of gender dysphoria
- Support family's neutral and affirming response to child's gender variant expression
- Support safety in the school and community



GENDER-EXPANSIVE CHILDREN

- Behavior, preferences or other traits are not gender-typical
- Not necessarily distressed –except because of bullying or stigma

TRANSGENDER CHILDREN

- Distressed about assigned sex and/or expected gender identity
- May call for gender transition

Gender Dysphoria

- DSM-V (2013) - Gender dysphoria replaced ‘Gender Identity Disorder’ focuses on dysphoria as the clinical problem and not identity per se.
- Emphasizes that gender non-conformity itself is not a mental /other disorder
- For a person to be diagnosed with gender dysphoria, there must be strong and persistent cross-gender identification that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- In children, the desire to be of the other gender must be present and verbalized.
- It is important to note that not all gender non-conforming people are dysphoric

Case 1
R a 9 year old natal male

- Gender variant history since the age of 2 with her second birthday the last time she celebrated her birthday as a boy
- Since that time R has shown a strong preference for female colours and toys.
- R”s play was with horses, unicorn and wearing the colour pink.
- R enjoyed dance and calisthenics in prep school and was teased for wearing tights and dance outfit
- Teased by older brothers' friends for being like a girl
- At age 6 R told her teacher she wanted to be a girl. This teacher provided children a safe place with wigs and dress ups which R felt comfortable to explore her gender preference. This occurred before R told her mother of her desire to be a girl
- The mother thought prior to this disclosure that R just liked female things because she also played tiggy and soccer with her brothers and male friends
- R was in a country town and was subjected to teasing and bullying. R became very tearful when discussing her experiences.

Case 1 continued

- • R grew her hair out to shoulder length at the end of Grade 1 and was frequently gendered as female
- • Mother provided her child with two wardrobes one for gender neutral clothes and the other with female clothes that R initially wore around the house.
- • The family were to use R her chosen name and female pronouns.
- • R moved with her family to another country town to support family in crisis
- • R was less able to express her gender variant behaviour in this setting.
- • R was to be returned to the family's original country town where the mother was determined for her child to make a full social transition at her new school
- • New school provided unisex toilets and showers for swimming lessons and undertaken " Safe Schools " training
- • Siblings attended their original school 8 km away.
- • R has told 5 of her friends at her school she is transgender.
- • R is a capable student and an excellent reader and her school accommodated her inter school competition with her previous school where she was known as a boy.

- Despite good immediate family support and stance which was neutral and accepting of their child's gender variant behaviours. R became anxious and distressed with the teasing she had experienced from peers and the impending birth of a younger cis gendered female with R at this being the only trans female with all the older brothers.
- There was a strong family history of anxiety
- R wanted all family portraits where she was photographed as a boy to be removed before the birth of the new sister and these to be replaced with photographs of her as an attractive young girl.
- Mother referred to her current pregnancy of her female child as her second daughter which R found supportive and validating

- Referrals were made to local CYMHS and to the Rainbow Group Porgramme with Relationships Australia

- Mother accessed online support groups as a busy mother living in a country area

- Family sessions were conducted to support R's older brothers who were being challenged from their peers about their siblings transgender status. Sibling were given strategies to handle peers

- Monitoring of early signs of puberty was causing R increasing anxiety. Strongest fears was a deeper voice and body hair.
- R was observed to become increasingly quick tempered and oppositional
- Endocrine appointments made to catch early puberty and offer reassurance

Case 2
Z 11 year old natal male

- • long history of gender variant behaviour
- • Fully transitioned at home and in her primary school
- • Was increasingly disliking her male body and feared a male puberty in the context of identifying more as a girl
- • Parent's concerns that their transgender child may be outed in her new school after another child saw her male name in Z 's log in a computer lab. The school have been protective in other ways and felt this was an accident
- • Counselling focused on how to come out in the community is a safe and staged way
- • Their worries about school camp and where Z was to sleep and what shower and toilet facilities were to be used.

Management

- Referral to the gender clinic endocrinologist for pubertal staging and puberty blockers
- Support transition to new high school and how to handle this setting after a successful primary school experience.

Case 3
W a 9 year old natal female

- • Diagnosed with ASD at 3 years of age with three brothers with diagnosis of ASD
- • History of social difficulties, solitary non imaginary play with a preference to be a “dog” where he would bark like a dog and seek affection by rubbing himself against others like a dog
- • Repetitive activities such as repeatedly watching the same TV show
- • Sensory sensitivities with certain socks or clothes and only eat crunchy food
- • Self stimulated with hand flickering and stimmed more as a younger child
- • W complained that he could not fit in with his peers

- • Strong history of gender variant behaviour since the age of 2 years
- • Wore boys clothes since the age of 4 years of age refusing any female clothes in the previous year to his presentation to the LCCH gender clinic
- • 18 months prior to his presentation to this clinic he insisted on the use of male pronouns at home and school which was supported in both settings.
- • Used male toilets
- • W had found social difficulties particularly with girls who had more advanced language and social skills than he possessed or could interact.
- • Mother who was fully informed on the rigidity of W's ASD could have meant he identified with boys because of these differences
- • W's revulsion of his female body part predated his social difficulties outside his family of origin
- • W remains driven to be a boy even when his social functioning and support of his friends reveal no social struggle at this time.

Case 3 continued

Management

- W's father was finding it hard to accept his only natal female child electing to be transgender. This needed grief counselling, support and psycho education around ASD and gender dysphoria
- Endocrine assessment and early use of puberty blockers with the onset of early puberty
- W 's mother at the end of a session wanted to explore the impact of puberty blockers on gender identity and wondered if the blocking of W's oestrogen prevented her child from experiencing the positive effects of this hormone on her child's gender identity which could detract from her child's experience and possibly negatively disadvantage her child's true gender journey. I explained that the reason we allowed W to enter early puberty was to expose W to oestrogen and that the intensification of his gender dysphoria W displayed was the reason we decided with his mother's consent to trial puberty blockers in the best interest of her child. It was explained that for a transgender child the experience of their natal hormones in puberty can cause severe distress and the removal of W gender dysphoria and natal hormones with the use of puberty blockers gave her child a better ability to explore and experience his gender identity without the distress of his gender dysphoria. W mother was reassured by this explanation.

Will a gender diverse child be a trans- or gender diverse adult?

- Previous studies have suggested that between 12-25% of young children showing gender non-conforming behaviours continue on to have gender dysphoria through adolescence likely reflects the heterogenous nature of this group

Factors associated with persistence of gender dysphoria

Wallien MS, Cohen-Kettenis PT. 2008 Zucker K, Bradley SJ. 1995

- • greater intensity of GD in childhood and
- • more gender-diverse behaviour in
- • persistence of GD during
- adolescence
- •more likely to meet full DSM criteria
- •more likely to have extreme scores on measures
- •more likely to present early
- •higher levels of body dissatisfaction

Case 4
C is a 15 year old natal male

- • Long history of gender variant behaviour
- • Early preference to wear her hair long, dress in fairy dresses with wings and ballet shoes and play with toy ponies with long hair
- • Always loved to play dress up often mis gendered as female which she liked
- • Announced to her mother at 12 that she wondered if she could have a sex change operation in the next 12 months
- • Mother was not initially accepting
- • Sister was also not accepting
- • The only living other natal male sibling died of lymphoma when he was 17 years of age C was aged 5 and at the time another pregnancy of a male child was to miscarriage following C in her sibship
- • Mother reluctantly bought neutral clothes and woke up one day and realised she was not losing another child and then became C greatest advocate
- • C was to attend catholic boys schools but over the last three years has been very successfully home schooled and is in stealth as a female with her home school group
- • C presented as a tall attractive adolescent girl tolerant of her male genitalia but refused to look at herself in the bathroom mirror the only signs of puberty she acknowledged was hair beneath her arms

- • C presents with long curly hair make up and attractive glasses and long fashionable fingernails
- • C would sit with her legs crossed and her hands held in a feminine posture
- • C was not wanting fertility preservation and the thought of the procedure brought her tears
- • She was wanting breasts to facilitate her female appearance and wants reassignemt surgeries once she is 18 years old
- • A bright student with ambitions to do architecture

Management

- Lucrin last 12 months awaiting stage 2 affidavits were written but not needed and is now awaiting new protocols within the gender clinic to receive HRT
- Family therapy to address grief and resistance particularly of the older lesbian sister to accepting her transgender sister status
- C has not come out to her friends as transgender and how she is to cope when confronted by male peers her that find her attractive.

Case 5
N is a 15 year old natal male

- • Long standing history of gender variant behaviour
- • Socially transitioned in school and home
- • Was on spironolactone prescribed by a private provider and was referred to this clinic for Lucrin and possible gender affirming hormone treatment given her presentation
- • Youngest in a sibship of 4 children N the only child to her father her parents separated when she was young. N has 3 older half siblings and 2 other siblings from her step father's other marriages. N is fully accepted as female with all his family apart from her biological father who was described as a intimidating and rigid man, however as a large man and meat worker had done security work in LBGTI nightclubs
- • N describes always having girls as friends
- • Preschool put scissors down her pants and declared she wanted to be a girl
- • Aged six wore white heeled shoes and her older sister's nighties to bed
- • Wore her sister's and mother's make up and remembers loving a particular glitter eye shadow
- • Collected heeled shoes and told her father that these were Captain Feathersword boots from the Wiggles to disguise her desire for female shoes

Case 5 continued

- Bought wigs from cheap retail outlets
- Girls as friends and played with girl's toys including Barbie dolls and pony with long hair
- Collected jewellery and handbag accessories
- Preferred the Cat woman outfit over her Batman costume
- Upset if her mother bought her male clothes
- Teased for being a girl in primary school but with family support has good self-esteem and psychological resilience
- Attracted men in Grade 6-7 researched online and did not identify as a gay man but researched transgender female as her identity with her long history of gender variant behaviour and emerging gender dysphoria as an adolescent.
- Came out to friends in grade 8 and accepted and mother at aged 14 years of age then father after a period of depression with masculine changes with gender dysphoria with deepening voice, masculinisation of her face and jaw development
- Her face was very important to her identity with her focus with make up
- N was a very attractive female
- Feared she would become a man trying to look like a woman with advancing male puberty
- Researching feminisation facial surgery and removal of her Adam's apple after she is 18

- • Female name change at school, use of female pronouns and attends school as a female using female toilets
- • Period of depression improved with engagement with the Gender Clinic and social transition as female but increasingly anxious with masculinisation
- • No family history of mental health conditions
- • N presented as a tall very attractive feminine androgynous adolescent with a beautiful face wearing make up and male clothing to the initial clinic appointment which was difficult to tolerate given she was already socially transitioned as female in all settings

Case 5 continued

Management

- Recommended for Phase 1 treatment with Lucrin appointments made
- No need for family support or education at this time
- Anxiety was managed with the use of fluoxetine 20 mg daily for OCD type symptoms (switching on/off light switches
- At the third appointment in this clinic
- • N was dressed as male and short male haircut
- • Ceased his spironolactone
- • Does not want to go all the way with her / his transgender transition
- • The extent of the transition a client elects to take is entirely their choice
- • N explained he was now more comfortable being a boy which left his mother and family totally perplexed given his lifelong gender variant behaviour and successfully transition as a female over the previous two years
- • Support was given and the clinic's neutral and accepting stance was reinforced

- •N revealed in individual session his changing relationship with his father after a number of heart to heart conversation with him and his recognition of other male role models availed him of a different identity that he now felt comfortable to adopt
- •N father was seen as abusive and verbally threatening in child hood. He recalls fights and tension and was forced as his only child to have access when the father ignored N on access. Father may have bipolar disorder according to N
- •N stated he felt it was safer for him to be a female in his intact family and was bullied and coerced to have access with his father on access
- •N had a problem with this form of masculinity and men as threatening violent and unsafe whereas females were safer, nurturing and safe.
- •Left school and was planning to go to college to complete grade 11/12 with ambitions to pursue his interest in music and the arts rather than law.
- •N was declaring himself now as a gay or bisexual male
- After another three supportive psychotherapy appointments N was discharged as male on no treatment as he had stopped all psychotropic and gender related medication.

Case 6
G is a 16-year-old natal female

- • longstanding and persistent gender variant behaviour since the age of 4 years
- • Always being one of boys, played mainly with boys and have sleep overs with boys
- • Refused to wear dresses and showed a preference for male clothing
- • Cut his hair off at 14 years of age and announced to his parents that he was a boy
- • Parents fully supportive and believed their child was always trapped in the wrong body and recall throughout G's childhood that he would say he doesn't feel he is a girl
- • Body revulsion since the age of 12 with early puberty and this led to anxiety depression and DSH (superficial cutting)
- • No psychiatric issues since full social transition as male at school and home over the last two years. He has a strong desire to be male binds his chest and exclusively wears male clothing

- Strong desire to be male persistent discomfort at his female birth gender and a strong desire to rid himself of female secondary sexual characteristics with a desire to remove his breasts and stop his menstruation.

- Very supportive parents who formed a gender alliance community group and with the mother working in her child's school administration formed a transgender support group for students in a large country town high school
- G current good psychological health and absences of secondary psychiatric issues can be attributed to his family's highly attuned, informed, proactive and validating support for their transgender child

- G has had two relationships with two girlfriends as trans male and has needed support to deal with one of his girlfriends's parent's acceptance of his transgender status

- G presents as a solidly built male with a short cropped masculine haircut dressed in bulky shirts. He was a confident and articulate young man.

Management plan

- No need for family or psychiatry support
- Commencement of Lucrin on a 3 monthly basis
- Family Court preparation of affidavit for Stage 2 no longer necessary
- G will be one of first adolescents to receive Gender affirming hormone with the LCCH Gender Clinic

Case 7
L 13 year old natal female

- Attended an all girls private college since preparatory class
- F diagnosed with a brain tumor and seizures when aged 5 months old
- F died in 2016 after years of illness
- Bionic ear
- DSH with in 2015 that led to DSH
- Seen by the psychiatrist with concerns that his developmental assessments had not been comprehensively evaluated concerns that L demonstrated features of ASD
- Gender variant history was not particularly present from maternal reports

L continued

- **ASD features**

- L has been observed to not socially function in a socially appropriate at school or in the family
- Sit and say nothing in family functions then talk at length about his area of interests in a loud voice
- Few friends at school and try's and models social interaction in this setting

- L is observed to lecture or talk at others and his interactions lack the normal social reciprocity and conversational style of other family members or peers.
- L recalls that he has researched what questions to say to his current friend because he feared that he is bored of him. L asked this friend randomly and out of context, ' What would your dream home be like." . Although L found this in reflection funny and inappropriate, he acknowledges that in social situations he often does not know what to say and has gone online to explore questions to ask and engage his social contact and friends at school.

- L expressed a number of sensory sensitivities including tactile and noise sensitivities with low muscle tone that lead to problems with gait and inability to climb stairs at an early age.
- L has poor handwriting and has only recently mastered the use of cutlery.
- L has a good memory
- L's tactile sensitivities and to some extent his social oddity and separation anxieties has been expressed in him carrying a pet comfort object , Cheetah to school until grade 6 when a silk worm was replaced to enable L to self-regulate his anxieties and stress with the touch of this less intrusive soft object in the school.
- L has always had an interest in animals which he shares with his family. They have a dog cat and amassed 21 birds over the last twelve months. L likes animals and prefers them to people. L particularly likes the breed of Japanese dog, Shiba-Inu.
- L is interested in history in particular his favourite topics of historical interest have included, Alexander Hamilton the close associated of George Washington and Prussia.
- L has a strong interest in drama and performance

- L’s mother has described L to have increasing avoidance of social situations and is now reluctant to go into a shop and ask for something that he wants.
- L acknowledges that he is becoming socially avoidant and experiences increasing anxiety in some social situations. He has reported experiencing intense anxiety over a number of hours that he has labelled panic attacks.

- ASD was diagnosed for the first time in the Gender Clinic and was screened by our Speech Pathologist who detected higher level language impairments and suspected ASD along with other clinic staff
- Delay in detection of ASD may have arisen with the preoccupation with the father' s illness and death throughout this child's development.
- Psychiatric issues
- Anxiety in social settings and the development of school refusal with social difficulties arising from ASD and gender identity issues in an all girls school.
- L became distressed and depressed with the realisation that he not only had the social difficulties of gender identity issues but now ASD.
- Managed with psychology support and pharmacotherapy with fluoxetine and Quetiapine
- Change of school was finally encouraged

- Referral to private Speech Pathologist for social skills training and learning support
- Referred to a psychologist with transgender experience and ASD for anxiety management
- L was encouraged to attend Jellybeans and other LBGGTI groups with Relationships Australia
- • L then presented with the following psychological phenomena
- • L has described having a number of people inside his head. These four personas consist of
- C, a gay man with HIV who is angry;
- R , an angel like character who is protective of all the other personas;
- V1, A man who likes sex; and finally
- V, who is wanting a physical form such as his own physical body to express himself.
- L was presenting with escalating and more elaborate identity-based psychopathology to cope with his inner dysphoria and self-loathing as evidence by the characters or persona he describes in himself that reflect his inner world of anger and rebellion of social stereotypes.

- L stated that had a new persona, a bi pedal wolf called “Dakata” a big strong dog that can’t speak English that is looking for his family to find where he fits in. This is clearly psychological phenomena that is a metaphorical representation of L’s need to find his social group that he fits into, and his desire to be accepted and validated by his peers that has not been possible in his private elite girls only college.

- L continues to present as a socially odd ASD transgendered adolescent who discusses his issues in the psychodrama of his various personas that dramatically and metaphorically communicate core social and personal identity issues that requires an integrative and containing approach with all therapeutic endeavours with L on an individual basis. L does not have (Dissociative Identity Disorder or prodromal psychotic illness). I have discussed this approach with the speech pathologist and psychologist that see L for support.

- Not psychotic or DID , mood and content congruent with L's identity issues and are described by treating clinicians as " Head mates" to integrate and contain L's need to startle and attention seek. In the context of his anxieties and possible depersonalisation and dissociation with his ASD and Gender Dysphoria

Autism

- In a young person with developmental challenges could be theorised that gender identity formation process may be slower or different. ASD youth often present later to gender clinics with a shorter history, ‘atypical’ or no history of gender variance
- Whilst gender identity is ‘brain based’ we need language to describe gender identity and the ‘social rules’ of gender expression are socially constructed and culturally influenced. Core challenges in ASD
- Individuals with ASD have the same rights as other individuals to appropriate assessment and treatment of gender-related concerns.

Autism Spectrum Disorder

- **A Persistent deficits in social communication and social interaction across multiple contexts as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive)**

  - 1.Deficits in social reciprocity, ranging for example, from abnormal social approach and failure of normal back and forth conversation, to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
  - 2.Deficits in non-verbal communicative behaviours used for social interaction ranging for example from poorly integrated verbal and non-verbal communication, to abnormalities in eye contact and body language, or deficits in understanding and use of gestures; to total lack of facial expressions and non-verbal communication.
  - 3.Deficits in developing, maintaining and understanding relationships ranging for example from difficulties adjusting behaviour to suit various social contexts; to difficulties in sharing imaginative play making friends; to absence of interest in peers.

- *Specify current severity:*

  Severity is based on social communication impairments and restricted, repetitive patterns of behaviour.

- **B. Restricted, repetitive patterns of behaviour, interests or activities, as manifested by at least two of the following, currently or by history (examples are illustrative not exhaustive)**
  - 1.Stereotyped or repetitive motor movements, use of objects, or speech e.g. simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
  - 2.Insistence on sameness, inflexible adherence to routines or ritualized patterns of verbal or non-verbal behaviour (e.g. extreme distress at small changes, difficulties transitions, rigid thinking patterns, greeting rituals, need to take the same route or eat same food every day).
  - 3.Highly restricted, fixated interests that are abnormal in intensity or focus (e.g. strong attachment to all preoccupation with unusual objects, excessively circumscribed or perseverative interests).
  - 4.Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/ temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement)
- *Specify current severity:*

  Severity is based on social communication impairment and restricted repaired achieve patterns of behaviour

- **C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life).**

- **D. Symptoms cause clinically significant impairment in social occupational important areas of current functioning.**

- **E. These disturbances are not better explained by intellectual disability (intellectual development disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur to make comorbid diagnosis of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.**

- Note. Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

- Specify if:
- • With or without accompanying intellectual impairment.
- • With all without accompanying language impairment.
- • Associated with a known medical or genetic condition or environmental factor. (Coding note: use additional code to identify the associated medical).
- • Associated with another neurodevelopmental, mental, or behavioural disorder. (Coding note: Use additional codes to identify the associated neurodevelopmental, mental, or behavioural disorder).
- • With catatonia. (Coding note: Use additional code 293.89. Catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia).

Challenges:

- Rigidity and concrete thinking styles in gender understanding and exploration, preoccupations and obsessions, ‘not fitting in’ especially in puberty, sexuality and gender confusion linked with limited social exposure/exploration
- Implications for gender
- Do gender concerns in neurotypical (or all) children prior to puberty represent a developmental process related to both gender and sexuality?
- It is possible that individuals with ASD may follow a different timeline than neurotypical individuals owing to reduced social interaction and fewer opportunities to explore their sexual identity
- Longer and more specialised/tailored support process for health decision making

- Earlier referral to gender services of an ASD child may be helpful. Support that includes activity vs language, visual tools, scaffolding of expression, specialist speech language input to facilitate a child's own gender narrative may be required. Education about sexuality, adapted sex education may be of value given findings that many children with childhood gender variance eventually identify with their assigned gender at puberty and may identify as sexuality

ASD and GD

- High rates of ASD in Gender Clinic Populations Slagberg, Ceglie and Carmichael 2015 JADD 45 (8)

- London Clinic for GD
- Screened 166 new referrals for ASD
- Mean age is 14 years of age
- Half had autistic features and half of these had not previously been diagnosed with ASD

- Reasons for higher rates on gender identity in ASD

- To find a community or tribe
- To solve a problem of ASD Tomboy Girls/ Boys finding support and friendships with girls Bullying social isolation A special interest factual knowledge Sexual assault: safer to change gender

ASD Girls

- Boys just want to have fun and don't have social rules
- Gossipy
- Don't like girl things
- Identify as gender neutral
- Like to play with trains lego building blocks
- Boys are logical girls are complicated and unkind in ways I don't understand

- Females 92% feel more the opposite sex
- Mechanically inclined logical not obsessed with appearance are not over dramatic prefer debate to gossip
- A high level of androgyny

- Increased Foetal testosterone allegedly create a male brain may in part explain ASD and GD in woman but not ASD men

ASD Boys

- Girls seem to have more friends
- Girls are kinder to each other
- Girls can nurture and care for me I want ti be like them

- ASD boys shy submissive and introverted don’t like dirt on their hands vulnerable and prefer intellectual pursuits

- These psychosocial explanations do not explain that for a socially disabled adolescent the choice of another gender variance to their biological assigned gender could in fact worsen underlying ASD factors

ASD Gender Sexuality differences

- Sexuality and gender identity may be delayed
- Socially limitation to have a romantic experience
- Social cues of flirting no aware or skilled
- Don’t pick on signals of mutual attraction
- Intimacy is delayed
- Sexual orientation diversity
- ASD males and females less heterosexual more homosexual bisexual or asexual
- Rate is ASD group 73 %
- GD around 18%

Do ASD patient have greater psychiatric morbidity than no ASD GD clients or does ASD protect them from social issues in GD

- ASD struggle more to understand their gender and sexuality greater rates of psychiatric morbidity
- Autism underpinned their difficulties

In ASD

- 71% describe as non binary
- Conceptual confusing

Long term follow up of ASD and GD

- Early research finding suggest ASD are less persistent in their gender identity than non ASD clients in a GD clinic
- Research is clearly required
- Are the non binary choices greater or less in ASD population arising from ASD individual not identifying with either stereotypical male or female gender stereotype.
- Does the black and white single minded thinking of ASD mean they in fact are more binary than non binary. Researched is clearly needled in this important subgroup of the GD population.

Case 8
S is a 12 year old natal male

- Initial psychology screen by allied health staff including the speech pathologist raised concerns that this patient had feature of ASD
- S described social difficulties with friends and cried
- Could initiate but not hold onto friends
- Spoke in a polite and formal manner
- Wanted to be a girl because they are kinder and seem to have and hold more friends than boys that he found rejected him after a period of time
- “ If I was a girl I would have more friends “
- S desire to be a girl arose from his need to have friends and be accepted in the context of his lifelong social skills deficits and impaired social functioning.

- S was unable to articulate any other benefits of his desire to be female,
- S was not able to describe any revulsion of his male body and his choice to do female things was to have connection with others rather than an expression of an innate sense of his gender preference.
- S seemed perplexed when this author tried to explore his inner sense of his gender.
- S sense of gender was around social connection and friendships. His preference for female activities was a way to develop connection.
- S has anxiety and mood disturbance secondary to his social difficulties and he internalises his distress. His reported initial ADHD symptoms at the commencement of school may in fact have been anxiety expressed as inattention and distractibility.
- S was described by both his parents to have longstanding interpersonal social difficulties throughout his childhood.

- S was observed to have limited or little to poor eye contact as a young child and still needs to be directed by his parents to look them in the face.
- S has been observed to have an inability to understand the social appropriate timing of his responses and appear socially to impact of his behaviours on others. Mother recalled again to this author that S approached her for a hug when she was holding a hot saucepan in the kitchen and became upset when she could not respond. He also would close the door on friends who came over to invite S to play and seemed not to understand the socially inappropriate nature or rudeness of his social response in this situation or the longer-term impact this would have on his friendship.

- S is aware he struggles to hold and sustain friendships.
- He has two friendship groups. In his local neighbourhood, the mother has observed that other neighbourhood children play with S because there are limited alternatives. S and his family live in a neighbourhood where there are a lot of army children that's come and go with their family army relocations. S is sensitive to the frequent move of children. He complains he can make friends but he can not maintain friendships.
- S tends to have a few friends at school and again find that friends become disinterested in him in time
- S has shown interests in particular subjects through-out his life that come and go.
- S has been observed to not know not to talk incessantly about his current topic of interest and the mother recalls that he will talk at her in the car when she clearly showing nonverbally that she no longer wishes to discuss the topic that absorbs him.
- The mother also reports that Spencer at time appears to have an accent with certain words but denied that he spoke like a "little professor" or in a formal prosodic manner which was this author impression of S on interview.
- Spencer is a good drawer and will occupy himself with drawing around his area of interests.
- S is not as skilled with gross motor functioning he needs to be explained how to do push ups and is poorly co-ordinated.
- After taking a detailed developmental history its my opinion that S fulfils the diagnostic criteria of ASD level 1 (Formerly described as Asperger's Syndrome)
- S currently did not fulfils the diagnosis of Gender Dysphoria in Childhood

Case S

Proposed assessments

- 1. Referral to Speech Pathologist for speech and language assessment to be conducted under the initial Medicare Item 296. These assessments are to clarify and elucidate S higher level language deficits and how these impairments affects his semantic and pragmatic language functioning.
- 2. Referral for occupational therapy assessment. This assessment is to establish a sensory profile to better understand S sensory issues that may underpin his behaviours, and establish ways he can self regulate his anxiety and mood disturbances with his social communication and adaptive impairments in the context of his ASD. The initial occupational therapy assessment are to be conducted under a GP generated EPC programme that should entitle Spencer to an initial 5 sessions in the next twelve months.
- 3. The psychiatrist generated Medicare item 289 (conducted today) will entitle S to 20 sessions of allied mental health care throughout his life. It is recommended a share of these sessions be used for social skills training and support with the speech pathologist and possibly for further occupational therapy sessions if required.

Case S continued

- EAP Educational Ascertainment Programme forms for school funding are yet to be documented.
- Mother will obtain this documentation from S's school for Dr. Ross to sign.
- Additional programmes discussed
- 1. Secret Agents Society (A family based social skills programme for children and younger adolescents with ASD)

Additional services discussed.

- Minds and Hearts (A private clinic for children and adolescents with ASD)

- S has not worn his female clothes for a period and he states that he does not really think about being a girl much anymore only every now and again.
- S was glad his puberty was starting and was not feeling any body revulsion that he was becoming a male.
- S was anxious about starting his new high school and having friends.

Case 9
FT 15 YR Natal male

- FT is a 15 year old natal male indigenous Brother Boy in care living in a residential in a rural provincial town interstate
- wears a binder and prefers male name and pronouns
- A very difficult historian with understandable trust issues who did no disclose to gender clinic staff his earlier child hood or adolescent gender variant behaviour because of transphobic reactions in his kinships placement
- Born with maternal substance abuse and opiate withdrawal removed from mother's care at 10 months
- 37 failed placements due to externalising behavioural issues

- Gender variant history finally obtained
- Was to be seen at an interstate Gender Clinic but was relocated by DOCS
- Disclosed to an aunt at a young age he was a boy
- Steal and wear his brother’s clothes in childhood
- Asked his carers not to buy female clothes
- Displayed in his bedroom of him being a boy photographs
- Increased dysphoria with the onset of puberty
- Anger when misgendered as female and his former female name was used.

- Wanting to stop periods and remove his breasts and wants to use testosterone to develop male secondary sexual characteristics such as a beard, deeper voice and male body shape
- Greater complexity in establishing obtaining consent for stage 1 Lucrin with children in care
- Referral to the endocrine team was made and FT was started in Lucrin
- Diagnostic considerations in the past have included ASD (Highly unlikely in the context of how FT presents during this consultation and his strong early history of trauma and intrauterine exposure to substance abuse by his biological mother.
- FT has said to have communication difficulties and developmental language disorders which is more plausible in the context of his earlier trauma.
- FT clearly fulfils the diagnosis of Reactive Attachment Disorder.