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Article *in* Journal of Homosexuality · April 2021

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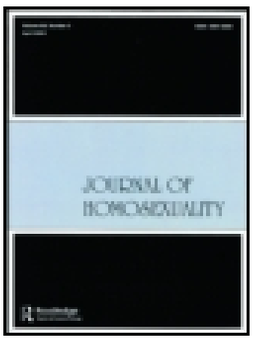

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Journal of Homosexuality

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wjhm20

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To cite this article: Alexandro Fortunato, Guido Giovanardi, Eleonora Innocenzi, Marta Mirabella, Giorgio Caviglia, Vittorio Lingiardi & Anna Maria Speranza (2021): Is It Autism? A Critical Commentary on the Co-Occurrence of Gender Dysphoria and Autism Spectrum Disorder, Journal of Homosexuality, DOI: 10.1080/00918369.2021.1905385

To link to this article: https://doi.org/10.1080/00918369.2021.1905385

Published online: 14 Apr 2021.

JOURNAL OF HOMOSEXUALITY
https://doi.org/10.1080/00918369.2021.1905385

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Is It Autism? A Critical Commentary on the Co-Occurrence of Gender Dysphoria and Autism Spectrum Disorder

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ABSTRACT

An increasing amount of literature revealed a link between GD and ASD. Both GD and ASD are complex and heterogeneous conditions characterized by a large variety of presentations. Studies have reported that individuals with GD tend to have higher prevalence rates of autistic traits in comparison to the general population. The purpose of this commentary is to provide, through the description of a clinical case, our reading and a possible interpretation of the correlation of these two conditions in light of the several methodological limitations found in literature. We hypothesize that the traits often classified as autistic could be more accurately related to the distress and discomfort evoked by GD. The autistic traits of individuals with GD as forms of psychological defenses and coping mechanisms aimed at dealing with socio-relational and identity problems are discussed.

KEYWORDS

Gender dysphoria; autism spectrum disorder; co-occurrence; critical aspects; treatment; gender diversity; assessment

> Most people have (with the help of conventions) turned their solutions toward what is easy and toward the easiest side of the easy; but it is clear that we must trust in what is difficult; everything alive trusts in it, everything in Nature grows and defends itself any way it can and is spontaneously itself, tries to be itself at all costs and against all opposition. We know little, but that we must trust in what is difficult is a certainty that will never abandon us.
>
> (Rainer Maria Rilke, *Letters to a young poet*)

When Angela was 13 years of age, her parents took her to therapy after an evaluation indicated that she had strong withdrawal traits, selective interests, obsessive thoughts, limited and selective communication, bizarre behavior, and little interest in and avoidance of both familiar and social relationships. Angela's experience of puberty was traumatic, and she had since concealed her body under shapeless clothes and did not perceive herself as a female. The evaluation, which was conducted at a psychiatric hospital using the Autism Diagnostic Observation Schedule (ADOS; Lord

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et al., 1989), revealed that she had autism spectrum disorder (ASD) in comorbidity with gender dysphoria (GD).

Although Angela had a young, round, sweet face, her body was concealed and camouflaged by large clothes. When she sat down, she swaggered and sat with her legs apart in a caricatural masculine manner. Her posture and the way she sat on the chair appeared to be relaxed; however, in reality, she was rigid. She kept her eyes fixed on the therapist. When Angela began to speak, a sweet voice was emitted from a display of masculinity that endeavored to be strong in every aspect. The therapist felt unsettled and paralyzed. He experienced in his body Angela's profound suffering.

Introduction

During the last two decades, a new research field related to the co-occurrence of GD and ASD has emerged (for a recent review, see Øien, Cicchetti, & Nordahl-Hansen, 2018).

ASD, a neurodevelopmental disorder with multifactorial etiology, is characterized by severe impairment of social interaction and communication, the presence of repetitive and restricted patterns of behavior, and a serious impairment of family functioning (American Psychiatric Association [APA], 2013; Zero to Three, 2016). GD is defined as an incongruence between an individual's gender identity and gender assigned at birth. It may cause significant discomfort and may require clinical attention. It is a heterogeneous and dimensional condition characterized by varying intensities and features depending on the individual (APA, 2013).

Currently, the constellation of autistic symptoms is classified in a single diagnostic category, namely the spectrum, which must be adapted in a dimensional sense to the peculiarity of individual clinical manifestations through the inclusion of clinical indicators including the severity level and verbal skills, as well as associated characteristics such as genetic disorders, epilepsy, and intellectual disability (APA, 2013). A revision of the condition's diagnostic criteria has been imperative because of its various features and to arrive at an accurate and specific diagnosis. However, despite the changes made to the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013) and Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (CD:05; Zero to Three, 2016), which were aimed at major specificity, a univocal definition of ASD remains complex. Clinicians have to deal with a large number of different features of ASD that often co-occur with other conditions. Therefore, a precise clinical definition of ASD is lacking, and a consequent significant risk of experiencing false positives remains (e.g., Monteiro et al., 2015). For instance, using the ADOS the risk

for the occurrence of false positives has been calculated to be 52 per 1000 children tested (Randall et al., 2018).

Similarly to ASD, previous to the definition of the DSM-5, numerous variations in the diagnostic field of GD were made. Recently, the International Classification of Diseases 11th Revision (ICD-11; World Health Organization [WHO], 2018) introduced various relevant changes. First, the new term "gender incongruence (GI)" was employed instead of GD, used by the *DSM-5*. Besides the change in terminology employed by the *ICD-11*, GI is no longer classified as a mental disorder but has been classified in a new section on conditions related to sexual health that also includes sexual dysfunctions and sexual pain disorders (WHO, 2018). The permanence of this condition in the diagnostic manuals, which has been widely debated, was nevertheless approved in relation to the state of discomfort and suffering that individuals experience in relation to their sexuality and gender roles.

Several studies have investigated the possible link between GD and ASD and the consequences thereof in relation to assessment and treatment. The approach employed to study this co-occurrence has been two-fold. Various studies (e.g., Akgül, Ayaz, Yildirim, & Fis, 2018; De Vries, Noens, Cohen-Kettenis, Van Berckelaer-onnes, & Doreleijers, 2010; Di Ceglie, Skagerberg, Baron-Cohen, & Auyeung, 2014; Heylens et al., 2018; Jones et al., 2012; Kristensen & Broome, 2015; Mahfouda et al., 2019; Pasterski, Gilligan, & Curtis, 2013; Shumer, Reisner, Edwards-Leeper, & Tishelman, 2016; Shumer, Roberts, Reisner, Lyall, & Austin, 2014; Skagerberg, Di Ceglie, & Carmichael, 2015; VanderLaan, Leef, Wood, Hughes, & Zucker, 2014; VanderLaan et al., 2015; Van der Miesen, Hurley, & De Vries, 2016; Vermaat et al., 2018; Zucker et al., 2017) have examined the presence of autistic traits in transgender samples and revealed impairments in participants' social functioning including difficulties in relationships with peer and family members, isolation, problems with social and emotional communication, and repetitive interests and stereotypies of a certain intensity. These studies found that individuals with GD tend to have higher prevalence rates of autistic traits in comparison to the general population. Moreover, two recent studies explored the co-occurrence of ASD traits and GD/Gender Variance (GV) in very large samples: the first by Hisle-Gorman et al. (2019) on a population of 292,572 children, finding that children with ASD were over four times as likely to be diagnosed with a condition indicating GD; the second by Warrier et al. (2020) investigated an even larger sample (more than 600,000 individuals) and found that transgender and gender-diverse individuals scored significantly higher on self-report measures of autistic traits, systemizing and sensory sensitivity and scored significantly lower on empathy traits compared to cisgender individuals.

Gender variance (GV) has also been explored in populations with ASD (e.g., Cooper, Smith, & Russell, 2018; Janssen, Huang, & Duncan, 2016; Lai et al., 2016; May, Pang, & Williams, 2017; Strang et al., 2014; Van der

Miesen, Hurley, Bal, & De Vries, 2018). The latter studies have revealed that in ASD populations there is an increased wish to be of the opposite gender, often assessing GV using a single item of the CBCL (Strang et al., 2014; Van der Miesen et al., 2018). In this commentary, we have focused on the former group of studies, which explored the critical aspects of some traits regarded as *autistic*, which in our opinion, are involved in the distress related to GD.

Critical aspects of the co-occurrence between ASD and GD

Recently, Turban and van Schalkwyk (2018) noted some critical aspects of the aforementioned studies as the risk of interpreting communicative and relational difficulties as autistic traits, which may be related to several other disorders that are not caused by neurodiversity but rather by stigma and social isolation. A debate among some of the authors of the studies and Turban and van Schalkwyk ensued. Within the generated debate, Strang et al. (2018) and Van der Miesen et al. (2018) stated that in studies conducted on participants with GD, they experienced not only relational and social difficulties but also repetitive interests and behaviors; characteristics associated specifically with ASD. In their response, Turban and van Schalkwyk cited previous research (e.g., Halls, Cooper, & Creswell, 2014) that demonstrated that the repetitiveness and intensity of certain attitudes and interests have also been found in those with social anxiety disorder, which is very common among transgender individuals.

Turban and van Schalkwyk also highlighted another critical point in the studies conducted on the correlation between GD and ASD, namely the use of non-diagnostic tools to detect GD. The two authors specifically questioned the reliability of the use of only one item (no. 110) of the CBCL (e.g., VanderLaan et al., 2015; Zucker et al., 2017) and stated that it was not sufficient to formulate a diagnosis of GD as the item merely provides a purely categorical answer and makes no endeavor to evaluate the true core of gender identity. Van der Miesen et al. (2018) agreed with this observation but noted that GV is represented well by this item. From a theoretical point of view, as Olson (2016) points out, the "wish" to be of the opposite sex (caught by the CBCL item 110) is distinct from the "affirmation" to be of the opposite sex, and thus this item could not be an accurate criterion to detect GD.

It should be noted, moreover, that most of the studies on the co-occurrence between GD and ASD lacked of control groups: many used prevalence estimates from the general population to do their comparisons.

In accordance with Turban and van Schalkwyk, we explored two primary critical aspects of the co-occurrence between GD and ASD: the complexity of the diagnoses/assessments and associated conditions to GD and ASD.

The first critical aspect, which is linked to the problem of the specificity and diagnostic accuracy of ASD and GD, is concerned with the oversimplification of the diagnosis of the two conditions.

Both ASD and GD are complex and heterogeneous conditions that are marked by a large variety of presentations. In recent years, there has been a significant increase in both conditions throughout the world. At present, the estimates of ASD frequency are between approximately 1% and 2.6% (APA, 2013; Atladottir et al., 2015) with 1 out of 68 cases in the United States of America (Zero to Three, 2016). Currently, it is not clear whether the increase is linked to an actual increase in cases or to the widening of the criteria, which currently include cases that were previously under-threshold, or to the refinement of diagnostic tools. Similarly, the number of people who have been referred to gender identity clinics has increased exponentially during the last few decades. A survey of the Center of Expertise on Gender Dysphoria of Amsterdam revealed that the number of people assessed per year increased 20-fold from 34 in 1980 to 686 in 2015 (Wiepjes et al., 2018). The Gender Identity Development Service (GIDS) in London, the largest in the world for gender variant minors, witnessed an increase from 51 referrals in 2009 to 1,766 in 2016 (De Graaf, Giovanardi, Zitz, & Carmichael, 2018). Reasons for this increase are much debated (Zucker, 2019), but it is likely that now that society became more accepting, more people are identifiying as transgender or non-binary, fewer are closeted. This worldwide increasing trend of referrals in specialized centers also revealed an increment in the variety of trans youth gender presentations. At present, the gender identities spectrum includes different types of experiences including gender neutrality, gender fluidity, and people identifying as bigender, pangender, and trigender (Barker & Richards, 2015; Matsuno & Budge, 2017; Scandurra et al., 2019). Furthermore, there is broad heterogeneity of the developmental paths of transgender youth: Some only perform the social transition without employing services; some undertake only hormonal therapy and do not perform gender-affirming surgery; and others complete the process so as to identify themselves in a binary perspective. Much is dependent on the age and stage of development during which the onset of GD occurs, more specifically childhood, adolescence, or adulthood. Therefore, it is very difficult to describe GD as a univocal phenomenon. Furthermore, organic and genetic components are not yet completely clear for both conditions. Although genetic and neurodevelopmental factors in conjunction with psychosocial factors probably contribute to GD, the causal mechanisms thereof are not understood in their entirety (Kreukels & Guillamon, 2016; Zucker, Wood, Singh, & Bradley, 2012). Some studies have suggested that the brain activity and connectivity of those with GD differ in comparison to those of cisgender individuals. The brain structures and patterns of transgender individuals are more similar to those of individuals of their experienced gender than to those of their natal sex (e.g., Uribe et al., 2020; for a recent review, see Polderman et al., 2018). Twin studies have revealed an increase in transgender identities among monozygotic twins in comparison to dizygotic

twins (e.g., Heylens et al., 2012). However, these studies are limited by many people not disclosing their gender diversity due to stigma. They also have used diverse inclusion criteria that do not necessarily measure that someone is transgender or has GD (e.g., one study uses an only DSM-IV-based scale where you can meet criteria while still identifying as cisgender, which you cannot do with the DSM-5 criteria for GD). In addition, a series of genes involved in sex hormone signaling that may alter the sexual differentiation of the brain *in utero*, thus contributing to the development of GD, has been found in transgender women (e.g., Foreman et al., 2019). On the contrary, several ASD susceptibility genes have been identified during the past decade, collectively accounting for between 10% and 20% of ASD cases. However, the remaining portion of ASD cases leaves the question of the genetic component unanswered and demonstrates that ASD is an etiologically heterogeneous condition. Studies on twins have revealed that there is a higher incidence of ASD among monozygotic twins and that parents with an autistic child may have another child with this disorder (for a review, see Tick, Bolton, Happé, Rutter, & Rijsdijk, 2016). Finally, first-degree relatives of subjects with ASD seem to be more exposed to the risk of developing relational and communicative difficulties in comparison to those who are not related to them (Bishop, Maybery, Wong, Maley, & Hallmayer, 2006; Ronald et al., 2006). Several alterations in brain circuitry have been found or hypothesized in children with ASD, which include a reduction in activity in the fusiform gyrus, superior temporal sulcus, dorsomedial prefrontal cortex, amygdala, and insula. These are areas implicated in social cognition, recognition of human faces, and in the theory of mind (Baron-Cohen, 1999; Castelli, Frith, Happé, & Frith, 2002; Dapretto et al., 2006; Hirstein, Iversen, & Ramachandran, 2001). Finally, no studies have established any psychosocial determinants of GD (see Turban & Ehrensaft, 2018).

It is evident from a consideration of these complex aspects that the assessment of both ASD and GD should be accurate and comprehensive. An assessment of ASD should not only be limited to the use of a self-report that cannot grasp and convey the complexity of the diagnosis but should also include clinical observations and diagnostic interviews. It is also imperative to refer to the clinician's experience and sensitivity. Furthermore, the clinician should possibly be trained specifically to diagnose and treat ASD (Frigaux, Evrard, & Lighezzolo-Alnot, 2019; Lingiardi & McWilliams, 2017). In relation to GD, it may be very difficult to distinguish a general GV from a proper GD, especially in childhood and before puberty (Drescher & Pula, 2014). Several psychodiagnostic sessions may have to be conducted with a young person and his/her family.

Therefore, an evaluation of the evidence of the co-occurrence of these two conditions with the use of self-report or parent-report checklists (e.g., VanderLaan et al., 2015; Van der Miesen et al., 2016; Zucker et al., 2017) could be indicative of a limited assessment. Various (Akgül et al., 2018;

Heylens et al., 2018; Mahfouda et al., 2019; Shumer et al., 2014; Skagerberg et al., 2015; VanderLaan et al., 2014) have employed the Social Responsiveness Scale (SRS) (Constantino & Gruber, 2005). The instrument has been used extensively to detect autistic traits. However, if used singularly, the SRS is not sufficient for formulating a diagnosis because its purpose is to detect behavioral problems that are present in numerous disorders (e.g., Cholemkery, Mojica, Rohrmann, Gensthaler, & Freitag, 2014). Rather, the SRS should be used in conjunction with more specific and widely utilized tools for ASD (Randall et al., 2018) including the Autism Diagnostic Observation Schedule (ADOS; Lord et al., 1989) and the Autism Diagnostic Interview—Revised (ADI-R; Lord, Rutter, & Le Couteur, 1994; Randall et al., 2018).

Finally, we are of the opinion that determining the presence of a co-occurrence between these two conditions is difficult because of the extensive range of comorbidities ASD and GD both present. The comorbidity between ASD and other disorders is fairly high. Problems related to language development and movement such as delays, an abnormal gait and/or clumsiness are common. Problems related to anxiety, depression, hyperactivity or distractibility, learning, sleep, feeding, negative affect and self-harm may occur (APA, 2013; Zero to Three, 2016). Because the co-occurrence of so many pathologies is common, we are of the view that the association of ASD with another complex diagnosis such as GD, which comprises several aspects of distress that overlap with other conditions including anxiety and depression, poses a theoretical issue. For instance, it is possible that when ASD traits are assessed with questionnaires or parent-reports, the assessment unveils pathological aspects which may better be comprised as internalizing psychological problems (i.e. anxiety and depression), which, for people with GD, literature highlighted that are mostly secondary to minority stress (e.g., Olson-Kennedy, 2016; Olson-Kennedy et al., 2016). Indeed, GD often co-occurs with other problems both during development (Ristori & Steensma, 2016) and adulthood (Dhejne, Van Vlerken, Heylens, & Arcelus, 2016). Becerra-Culqui et al. (2018) revealed that among children and adolescents with GD the most common categories are internalizing conditions, which include anxiety disorders and high levels of depression; the latter is particularly prevalent during adolescence. With respect to externalizing behavior, research has demonstrated that trans children and adolescents present disruptive disorders because they suffer from bullying and harassment frequently because of their gender nonconformity (Levitan, Barkmann, Richter-Appelt, Schulte-Markwort, & Becker-Hebly, 2019). However, associated psychopathologies vary a great deal among studies (e.g., De Vries & Cohen-Kettenis, 2012; Reisner et al., 2015; Ristori & Steensma, 2016), thus indicating a high variance in the comorbidity with other disorders, with a range varying between 12% and 64% (Chiniara, Bonifacio, & Palmert, 2018). Several studies have highlighted the central role of body dissatisfaction (Jones, Haycraft, Murjan, &

Arcelus, 2016; Mirabella et al., 2020; Turan, Poyraz, & Duran, 2015; Turan et al., 2018; Witcomb et al., 2015) and eating disorders (Ålgars, Alanko, Santtila, & Sandnabba, 2012; Ewan, Middleman, & Feldmann, 2014; Hepp & Milos, 2002) in the distress suffered by individuals with GD.

It is important to emphasize that the cited studies have revealed that many of these psychopathological aspects related to anxiety, depression, and body dissatisfaction are characteristics found in gender variant individuals with ASD (e.g., Van der Miesen et al., 2018).

The clinical account presented at the beginning of the article is subsequently discussed. The therapeutic work with Angela highlighted the inconsistency of an initial ASD diagnosis and helped to frame the adolescent's difficulties in the context of severe dysphoria related to gender, accompanied by a sense of isolation and lack of parental mirroring.

The case of Angela/Oscar[1]

After a few initial psychotherapy sessions conducted with the whole family, the therapist, a cisgender male, decided to refer the parents to a colleague so as to conduct therapy in separate settings. In the case report, the feminine pronoun is used when the patient used it but is changed to the masculine pronoun from the moment the patient asked to be called Oscar.

At the beginning of the therapy, Angela spoke very little. She never made eye contact with the therapist and appeared to manage the anguish she displayed with self-comforting rocking. She used drawing and writing to broaden her communication with the therapist. She wrote violent short stories that were filled with pain and death, which she employed to *tell* the therapist about herself and how she felt. During the first sessions with Angela and her parents, the therapist felt a deep sense of unease. He did not perceive any concern from the parents or that they were really listening to their daughter's requests. He understood their distance as a defense that they employed to shield themselves from their daughter's discomfort. The therapist reflected on Angela's immense loneliness in the face of such deep anxieties. They were adamant that they would never accept if their daughter were transgender. Angela's mother, in particular, demonstrated her intolerance when she stated "better dead" at the end of a session.

When they described her childhood development, Angela's parents explained that from birth onward, everything had gone well, and she had not experienced any problems at school. Their descriptions were rather bidimensional: They focused on Angela's behaviors and, in particular, her preference for boys' games and clothes and appeared to disregard her emotions. Her suicidal ideations and her assertion that she is a boy were minimized and interpreted as provocative acts toward them. It soon emerged that there was

a profound distance between Angela's self-representation and her parents' representation of their child.

Gradually, during the first year of therapy, Angela began to talk about her emotions. She related that her parents had never "seen me"; thus, she never felt recognition by them. She also felt very isolated from her peer groups: She experienced discomfort among females and shame among males. Since the onset of puberty, she had felt clumsy and uneasy with her body and awkward in social situations. Angela's recurrent suicidal ideations troubled the therapist the most. Contrary to her parents' minimizing view, the therapist acknowledged the patient was at high risk.

Suddenly, at the beginning of her second year of therapy, Angela told the therapist to call her Oscar. The therapist agreed. Furthermore, this pact became a fundamental step for therapy. For a long time, the therapist was the only person who called the patient by his male name. This recognition, in line with what literature shows about the importance for transgender people of the use of the chosen name in several contexts (e.g., Russell, Pollitt, Li, & Grossman, 2018), led to a perceptible decrease in the discomfort Oscar experienced with his body. His image, his movements, and his self-perceptions became better integrated, and dysphoria generally attenuated. However, for several months, Oscar remained terrified of admitting this to his parents, especially to his mother.

The mitigation of dysphoric feelings corresponded with an opening to Oscar's outside world and relationships. He joined a group of high school peers and disclosed his masculine name and identity to them. Although his friends called him Oscar, at home, he was not able to even make the proposal that he be called by another name. During the sessions, he often rehearsed what he wanted to tell them. He hinted to his parents while conversing with them by referring to himself using masculine pronouns and leaving traces of his masculine identity around such as a gym pass with the name *Oscar*. However, his parents were impervious to all his clues.

Oscar started to escape his undifferentiated emotional chaos during therapy. He managed to name his distress, and understood how his suicidal thoughts were aimed to escape from the unexpressed pain. It gradually emerged that a critical transition was represented by the arrival of puberty that caused his collapse. During this time, it was difficult to disguise his body with its noticeable female features. He linked his social anxiety to the terror of being seen as a female individual. The terror resulted in his secluded life, withdrawal and silence, and attempt not to be noticed. With time, Oscar was also able to talk about sexuality. He shared that puberty was a shock that led him to compulsive autoerotism accompanied by imaginary scenarios of him penetrating a female body. These fantasies helped the therapist to work around his suffering related to his own body image, thus lessening his feelings of bodily clumsiness and detachment.

These acquisitions helped Oscar to face the *ghost* of autism. He became aware of his withdrawal traits and was able to carry out several improvements. The diagnosis of ASD emerged as another imposition, as his female body. Oscar asked the therapist whether he would be able to recover from autism. He experienced disbelief in relation to his diagnosis of autism, and accordingly, they together arrived at a decision to undertake diagnostic tests again. After repeating the evaluation with the same procedure (using the ADOS), the psychiatrist affirmed that a diagnosis of autism no longer existed. Cheerfully, he asked the therapist, "So, is it possible to recover from autism?" It is noteworthy that in the following session, Oscar reported that his parents had finally asked him if he wanted to be called by a male name.

After 4 years of therapy, Oscar enjoyed an active and satisfying life. Furthermore, his suicidal ideas had disappeared, and he wanted to undergo the process of gender-affirming hormones and surgery. He went to a specialized center and intended considering the various options cautiously and taking time to figure out what to do. Currently, Oscar is living his male identity freely and more peacefully.

Discussion

One may ask whether in the case of Angela/Oscar, it was autism. One may further question whether the initial diagnosis was the result of a sort of "diagnostic prejudice," which led the evaluator to produce a "false positive" at the first ADOS procedure. At first, Oscar's experience and expression of emotions were completely blocked. It seemed as though he would never find the words to express his feelings and perceptions. By exploring his countertransferential responses, the therapist felt this block of pain reflected in his feelings of isolation and solitude, which emerged notably in the preliminary sessions with the whole family. The therapist's mirroring enabled Oscar to open up his emotional world; it appeared that for the first time, Oscar experienced recognition of his true identity. Disclosing the dysphoric feelings revealed the core of his distress; that is, his feeling of shame and extraneousness related to his feminine body.

Research on the co-occurrence between GD and ASD has shed light on areas of overlap between GD and ASD. For instance, in the GIDS in London, between April 2011 and August 2018, 48% of children and adolescents whose parents had completed the SRS were classified within the mild to severe range, with 10% and 7% of birth-assigned females and birth-assigned males young individuals, respectively, scoring in the severe range (Churcher Clarke & Spiliadis, 2019). Moreover, the recent studies on large samples surely consolidated the finding of an overrepresentation of these traits in individuals with GD (Hisle-Gorman et al., 2019; Warrier et al., 2020). However, we think that these results may be better understood not as signs of neurodiversity, but rather as the expression of specific issues of the discomfort related to GD. Specifically, social isolation,

difficulties in their relationship with peers, repetitive patterns of behavior, intense fixations, and behavioral rigidity could be features of GD due to the deep discomfort and intense suffering that this condition may cause. We hypothesize that those aspects could be the result of individual defenses, which are displayed to cope with a two-fold need: first, with a socio-relational discomfort and second, with expression of the need to self-affirm one's identity.

In this regard, the research of Di Ceglie, Skagerberg, Baron-Cohen, and Auyeung (2014), which revealed autism constructs in dimensional terms of less empathy and a greater tendency to systematization, is noteworthy. In their study on adolescents with GD, they revealed typical sex differences in these traits and further found that while transgender males had less of a tendency to empathize in comparison to cisgender female controls, transgender females had similar empathizing quotients when compared to cisgender male controls. No differences were found on the systemizing dimension. The lack of empathy in FtMs and not in MtFs may indicate different pathways to the development of GD, which have more to do with the identification with gender roles than with neurodiversity (e.g., Halberstam, 1998).

We propose that this phenomenon of co-occurrence in transgender individuals is better explained by the entrenchment of these children and adolescents and their families in suffering and withdrawal. In the case of Angela/Oscar, the initial *incorrect* diagnosis demonstrates the degree to which, in the encounter with trans experiences, many of our theories and references are no longer viable. Many individuals have the ontological certainty that according to one's anatomy, one can only be either male or female. This places therapists in the difficult situation of having to deal with countertransference that unravels questions and doubt, not certainties.

It is likely that the interpretations found in the literature are the result of the notion born within psychoanalysis that transsexualism is a form of psychotic denial (e.g., Argentieri, 2009; Chiland, 2009). One may question who is denying what? One may ask whether Angela/Oscar was denying his body or whether his parents were denying his sense of identity. Clinical and empirical literature (e.g., Saketopoulou, 2014; Suchet, 2011) has revealed that unlike one's body, one's sense of gender identity cannot be changed. Literature demonstrates that attempting to change a person's gender identity from transgender to cisgender is associated with adverse mental health outcomes and suicide attempts (e.g., Turban, Beckwith, Reisner, & Keuroghlian, 2020). An absolute denial of this sense of identity may lead to the use of massive defenses to counter the lack of mirroring, resulting in rigidity and withdrawal. Linking GD to autism may thwart an in-depth understanding thereof. And as Turban (2018) first theorized, social deficits among trans youth may be reversible with affirmation and as minority stress improves, in contrast to what would be seen in ASD. As noted previously, in this commentary we have refrained from considering those studies that investigated GD traits in individuals with ASD. However, we have

made it explicit that a diagnosis on the autism spectrum encompasses several aspects of distress. In particular, we are currently witnessing the process of depathologization of transgender conditions, reflected by the new ICD diagnosis of *gender incongruence* (WHO, 2018). Thus, classifying GD as a single pathological entity and associating it with ASD appear to reflect an outdated and reductionist view of the complexities of gender.

To conclude, the central aspect of the existence of these overlapping features between ASD and GD undoubtedly concerns the attention to treatment. Saketopoulou (2014, p. 10) noted, "The body one has needs to be known to the patient so that, when necessary, it may eventually be given up." By interpreting these defenses as symptoms of autistic conditions, the role of stigmas and non-mirroring, which are at the core of GD, may be minimized (Lemma, 2013). Furthermore, as in the case of Angela/Oscar, an inaccurate ASD diagnosis may exacerbate the perception of stigma by adding a severe psychopathological label to one's own identity. As the poet Rainer Maria Rilke suggested, we must "trust in what is difficult," repudiate the oversimplifications, and embrace complexity, especially when we as clinicians have to deal with trans youth. It is imperative to evaluate the social components of the distress in the family and wider social environment of the youth carefully so as to offer possibilities for exploration that will accept any outcome.

Note

1. Angela/Oscar, now 18, gave his consent to publish this article, read it and approved it. We used pronuns and adjectives following his guidelines: feminine until he "came out" as Oscar with the therapist.

Author contributions

We state that all authors have participated in the work with a substantial contribution to conception, design, clinical discussion and interpretation of constructs. Moreover, all authors have been involved in drafting the article and approved the final version of the manuscript. Agreement has been accountable for all aspects of the manuscript in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Disclosure statement

The authors report no conflicts of interest

Funding

Guido Giovanardi was funded by the "V:ALERE plus" project, University of Campania "Luigi Vanvitelli," Caserta, Italy. The other authors did not receive financial support for the conduct of the research and/or preparation of the article.

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