We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

6,300

Open access books available

172,000

International authors and editors

190M

Downloads

Our authors are among the

154

Countries delivered to

TOP 1%

most cited scientists

12.2%

Contributors from top 500 universities

WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.
For more information visit www.intechopen.com

Autism and Gender Identity

Yulia Furlong

Abstract

Since the turn of the century, we are witnessing a dramatic surge in the numbers of children and adolescents referred to gender clinics, this is happening in the context of general increase in numbers of individuals identifying as non-binary. The chapter ahead will initially address the shifting landscape of gender dysphoria (GD), and provides a comprehensive overview of the latest findings in the fields of autism and GF. The higher rates of autism' diagnosis among gender diverse samples prompted the development of several hypotheses that attempt to explain the link between autism spectrum and gender spectrum, as well as development of relevant clinical guidelines that contain strong advocacy for adolescents with neurodiversity not to be precluded from gaining access to gender-related services. In the public arena, a highly publicised UK High Court's case that is commonly referred to as *Bell v Tavistock* highlighted the growing concerns regarding the unexplained surge in the number of adolescents identifying as having GF, as well as pointed to the lack of evidence that hormones and surgery improve long-term outcomes. The chapter explored the recommendations that came out of this ruling and highlighted the implications for Australian jurisdiction by illustrating medico-legal changes on Perth-based gender services.

Keywords: gender identity, gender dysphoria, autism spectrum disorder, sex differences, clinical guidelines, gender reassignment, consent to treatment, puberty suppression, cross-hormone treatment

1. Introduction

The empirical and research interest in the topic of gender identity and gender diversity in children and adolescents has increased exponentially over the last two decades. Such trend has been evident from inspired research activity in the field of transgender youth, as illustrated by **Figure 1** depicting the steady increase in the volume of relevant publications from 1997 to 2016 [1]. Since the turn of the century, we are witnessing a dramatic surge in the numbers of children and adolescents referred to gender clinics, this is happening in the context of general increase in numbers of individuals identifying as transgender. Internationally, this trend is well documented in the Western countries, for example in Canada between the periods 2000–2003 and 2008–2011 [2], in United States [3], the Netherlands [4], in the United Kingdom [5] and in Australia [6]. To address this gap of unmet clinical needs, the dedicated gender identity clinical services have been set up out of existing child and adolescent mental health services in collaboration with paediatric endocrinology services in order to deliver specialised gender affirming care.

Figure 1.
PubMed indexed publications from 1997 to 2016 using the search term “transgender youth”. Turban and van Schalkwyk [1]. Copyright © 2021 Elsevier Inc. except certain content provided by third parties.

In the public arena, a well-publicised UK High Court’s case that is commonly referred to as *Bell v Tavistock* [7] highlighted the growing concerns regarding the unexplained surge in the number of adolescents identifying as having gender dysphoria, as well as pointed to the lack of evidence that hormones and surgery improve long-term health outcomes, including suicidal risk. This well-publicised court decision caused ripple effect across community of trans activists, gender and legal scholars, advocacy groups and service users who are still reeling from the ruling. There are loud voices on both sides of the argument with popular opinion that this landmark judgement will result in a fundamental transgression of trans and adolescent rights. On the other hand, the ruling was welcomed by traditionalists and more conservatively inclined “as a victory for common sense and safeguarding” [8].

2. Gender identity

Gender dysphoria (GD) has been defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), as a characteristic of the individuals presenting with incongruence between their natal sex (sex at birth) and their experienced gender [9]. The diagnosis is characterised by intense and persistent cross-gender identification, which is often associated with significant distress of one’s own assigned biological and social characteristics. The key elements of GD’ diagnostic construct evolved from DSM-IV-TR diagnostic criteria for Gender Identity Disorder [10] by shifting the focus towards the dysphoria associated with the incongruence and moving away from the notion of identity disturbance.

The International Classification of Diseases, 10th Edition [11] describes the desire to live and be accepted as a member of the opposite sex as transsexualism, under the “disorders of adult personality and behaviour” which limits the use of this diagnostic category for children and adolescents. We are looking forward to the rolling out of ICD-11 [12] that will come into effect on January 1, 2022, as it contains new taxonomies of Gender Incongruence of Childhood (2- year duration) and Gender Incongruence of Adolescents and Adults (“at least several months” duration, criteria otherwise similar to Gender Dysphoria.) These new diagnostic categories moved out of Chapter V and no longer under the “Mental and

behavioural disorders” section, instead they can be found under the “Conditions related to sexual health”, chapter 17. Such move is justified based on the notion that the broader spectrum of gender identity issues is increasingly recognised as part of normal human diversity and should not be classified as a mental illness [13].

Gender diversity is an umbrella term that reflects the growing recognition that being transgender is part of the continuum of gender spectrum. It is used to describe different gender identities in a non-stigmatising way, similar to the way researchers use ‘neuro-diverse’ to describe variations in cognitive style that are characteristic of autism and attention deficit hyperactivity disorder (ADHD). The diversity in

Figure 2.
Genderbread Person v4.0. A teaching tool for breaking the big concept of gender down into bite-sized, digestible pieces (author Sam Killermann, [16]).

gender expression encompasses a range of descriptions, including ‘non-binary’, ‘transgender’, ‘gender nonconforming’ - that individuals may adopt when their gender identity, expression or behaviours do not conform to the expected norms and stereotypes of their natal sex [14]. There is a renewed freeing sense that gender is more fluid than it was ever thought to be before, and either that gender of self and others are less deterministic of who we are or that it is seen as natural that a person’s sense of their gender fluctuates. The narrative of suffering and gender dysphoria are not universal to Trans’ population and not every gender diverse person hates their body, hence it’s important to avoid misleading assumptions. Views about gender and sexuality are influenced by multitude of factors, including one’s own orientation and identity, personal experiences and upbringing, religious and moral beliefs, as well as popular cultural stereotypes. At any given time, gender identity belongs to the intersubjective field where possibilities for evolving gendered roles may be created, for example, in a situation where women and men may experience the impact of hierarchical structures in a workplace that can trigger the identity of dominance to emerge as a way of healthy adaptation process.

Two-spirit is a contemporary term adopted by some Native American Nations, and Aboriginal peoples to signify their spiritual, sexual, gender, cultural, and community identities, and the use of this term has been known to facilitate an individual’s reconnection with the tribal understandings of non-binary sexual and gender identities [15]. Some traditional Diné Native Americans acknowledge a spectrum of four genders: feminine woman, masculine woman, feminine man, and masculine man. The term “third gender” has been used to describe the hijras of India (male at birth choosing a female identity) who have gained legal identity in 2014. Third gender also applies to fa’afafine of Polynesian Samoa’s population and to ‘sworn virgins’ of Albanian Alps. In Thailand one can find up to 18 different gender roles, identities and diverse visual markers of masculinity and femininity.

Gender, psychosexual development and identity formation are all intertwined. One way to integrate the many components of gender identity and gender expression is by utilising the so-called ‘Genderbread Person’ model [16], see **Figure 2** above.

3. Psychodynamic underpinning of gender

Psychoanalytic contribution to the study of gender issues first of all belongs to Sigmund Freud and his theory of psychosexual development and the recognition of Freud’s understanding of the ego as body-ego, which is under the influence of the id [17]. Freud’s theories are echoed by the contemporary gender theories that propose that the id, like genetic material, has male and female impulses [18]. Freud also speaks of “psychical hermaphroditism” and human ability to produce a different core gender identity under certain conditions, the notion debated by Myra J. Hird who argues that there is, at some level, a refusal to allow a person to transgress the boundaries of traditional gendered identities as represented in the visual ‘cultural genitals’ [19]. Freud saw nature as masculine and coined the phrase “anatomy is destiny” [20], that can be summed up as - one’s gender determines one’s main personality traits. Nevertheless, with the rise of the feminism, the Freudian father-centred theory rooted in the concepts of the ‘penis envy’ and the ‘castration complex’ had been gradually replaced by maternal or more gender neutral primary caregiver’ determinants [21–23]. Anne Fausto-Sterling suggests that the critical aspects of pre-symbolic gender embodiment occur during infancy as part of the synchronous interplay of caregiver-infant dyads. Around the time children begin to speak, they recognise themselves as distinct entities in the mirror and commence their transition to symbolic representation and achieving accurate gender labelling

of self and others by the age of three [24]. “Gender is about affinities” – does it feel “like me”, or different from me? Gender may remain stable or evolve and change, the author urges that clinicians take a dynamic developmental view of gender identity formation after into account [24]. Finally, the Lacanian perspective on gender difference is rooted in the original concepts that situate in the space between life and death and propose that a gender transition is more about strategy of being than about sexuality [25].

4. Mental health comorbidities

Review of the recent literature suggests that 0.17% to 1.3% of adolescents and young adults identify as transgender [26]. Transgender individuals experience disproportionately high rates of negative mental health outcomes, as compared with their cisgender heterosexual peers, as well as their gender-normative lesbian, gay and bisexual peers [27]. Recent studies have offered a deeper understanding of the prevalence of depression among trans- and gender-variant youth, providing evidence that rates of depression are 2.4 to 3.5 times higher than in their cisgender peers, 50.6% vs. 20.6% in a retrospective matched cohort (n = 360) of 12–29 years old patients at community health centre in Boston [28] and 41.3% vs. 11.8% in a high school-based sample (n = 8,166) from New Zealand [29]. A study by Veale et al. measured stigma-related experiences, social supports, and mental health (self-injury, suicide, depression, and anxiety) among a sample of 923 Canadian transgender adolescents and young adults aged 14 to 25; they reported that over two-thirds (68.3%) of the sample experienced a major depressive episode in the past year [30].

The large scale 2015 U.S. Transgender Survey (USTS) with 27,715 respondents with a median age of 26 years, found that 40.4% of respondents reported attempted suicide in their lifetime, 81.7% of respondents had seriously thought about killing themselves in their lifetimes, and 48.3% had done so in the past year while 7.3% had attempted suicide in the past year; respondents who reported having a disability had higher prevalence on all suicide-related measures than those without disabilities [31].

Another large survey that was primarily capturing an eating-related pathology revealed that transgender students had increased rates of eating disorder diagnosis compared to cisgender heterosexual women (15.8% vs. 1.85%), this set of data was collected from 289,024 students via the American College Surveys from 233 U.S. universities [32].

5. Autism spectrum disorders and gender identity

Among the general population, the prevalence of autism spectrum disorder (ASD) in children is estimated at 1% with a ratio of 1:42 for boys and 1:189 for girls respectively [33]. The evidence that suggests an overrepresentation of ASD in gender diverse samples, particularly in children and adolescents [34, 35], is robust and largely accepted by scientific community. The association between GD and ASD has been of great clinical interest because it has implications for diagnosis and treatment.

5.1 Co-occurrence rates

Trans Pathways study conducted in Australian large sample of trans and gender-diverse young people (n = 859; mean age = 19.4), found that 22.5% of the sample

reported having received a formal ASD diagnosis, while more than one third (35.2%) had highly suspected but undiagnosed ASD [34]. This type of large epidemiological study is difficult to construe in view of diagnostic imprecision of gender dysphoria and heterogeneity of both, GD and ASD constructs and therefore studies in this field significantly vary in methodology and chosen diagnostic constructs. A focus on diagnosis is less sensitive to the presence of subthreshold or mild autistic symptoms, which is why some studies utilised the Broader Autistic Phenotype (BAP) that is defined as a collection of sub-diagnostic autistic traits more common in families of individuals with ASD than in the general population. Evidence of an intermediate phenotype and a latent construct in autism was first reported in the landmark twin study of Folstein and Rutter [36]. Jones et al. [37] used Autism Spectrum Quotient – AQ [38] to measure BAP in a sample of adults with GD, typical adults and adults diagnosed with ASD, and found that 17.5% of the GD sample had a score above the AQ cut-off for BAP. Interestingly, more females with GD scored above the cut-off than males with GD, which is in contrast to the recognised male - female distribution in ASD.

The first systematic study into the incidence of autism diagnosis in young people referred to a specialised gender clinic via the use of a diagnostic interview, reported an ASD' higher than expected prevalence rate of 7.8%, and an overrepresentation of ASD diagnoses in boys compared to girls with a ratio of 3:1 [39]. While, overall, this study was methodologically sound, it sadly lacked a clinical control group for comparison. Contrary, the study by Pasterski et al. [40] has shown no difference in relation to ASD' prevalence rate between trans people and the general population by utilising the threshold for a potential diagnosis with an ASD-rate of 5.5%. The disparity of these findings and the difference in prevalence rates could be as a result of the chosen study populations with recognised difference in presentation between children and adults, study design and methodology, utilised diagnostic categories and assessment tools.

Skagerberg et al. [41] reported ASD scores that fell, on average, in the mild/moderate range in a sample of children and adolescents with GD with no significant difference between boys and girls with GD, and scores that fell in the normal range in a control sample of typically developing young people. Skagerberg et al. measured autistic symptoms using a quantitative measure - the Social Responsiveness Scale [42], that was also used in another controlled study of children with GD [43] with 44.9% of GD' sample scoring within the clinical range for autistic traits with, on average, moderate scores. This Canadian study also examined risk factors for ASD with an overlap of only high birth weight, but not the other risk factors, with both, raised gender nonconformity and autistic traits among children with GD [43].

Glidden et al. [44] systematically appraised 19 out of 58 available articles regarding the co-occurrence of gender dysphoria and ASD from Medline, PubMed, PsycINFO, and Embase databases in the period from 1966 to July 2015. The authors of this systematic literature review concluded that the research in to the co-occurrence between gender dysphoria and ASD is limited, especially for adults. The literature investigating ASD in children and adolescents with gender dysphoria showed a higher prevalence rate of ASD compared with the general population. Since Glidden's systematic review, recent well-designed Dutch study confidently confirmed an over-representation of symptoms of ASD in children and adolescents with GD [45]. Their estimated prevalence of ASD was 14.5%, which is approximately four times higher than the 3.5% in the normative sample and much higher than the prevalence estimate of 1% found in the general population [33]. Their GD sample showed elevated levels of autistic symptomatology on all subdomains, not just on stereotyped behaviour and resistance to change' measures. van der Miesen and colleagues [45] found that young people with GD had more reported autistic

symptoms compared to typically developing children and adolescents, but less reported autistic symptoms compared to children and adolescents with ASD.

There seems to be less studies that took an alternative root and investigated GD symptoms within an ASD population. Australian survey by George and Stokes [46] aimed at measuring prevalence of “gender variance” in ASD and found that individuals with ASD of all ages report increased homosexuality, bisexuality, and asexuality, but decreased heterosexuality. Sexual Orientation was surveyed using the Sell Scale of Sexual Orientation in an international online sample of 309 young adults with ASD that were screened with Autism Quotient ($M = 90$, $F = 219$, $M = 32.30$ years, $SD = 11.93$) which was compared to sexual orientation of 310 controls that were represented by aged-matched neurotypically developing individuals ($M = 84$, $F = 226$, $M = 29.82$ years, $SD = 11.85$). In the group with ASD, 69.7% identified as non-heterosexual, while in the control group, 30.3% identified as non-heterosexual.

Strang et al. [47] found that children with ASD were 7.59 times more likely to express gender variance by expressing “wishes to be of the other gender” as per Child Behaviour Checklist [48] compared to their neurotypical peers and established equal sex distribution for the gender variance. Similarly, Janssen et al. [49] found that children with ASD were 7.76 times more likely to express gender variance than children from the non-referred comparison group, with no significant difference between boys and girls. There is a consensus that in most cases, gender diverse identities and behaviours are stable and not secondary to ASD but co-occur as an aspect of personal identity’ development [34].

The exact numbers accounting for the overlap between autism and gender variance has a wide degree of variation, ranging between 6% and 26% of for ASD among gender-variant people, while the rate of gender variance among people with ASD is estimated between 4% and 8% [39, 49–51].

5.2 Hypotheses attempting to explain ASD/GD association

Gender diverse behaviours, including crossdressing, tomboyism and paraphilias in children and adolescents with ASD may be considered as part of the ASD phenotype and representations of unusual, restricted interests and the development of atypical gender identity in autism could relate to the developmental rigidity that is characteristic of autism. This hypothesis focusing on individual psychological characteristics and obsessional interests suggesting that gender could be among the preoccupations or obsessions often seen in ASD was not fully supported by van der Miesen and colleagues [52]. The study of VanderLaan et al. [53], which suggested that specifically intense obsessional interests are one of the hypothesised mechanisms underlying the possible GD-ASD co-occurrence. Van der Miesen’s findings highlight several subdomains of the autistic spectrum that might be involved in this possible association, including social and communication difficulties, but not obsessional interests [52].

5.3 Developmental hypothesis

The individuals with ASD might not reach normative flexibility in gender development that will equip them with necessary skills to deal with gender variant feelings, which might explain the overrepresentation of ASD in GD. Furthermore, Robinow [54] suggested that neurobiological abnormalities associated with reduced social functioning in ASD, such as those found for frontal and temporal regions, might make it difficult for some children to acquire concepts regarding gender norms. Clinicians have observed that at least some children with GID misclassify

their own gender, even at ages beyond those in which correct self-labelling is expected [55]. Social communication deficits might, therefore, underlie the cognitive “lag” that many GD children exhibit in terms of their gender constancy development [55].

Erik Erikson described eight stages of psychosocial development through which a neurotypically developing adult should pass from infancy to adulthood [56]. As articulated by Erikson, Identity versus Role Confusion represents the fifth stage of psychosocial development that take place during adolescence between the ages of 12 and 19. It has been hypothesised that individuals with ASD become acutely aware of their uniqueness and differences compared to others during their formative years, and, as a result, may develop confusion of identity and identity crisis which could include gender nonconforming behaviour and GF.

5.4 Social perception and preoccupations hypotheses

This theory implies that core ASD symptoms of social deficit will likely influence child’s ability to interpret social cues when it comes to gender conforming behaviour and navigating nuanced social interactions with same and opposite peer groups. Specific neuropsychological profiles with deficits in “theory of mind,” the ability to attribute mental states (beliefs, intents, desires, etc.) to oneself and others and recognise that these are different from one’s own, may affect development of the “self” in general. When expressing their gender variance and sexuality young people with ASD may be less inhibited by the social norms or even more oppositional to social restrictions when expressing their gender variance. It could be theorised that excessively rigid cognitive style or dichotomous thinking pattern could predispose a child with ASD to interpret slight gender nonconforming inclination as total and fundamental preference.

5.5 Neurodevelopmental masculinisation

The theory of the extreme male brain (EMB) stipulates that individuals with autism may develop an extreme variant of the typical male pattern of behaviours and cognitions originating from high levels of foetal testosterone [57]. While pre-natal testosterone is linked to the the association between ASD and GD in assigned girls, explaining the male pattern of their identity and behaviour, same theory cannot applied to assigned boys. Adolescent girls with ASD had a significantly higher prevalence of endorsement of item ‘the Wish to be of the Opposite Gender’ compared to adolescent boys with ASD [52]. Thus, Van der Miesen et al. [52] partly supports Neurodevelopmental Masculinisation hypothesis but found no significant differences in CSBQ total score between boys and girls with GD, and diverging gender differences on the subdomains of ASD, which are not all consistent with the EMB theory, rendering it highly unlikely [52]. In a comparison sample of birth-assigned females diagnosed with GD, Jones and colleagues [37] established increased rates of ASD symptoms, while birth-assigned males diagnosed with GD did not have increased levels of ASD symptoms. Jones and colleagues hypothesised that elevated levels of foetal testosterone may lead not only to reduced empathy, reduced social interest, reduced social skills, and more ASD, but also contribute to developing GD via neurodevelopmental masculinisation pathway [37]. Among adults with ASD, the symptoms of tomboyism and bisexuality were commoner in females with ASD, while assertiveness and leadership, the aspects that are considered to be typically masculine were reportedly weaker in both, females and males with ASD, compared with typically developing controls [57]. This data signifies that an extreme male pattern might not apply to all aspects of gender roles and sexuality.

A brain MRI study in individuals with ASD also found attenuated typical gender differences in white matter tracts [58], providing support for gender atypicality as one of the potential underlying mechanisms for co-occurring GD–ASD.

5.6 ADHD comorbidity theories

Evidence suggests that core ADHD symptoms and associated externalising disorders are overrepresented in both groups of interest, young people with neurodiversity and young people with gender variance. One large retrospective study had a surprising finding of a significant overrepresentation of gender variance, occurring 6.64 times more frequently among children with ADHD, than among a non-referred comparison group [47]. This study determined that parental report of gender variance was significantly greater in two groups of children, ASD group (5.4%) and ADHD group (4.8%) that collectively represent children with neurodevelopmental disorders, while the proportion of children with gender variance among combined medical group (1.7%) and non-referred comparison group (0–0.7%) were statistically different from ASD and ADHD groups; gender variance occurred equally in girls and boys [47]. In ADHD, impulse control difficulties are essential criteria for diagnosis and could potentially affect gender expression by reducing ability to inhibit primary gender impulses in spite of societal pressure to conform to gender stereotype [47]. Among transgender youth with ASD, children and adolescents may be less aware of the social stereotypes, hence the ASD/ADHD cohort are likely to ignore the societal influences against cross-gender expression and express their gender inclinations more freely or even parade their feelings of gender incongruence as an oppositional response to unaccepted societal rules.

6. Clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents

The initial clinical guidelines for ASD-GD [59] in adolescents have been developed using Delphi method [60] and contain strong advocacy for adolescents with ASD to gain equal access to gender-related services and not be precluded from gender affirming care when diagnostic criteria of GD are met. The guidelines emphasise the need for carrying out gender assessments in tandem with an in-depth consideration and accommodation of ASD-related factors that may impact gender-related exploration and identify broader needs of neuro-diverse adolescents [59]. Since the initial guidelines' have been publicised, more recent study by Strang et al. [61] reported on a proposed community-driven clinical model to attend to the broader care needs and preferences of adolescents with ASD/neurodiversity and GD. It is also important to engage young people with a lived experience of ASD/GD and their carers into a productive dialogue about further services and interventions as they hold unique insights into how services can best respond to the complex needs of affected individuals and promote many other related domains including education, employment, housing and family services. Certainly, there are reports that the education and community outreach programs as part of gender diversity services are very important to the service users and have grown exponentially in a way that was not initially anticipated [62].

Adolescents with ASD may not embody a binary transgender presentation, while some may conflate sexuality with gender and need affirming education. In the course of psychological therapy, one may wish to explore whether traits of ASD such as intense/obsessional interests or social communication deficits contribute to a child's gender schema (e.g. wishing to be a specific anime character) and, eventually

determine their gender-nonconforming identity. It is especially valuable to discriminate if ASD' influence is long-lasting with no alternative gender preferences, especially in light of reports that highlighted the desistence pattern of gender variance among young people with ASD [54, 63]. The results of these studies should be viewed with caution owing to the lack of robust evidence underpinning the conclusions.

Gender transition is a complex multi-stage procedure that could be difficult to achieve by individuals with neurodevelopmental disorders, including autism and ADHD, as their treatment decisions, planning and follow through may be compromised due to a deficit at a higher-level executive functioning. Typical ASD' cognitive profile also implies a certain level of inflexibility and a highly selective hyper-focus; these qualities are likely to reduce an individual's ability to set and complete goals [64] and may compete with their care needs and treatment priorities. Having a rigid cognitive set may make it hard for a young person with ASD to recognise gender fluidity and to see gender expression as a spectrum; rigid thinking may also lead some to assume that having gender incongruence means that they must seek affirming medical treatment. These more vulnerable individuals may need additional help in navigating the care system and deciding on appropriate service and management plan, its important to ensure that they understand that gender affirming treatment is optional.

7. Bell v Tavistock and consensus on treatment

More recently, gender affirming models of care have come under the medico-legal scrutiny and now the issues of consent to gender altering treatments are being regular debated as part of legislative agendas in English, European, American, Canadian, Australian and New Zealand's' family courts.

7.1 Court case details

This came on foot of highly publicised UK-based Bell v Tavistock high court ruling in December 2020 that found against Tavistock NHS trust in relation to their gender affirming clinic providing "potentially misleading" advice around hormone therapy and therefore jeopardising the integrity of informed consent' gathering, thus making consent process legally invalid [7]. This case was brought by Keira Bell, a 23-year-old woman who was commenced on puberty blockers at the age of 16 before desisting and de-transitioning, and who was joined by the unnamed mother of a 15-year-old girl with autism who is on the waiting list for gender affirming treatment [7]. In their decision, the Rt Hon Dame Victoria Sharp, Lord Justice Lewis and Mrs. Justice Lieven, ruled that it unlikely that children under the age of 16 who were considering gender reassignment treatment were mature enough to give informed consent to be commenced on puberty-blocking drugs [7].

7.2 Specific findings

More specifically, the high court determined that:

1. informed consent in the legal sense cannot be given by young persons under the age of 13.
2. the court was also doubtful that a young person aged 14 or 15 could fully understand the immediate and long-term consequences of the treatment in physical and psychological sense.

3. trans persons under the age of 16 will likely need a court authorisation before starting treatment with puberty blocking drugs [7].

7.3 Examining outcomes

In a more nuanced examination of evidence on treatment outcome, the court highlighted the finding that the overwhelming majority of patients taking puberty blocking drugs proceed to the first step of actual gender reassignment by taking cross-sex hormones, in some cases 100% of eligible transgender individuals who received puberty suppression proceeded to cross-hormone treatment [65]. Reflecting on this trend, some critiques of puberty suppression treatment have even suggested that puberty blockade ‘locks’ a child into a permanent state of gender incongruence [66]. Therefore, describing puberty blockers as simply a “pause button,” “completely reversible” or “life-saving” is misleading to young patients and their families.

7.4 Gillick competence

In the context of gender reassignment treatment, the *Bell v Tavistock* ruling takes a different view of the Gillick competence and reassesses how a consenting right of a person under 16 years of age operates in practice. While considered fundamentally progressive and encompassing the right to self-determination and autonomy, the Gillick competence could be detrimental to minors and to, so-called, vulnerable populations. The high court was also critical of what it characterised as the Tavistock’s “surprising” lack of investigation into the steady rise in referrals of native girls and of individuals with autism spectrum disorder [8]. Social factors, in particular peer influence, social contagion, parent–child conflict, and maladaptive coping mechanisms may be significant contributing factors in cases of adolescent onset gender dysphoria in natal females, recently termed ‘rapid onset gender dysphoria’, a socially mediated subtype, the validity of which was disputed by scientific community [67, 68].

7.5 Lack of consensus

The issue of a lack of consensus on current early medical treatment was another issue of concern highlighted by the court. Indeed, the clinical guidelines for the management of adolescents with GD differ widely with no clear agreement that has the backing of the colleges of psychiatry or other leading medical colleges. The Royal College of Psychiatrists in the UK takes a conservative view by stating the following: “The College acknowledges the need for better evidence on the outcomes of pre-pubertal children who present as transgender or gender-diverse, whether or not they enter treatment. Until that evidence is available, the College believes that a watch and wait policy, which does not place any pressure on children to live or behave in accordance with their sex assigned at birth or to move rapidly to gender transition, may be an appropriate course of action when young people first present” [69]. The Royal Australian and New Zealand College of Psychiatrists is currently reassessing their position statement by engaging with a working group of relevant experts and representative groups, which provides little in the way of direction right now.

7.6 Desisters

In addition to raising the consent issues, the premise of the *Bell v Tavistock* court case also shines the light on the transgender youth who choose to de-transition, as

the complainant Keira Bell is certainly not alone in the so-called ‘desisters’ camp. According to the Amsterdam outcome study of 77 individuals who were followed up from a young age of approximately 9 years (mean age 8.4 years) until adulthood (mean age 18.9 years), most children with gender dysphoria will not remain gender dysphoric after puberty [70]. This is represented by 43% of original cohort that belonged to desistance group who no longer had a desire for gender reassignment, as opposed to 27% of persistence group who remained cross-gendered [70]. Many children who experience GD will not continue to experience dysphoria into adolescence and adulthood.

The qualitative data that was generated in the same study sample was analysed by Steensma and colleagues and represents insightful interpretation of influences that determined gender identification for desisters and persisters. Interestingly, all subjects representing both groups pointed towards the changes in their social environment, physiological and biological changes that were either anticipated or took place, and their first experiences of falling in love and developing sexual attraction as major influences in their gender related interests and behaviour [71]. Taken together, the prior research supports the notion that persistence of childhood GD is most closely linked to the intensity of early GD, as well as the amount of gender diverse behaviour and body discomfort as a result of the feeling of the incongruence between the bodily characteristics and gender identity. There are also recognisable differences in motives or cognitive constructs of the dysphoria. Although, both persisters and desisters in Steensma et al. study [71] reported a desire to be the other gender during their childhood years, the underlying motives of their desire differed between persisters who explicitly indicated that they believed to be the “other” sex and the desisters who only wished to be the “other” sex. Interestingly, the desisters also indicated that their incongruence was more likely to be caused by the perceived mismatch of their bodily representations and the desired social gender role. In line with these findings, Drummond et al. [72] found that girls with persisting GD recalled significantly more gender-variant behaviour and GD during childhood than the girls classified as having desisting GD. Another study of 139 natal boys with gender identity disorder by Singh [73] confirmed the link between the intensity of childhood GD and adolescent and adult persistence of GD; Singh also linked the desistence of GD with a higher social class.

7.7 Seven points of difference

The high court judgement reads like a cautionary tale reminding us that over-confidence in new treatments is dangerous. With this ruling, the High Court has set up an expectation of accountability of the health professionals engaged in the provision of paediatric and adolescent medical transition. The issue of consensus on best treatment was explored by the recent Dutch empirical ethical study that generated seven points of difference that needs resolving before the views on treatment could be unified [74]. Among these seven contentious points are following themes:

1. a sound explanatory model for GD
2. the heterogeneity and the diagnostic construct’ stability of GD
3. the role of comorbidity
4. the recognition of normal gender variation

5. an issue of social contagion
6. the implications of medical treatment, and finally
7. the validity of consent, recognising complexities around parental rights to consent and ability to understand where the person is on their transgender journey, believing in people trusting themselves and being in charge of their bodies and their own destiny.

Most of these queries remain either unexplained or fraught with controversy at present, hence, we require more strict system of checks and balances to deliver the right treatment for GD's sufferers.

8. Perth experience

The Gender Diversity Service (GDS) located at Perth Children's Hospital (PCH) in Western Australia, has been specifically designed as a dedicated tertiary specialist service for children and adolescents who present with clinically significant forms of GD. The author's first-hand experience of working in GDS gives her additional insight into the benefits and challenges of operating of such Tier-4 clinical service. GDS is a state-wide service that has been set up in 2015 as part of local child and adolescent mental health services to provide assessment, consultation and gender-affirming treatment for young people under 18. From the outset, this recently established public service has been committed to embedding research in everyday care by developing a longitudinal cohort database "The GENDER identiTY Longitudinal Experience" (GENTLE) and attracting research staff to their multi-disciplinary team [13]. GDS has been conceptually developed with so-called Dutch model of care in mind after the process of comprehensive national and international consultation and developing adequate skill base.

For the purpose of this publication, the author wanted to use Western Australian example in order to illustrate how does influential *Bell v Tavistock* ruling affect other jurisdictions. The Australian legal system historically takes a very respectful view of advances in English law, and it is assumed that an Australian judge would be expected to give significant weight to the *Bell v Tavistock* ruling. Australian services, such as PCH GDS, are following the recommendations from *Bell v Tavistock* ruling and there is a sense that Australian health practitioners would be viewed in a negative light if they were aware of the *Bell v Tavistock* ruling but continued to practice in a way that is not consistent with court's recommendations. The Court authorisation is intended to take into consideration the young person's best interests as well as the court's view of their capacity and will provide some validation to the consent gathering process and lend some additional support and security for treatment to be considered medico-legally sound.

From now on, all young people under 18 who wish to start new puberty suppression treatment or cross sex hormone treatment will need to go through the Family Court via Legal Aid and gender service providing necessary mental health and endocrinology reports to the court. Regardless, if both parents consent, or/and if the gender clinician determines that the young person does have capacity to consent, the decision to treat is to be taken to the Family Court to provide a further level of authorisation. On a positive note, it could be opportunistic that a new body of case law, arising from young people's cases, may establish Australian precedents which could support young people in accessing gender affirming health care in Australia and internationally.

9. Conclusion

In conclusion, taking into account latest research findings and vast body of information generated and shared by specialists and researchers in both fields, autism and gender identity, the evidence is supportive of higher rates of clinical diagnoses of ASD among gender diverse samples, including social deficit and various degree of restricted and repetitive behaviours, thus confirming a link between autism and gender incongruence. The scientific community is concerned that dismissing gender variance as another manifestation of autism may place affected individuals at risk and delay people with ASD accessing gender diversity services.

With regard to diagnostic process and increased recognition of heterogeneity that exists within transgender youth populations, there is a growing concern that the current diagnostic categories do not adequately differentiate the children with true forms of GD from those who show merely gender nonconforming behaviour. Clinically, the intensity of early GD is an important predictor of persistence of GD and may help clinicians to accurately discriminate between persisters and desisters before the start of puberty. Some experts believe that the clinical recommendations should be separated between natal boys and girls, as their presentation of GD is distinct with different predictive factors for the persistence of GD.

The international commitment to rigorous clinical research in the area of gender diversity and running more naturalistic studies that are unaffected by a clinical context, will hopefully provide us with reliable and safe treatment options for children and adolescents experiencing gender dysphoria. Until that time we will be exploring all available options with young people and their families before undergoing invasive interventions with unknown long-term implications. For now, the enormous, growing body of knowledge on gender dysphoria requires synthesis, integration, and generation of sound clinical recommendations. There is a call for more systematic and adequately powered multi-centre studies that are expected to move beyond a confirmation of the existing overlap between ASD and GD and towards a translational research into the underlying causes of the overlap between these two spectrums of autism and gender diversity, as well as offering insight on how autism presents in gender-diverse people. I would like to end with a notion that a gender curiosity, “fantasy that one can change one’s gender on demand” [75] sometimes is just that; and at least for some, this fantasy is better than reality of gender reassignment. Knowing that may open our minds to more sensitive and exploratory approach that informed by therapeutic listening, mentalisation, non-judgmental positive regard with empathy, respect and ability to tolerate uncertainty.

IntechOpen

Author details

Yulia Furlong^{1,2}

1 Child and Adolescent Psychiatrist, Head of Service—Paediatric Consultation Liaison and Gender Diversity Service, Perth's Children Hospital, Perth, Western Australia, Australia

2 Clinical Senior Lecturer, Medical School, University of Western Australia, Perth, Western Australia, Australia

*Address all correspondence to: yulia.furlong@health.wa.gov.au

IntechOpen

© 2021 The Author(s). Licensee IntechOpen. This chapter is distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/3.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

References

- [1] Turban JL, van Schalkwyk GI. Revisiting the Link: Evidence of the Rates of Autism in Studies of Gender Diverse Individuals. *J Am Acad Child Adolesc Psychiatry* 2018; 57: 8-9.e2. DOI: <https://doi.org/10.1016/j.jaac.2017.08.017>
- [2] Wood H, Sasaki S, Bradley SJ, et al. Patterns of referral to a gender identity service for children and adolescents (1976-2011): Age, sex ratio, and sexual orientation [Letter to the Editor]. *Journal of Sex and Marital Therapy* 2013; 39, 1-6. doi:10.1080/0092623X.2012.675022.
- [3] Spack NP, Edwards-Leeper L, Feldman HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics* 2012; 129:418-425. doi:10.1542/peds.2011-0907
- [4] de Vries ALC & Cohen-Kettenis P T. Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality* 2012; 59, 301-320. doi:10.1080/00918369.2012.653300.
- [5] The Tavistock and Portman NHS Foundation Trust. GIDS referrals increase in 2017/18, 2018. Available: <http://gids.nhs.uk/news-events/2018-05-16/gids-referrals-increase-201718>
- [6] Telfer M, Tollit M, Feldman D. Transformation of healthcare and legal systems for the transgender population: the need for change in Australia. *J Paediatr Child Health* 2015; 51:1051-1053.doi:10.1111/jpc.12994
- [7] Bell-v-Tavistock Judgement. Published online December 1, 2020. Accessed December 2, 2020. <https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>
- [8] Brooks L. Puberty blockers ruling: curbing trans rights or a victory for common sense? *The Guardian* Thu 3 Dec 2020.
- [9] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*; American Psychiatric Publishing: Washington, DC, USA, 2013.
- [10] DSM-IV-TR Diagnostic Criteria For Gender Identity Disorder. *Psychiatric News*. American Psychiatric Association Publishing. Published Online:18 Jul 2003 <https://doi.org/10.1176/pn.38.14.0032> Accessed 16/03/2021
- [11] World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. World Health Organization. <https://apps.who.int/iris/handle/10665/37958>
- [12] World Health Organization. (2018). *International classification of diseases for mortality and morbidity statistics (11th Revision)*. Retrieved from <https://icd.who.int/browse11/l-m/en>
- [13] Mahfouda S, Panos C, Whitehouse AJO, et al. Mental Health Correlates of Autism Spectrum Disorder in Gender Diverse Young People: Evidence from a Specialised Child and Adolescent Gender Clinic in Australia. *Journal of Clinical Medicine* 2019; 8(10), [1503]. <https://doi.org/10.3390/jcm8101503>
- [14] Rafferty J. Committee on Psychosocial Aspects of Child and Family Health. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics* 2018; 1, e20182162.
- [15] Elm JH, Lewis JP, Walters KL, Self JM. "I'm in this world for a reason": Resilience and recovery among

- American Indian and Alaska Native two-spirit women. *J Lesbian Stud.* 2016; 20(3-4):352-371. doi:10.1080/10894160.2016.1152813
- [16] Killerman S. The Genderbread Person version 4, 2017. <https://www.itspronouncedmetrosexual.com/2018/10/the-genderbread-person-v4/> Accessed January 25, 2021.
- [17] Freud S. The ego and the id (1923-25). In: Strachey J, editor, The standard edition of the complete psychological works of Sigmund Freud. London: Hogarth Press; 1995. p 48-59.
- [18] Barbieri N.B. Psychoanalytic Contributions to the Study of Gender Issues. *Can J Psychiatry* 1999; 44:72-76
- [19] Hird M. Considerations for a Psychoanalytic Theory of Gender Identity and Sexual Desire: The Case of Intersex. *Signs* 2003; 28(4), 1067-1092. doi:10.1086/343131
- [20] Freud S. The dissolution of the Oedipus complex (1924). In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud. London: Hogarth Press 1995. p 172.
- [21] Horney K. The denial of the vagina. In: Kelman H. *Feminine psychology*. New York: WW Norton Press 1993. p 147-161.
- [22] Jacobson E. Ways of female superego formation and the female castration complex. *Psychoanal Q* 1976; 45:525-538.
- [23] Winnicott D. *The maturational process and the facilitating environment*. London: Hogarth Press 1972.
- [24] Fausto-Sterling A. The Dynamic Development of Gender Variability, *Journal of Homosexuality* 2012; 59:3, 398-421, DOI: 10.1080/00918369.2012.6533100.
- [25] Gherovici, P. (2017) *Transgender Psychoanalysis: A Lacanian Perspective on Sexual Difference* Routledge; 1st edition 2017
- [26] Connolly MD, Zervos MJ, Barone CJ, et al. The mental health of transgender youth: Advances in understanding. *J. Adolesc. Health* 2016, 59, 489-495.
- [27] Carmel TC, Erickson-Schroth L. Mental Health and the Transgender Population. *J Psychosoc Nurs Ment Health Serv* 2016 Dec 1;54(12):44-48. doi: 10.3928/02793695-20161208-09. PMID: 28001287
- [28] Reisner SL, Veters R, Leclerc M, et al. Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *J Adolesc Health* 2015; 56:274e9.
- [29] Clark TC, Lucassen MFG, Bullen P, et al. The health and well-being of transgender high school students: Results from the New Zealand adolescent health survey (Youth'12). *J Adolesc Health* 2014; 55:93e9.
- [30] Veale, J.F.; Peter, T.; Travers, R.; Saewyc, E.M. Enacted stigma, mental health, and protective factors among transgender youth in Canada. *Transgender Health* 2017, 2, 207-216.
- [31] Herman, J. L, Brown, T. N, & Haas, A. P. (2019). Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey. UCLA: The Williams Institute. Retrieved from <https://escholarship.org/uc/item/1812g3hm> on 30.01.21
- [32] Diemer EW, Grant JD, Munn-Chernoff MA, et al. Gender identity, sexual orientation, and

eating-related pathology in a national sample of college students. *J Adolesc Health* 2015; 57:144e9.

[33] Lai M, Lombardo MV, Baron-Cohen S. Autism. *Lancet*. 2014; 383(9920):896-910. doi: 10.1016/S0140-6736(13)61539-1.

[34] Strauss P, Cook A, Winter S, et al. *Trans-Pathways: The Mental Health Experiences and Care Pathways of Trans Young People-Summary of Results*; School of Public Health, Curtin University of Technology: Bentley, WA, USA, 2017.

[35] Mahfouda, S., Panos, C., Whitehouse, A. et al. (2019). Mental Health Correlates of Autism Spectrum Disorder in Gender Diverse Young People: Evidence from a Specialised Child and Adolescent Gender Clinic in Australia. *Journal of Clinical Medicine*, 8(10), [1503]. <https://doi.org/10.3390/jcm8101503>

[36] Folstein S, Rutter M. Infantile autism: A genetic study of 21 twin pairs. *J Child Psychol Psychiatr*. 1977;18: 297-321.

[37] Jones RM, Wheelwright S, Farrell K, et al. Female-to-male transsexual people and autistic traits. *Journal of Autism and Developmental Disorders* 2012; 42, 301-306.

[38] Woodbury-Smith M, Robinson J, Baron-Cohen S. Screening adults for Asperger syndrome using the AQ: Diagnostic validity in clinical practice. *Journal of Autism and Developmental Disorders*. 2005;35(3):331-335. doi: 10.1007/s10803-005-3300-7.

[39] De Vries AL, Noens IL, Cohen-Kettenis PT, et al. Autism spectrum disorders in gender dysphoric children and adolescents. *J Autism Dev Disord* 2010; 40:930.

[40] Pasterski V, Gilligan L, Curtis R. Traits of autism spectrum disorders in

adults with gender dysphoria. *Arch Sex Behav* 2014; 43:387

[41] Skagerberg E, Di Ceglie D, Carmichael P, et al. Brief report: Autistic features in children and adolescents with gender dysphoria. *Journal of Autism and Developmental Disorders*. 2015;45(8):2628-2632. doi: 10.1007/s10803-015-2413-x.

[42] Constantino JN, Gruber CP. *Social Responsiveness Scale (SRS)* Los Angeles, CA: Western Psychological Services; 2005.

[43] Vander Laan DP, Leef JH, et al. Autism spectrum disorder risk factors and autistic traits in gender dysphoric children. *Journal of Autism and Developmental Disorders* 2015; 45(6):1742-1750. doi: 10.1007/s10803-014-2331-3.

[44] Glidden D, Bouman WP, Jones BA, Arcelus J. Gender Dysphoria and Autism Spectrum Disorder: A Systematic Review of the Literature. *Sex Med Rev* 2016 Jan; 4(1):3-14. doi: 10.1016/j.sxmr.2015.10.003. Epub 2016 Jan 8. PMID: 27872002.

[45] van der Miesen A, de Vries A, Steensma TD & Hartman CA. Autistic Symptoms in Children and Adolescents with Gender Dysphoria. *Journal of autism and developmental disorders* 2018; 48(5), 1537-1548. <https://doi.org/10.1007/s10803-017-3417-5>

[46] George & Stokes. *Sexual Orientation in Autism Spectrum Disorder*. *Autism Research*, Volume11, Issue1, January 2018, Pages 133-141

[47] Strang JF, Kenworthy L, Dominska A, et al. Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder. *Archives of Sexual Behavior*. 2014;43(8):1525-1533. doi: 10.1007/s10508-014-0285-3.

- [48] Achenbach TM, Rescorla LA. Manual for ASEBA school-age forms & profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth & Families; 2001.
- [49] Janssen A, Huang H, Duncan C. Gender variance among youth with autism spectrum disorders: A retrospective chart review. *Transgender Health*. 2016;1(1):63-68. doi: 10.1089/trgh.2015.0007.
- [50] Kaltiala-Heino R, Sumia M, Työläjäarvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child Adolesc Psychiatry Ment Health*. 2015 Apr 9;9:9. doi: 10.1186/s13034-015-0042-y.
- [51] Strang JF, Janssen A, Tishelman A, et al. Revisiting the Link: Evidence of the Rates of Autism in Studies of Gender Diverse Individuals. *J Am Acad Child Adolesc Psychiatry*. 2018 Nov; 57(11):885-887.
- [52] van der Miesen AIR, Hurley H, Bal AM, et al. Prevalence of the Wish to be of the Opposite Gender in Adolescents and Adults with Autism Spectrum Disorder. *Arch Sex Behav* 2018; 47, 2307-2317.
- [53] Vander Laan DP, Postema DP, Wood L, et al. Do children with gender dysphoria have intense/obsessional interests? *Journal of Sex Research* 2015; 52(2):213-219. doi: 10.1080/00224499.2013.860073
- [54] Robinow O. Paraphilia and transgenderism: A connection with Asperger's disorder? *Sexual and Relationship Therapy* 2009; 24, 143-151. doi: 10.1080/14681990902951358.
- [55] Zucker KJ, Bradley SJ, Kuksis M, Pecore K, Birkenfeld-Adams A, Doering RW, Mitchell JN, Wild J. Gender constancy judgments in children with gender identity disorder: evidence for a developmental lag. *Arch Sex Behav*. 1999 Dec;28(6):475-502. doi: 10.1023/a:1018713115866. PMID: 10650437.
- [56] Orenstein GA, Lewis L. Eriksons Stages of Psychosocial Development. [Updated 2020 Nov 22]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK556096/> Accessed Jan 25, 2021.
- [57] Baron-Cohen S. The extreme male brain theory of autism. *Trends in Cognitive Science*. 2002;6(6):248-254. doi: 10.1016/S1364-6613(02)01904-6
- [58] Beacher FD, Minati L, Baron-Cohen S, et al. Autism attenuates sex differences in brain structure: A combined voxel-based morphometry and diffusion tensor imaging study. *American Journal of Neuroradiology* 2011; 33, 83-89.
- [59] Strang J F, Meagher H, Kenworthy L, et al. Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child and Adolescent Psychology* 2016, 1-11. doi:10.1080/15374416.2016.1228462
- [60] Dalkey N, Helmer O. An Experimental Application of the Delphi Method to the use of experts. *Management Science* 1963; 9 (3): 458-467. doi:10.1287/mnsc.9.3.458. hdl:2027/inu.30000029301680.
- [61] Strang JF, Knauss M, van der Miesen A, et al. A Clinical Program for Transgender and Gender-Diverse Neurodiverse/Autistic Adolescents Developed through Community-Based Participatory Design. *Journal of Clinical Child & Adolescent Psychology* 2020. DOI: 10.1080/15374416.2020.1731817

- [62] Chen D, Hidalgo MA, Leibowitz S, et al. Multidisciplinary care for gender-diverse youth: A narrative review and unique model of gender-affirming care. *Transgender Health* 2016; 1(1), 117-123. doi:10.1089/trgh.2016.0009
- [63] Parkinson J. Gender dysphoria in Asperger's syndrome: A caution. *Australasian Psychiatry* 2014; 22(1): 84-85. doi: 10.1177/1039856213497814.
- [64] Kenworthy L, Yerys BE, Anthony LG, Wallace GL. Understanding executive control in autism spectrum disorders in the lab and in the real world. *Neuropsychol Rev*. 2008; 18(4):320-338. doi:10.1007/s11065-008-9077-7
- [65] de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011 Aug; 8(8):2276-2283.
- [66] d'Abrera JC, D'Angelo R, Halasz G, Prager S, Morris P. Informed consent and childhood gender dysphoria: emerging complexities in diagnosis and treatment. *Australasian Psychiatry* 2020; 28(5):536-538.
- [67] Littman L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLOS ONE* 2018;13(8): e0202330. <https://doi.org/10.1371/journal.pone.0202330>
- [68] Littman L. Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLOS ONE* 2019; 14(3): e0214157. <https://doi.org/10.1371/journal.pone.0214157>
- [69] RCPsych Position Statement. Supporting transgender and gender-diverse people. March 2018; https://www.rcpsych.ac.uk/pdf/PS02_18.pdf
- [70] Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. *J Am Acad Child Adolesc Psychiatry* 2008 Dec; 47(12):1413-1423.
- [71] Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry* 2011 Oct; 16(4):499-516.
- [72] Drummond KD, Bradley SJ, Peterson-Badali M, Zucker KJ. A follow-up study of girls with gender identity disorder. *Dev Psychol* 2008; 44:34-45.
- [73] Singh D. A follow-up study of boys with gender identity disorder. Doctoral dissertation, University of Toronto; 2012.
- [74] Vrouenraets L, Fredriks A, Hannema S, et al. Early medical treatment of children and adolescents with gender dysphoria: an empirical ethical study. *J Adolescent Health* 2015; 57: 367-373.
- [75] Gherovici P. (2010) *Please Select Your Gender: From the Invention of Hysteria to the Democratizing of Transgenderism*, Routledge, 2010.