Gender identity disorder presenting in a girl with Asperger's disorder and obsessive compulsive disorder

H Perera[1], T Gadambanathan[2] and S Weerasiri[3]

Introduction

Gender identity refers to an individual's sense of being male or female. It is typically established by the age of 3 or 4 years (1). Gender identity disorder (GID) is defined as behaviour that signifies cross gender identification. In children and adolescents, GID presents as persistent and intense desire to be the other sex (2). Some associated behaviours include an aversion to the same sex, and a preference for cross gender clothing, toys, peers and role play.

Case report

We report a case of GID in a girl who was followed up as an outpatient from the age of 9 years. Initially the main complaint by the parents was her socially awkward behaviour that had persisted for over a year. This included laughing or talking to herself, repeatedly asking irrelevant questions, displaying odd mannerisms and frequent physical aggression, with disregard to situations and the presence of outsiders. A behaviour that caused much distress to the parents was her habit of suddenly bending down and licking the floor, sometimes even inside a bus. It became evident later that this was triggered by a recurring intrusive and irrational thought that her parents would suddenly die and that she would be left on her own. There were other problems such as not having any friends and rejection of peer group activities. Restlessness in the classroom and lack of cooperation were the complaints from her teacher. Despite all these problems, she was a high achiever in school work and was particularly talented in drawing.

At about 14 years she began insisting on being a male and deeply resented any reference to her as a female. There were instances of physical violence towards persons who tried to reason with her on this issue. After menarche a year later, she rejected all medication, believing that these were given to induce menstrual periods. She demanded immediate referral for sex reassignment surgery and hormonal treatment. There was no cross-dressing but she attempted to hide her breasts by adopting a hunchback posture.

In addition to the diagnosis of GID, persistent irrational thoughts and associated rituals justified a diagnosis of obsessive compulsive disorder (OCD). Her persistent characteristics of poor social interaction and other behaviour patterns supported a diagnosis of Asperger's disorder (2). Of the drug treatments she received, the response to haloperidol was variable but a significant improvement in OCD was obtained with clomipramine. Drugs did not have any impact on the distress about her assigned sex. Throughout her contact with us, poor compliance in keeping clinic appointments and taking medication was a major challenge to management. Now at 20 years, she still has OCD but less overt features of GID. Currently, she is preoccupied about the GCE Advanced Level examination and has already missed one attempt because of excessive anxiety, doubts and low confidence.

Discussion

We could not find any previous documentation of GID associated with Asperger's disorder and OCD in children and adolescents. A single case report that resembles our patient to some extent is that of a high functioning autistic female adolescent with transexualism (3). Our patient also wished to live the life of a male (transexualism), though her age did not permit such independence. Adults with OCD and GID have been reported (4) but not children or adolescents. In cases with both diagnoses, the primary diagnosis is more likely to be OCD than GID (1,4).

Hence, it is possible that the gender identity problem in this patient represented psychopathology of OCD, though lack of response to medication is not explainable. It is likely that the presence of Asperger's disorder complicated the clinical picture. These issues have implications for continued drug treatment and the management of possible future demands for sex reassignment. Other case reports on GID have indicated an association between sex chromosomal abnormalities and GID (5) but we have not established the karyotype in our patient.

References

1. Bradley SJ, Zucker KJ. Gender identity disorder: a review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry* 1997; **36**: 872-80.

[1]*Senior Lecturer, Department of Psychiatry, Faculty of Medicine, University of Colombo,* [2]*Senior Registrar in Psychiatry,* [3]*Registrar in Psychiatry, National Hospital of Sri Lanka, Colombo 8. (Correspondence HP, telephone + 94 1 695300.*
Received 22 February, accepted 5 March 2003).

2. Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association. Washington DC, 1994.

3. Landen M, Rasmussen P. Gender identity disorder in a girl with autism – a case report. *European Child and Adolescent Psychiatry* 1997; **6**: 170-3.

4. Abdo CH, Hounie A, de Tubino Scanavino M, Miguel EC. OCD and transvestism: is there a relationship? *Acta Psychiatrica Scandinavica* 2001; **10**: 471-3.

5. Turan MT, Esel F, Dundar M, Candernir Z, Basturk M, Sofuoglu S, Ozkul Y. Female to male transsexual with 47XXX karyotype. *Biological Psychiatry* 2000; **48**: 1116-7.