Autistic spectrum disorders, personality disorder and offending in a transgender patient: clinical considerations, diagnostic challenges and treatment responses

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Abstract

Purpose – *The case of a woman with a history of offending and prolonged imprisonment is given. The purpose of this paper is to explore the complex interplay between diagnoses of autistic spectrum disorder (ASD), personality disorder and gender dysphoria. A discussion on useful and less useful treatment approaches follows, given the unusual and complex clinical presentation.*

Design/methodology/approach – *This is a case report with a summary of the background to this under-researched area.*

Findings – *The way in which the diagnostic picture clarified over time is explained. The difficulties in accurately diagnosing are put forward and strategies to address this are suggested. Successful treatment of unusual clinical problems may require highly individualised care within generic services.*

Originality/value – *The authors know of no similar case reports in the published literature. The clinical associations between ASDs, personality disorders and gender dysphoria, in forensic mental health populations, appears to be unexplored in the literature.*

Keywords *Services, Adults, Autism spectrum disorder, Complex needs, Mental disorder, Offending behaviour*

Paper type *Case study*

Background

Autism and offending

The relationships between autistic spectrum disorders (ASDs) and offending have been extensively reviewed (Dein and Woodbury-Smith, 2010). It is well established that patients with ASDs can present with challenging behaviours. These behaviours put such individuals at risk of entering the criminal justice system, especially if they are more able. The patients less able may be protected on the grounds of possibly being unfit to plead, or lacking in *mens rea* (Cashin and Newman, 2009). In relatively recent years there have been policy-based publications focusing specifically on offenders with autism, such as "autism, a guide for criminal justice professionals" (National Autistic Society, 2011). However, further understanding is required into the prevalence of autism in offenders and co-existing factors that might lead to offending behaviour.

The Royal College of Psychiatrists' Report on the management of autism in adults details characteristics in individuals with autism that may predispose them to entanglements with the law

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(Berney *et al.*, 2014). Research carried out in inpatient forensic psychiatric services has demonstrated the greater prevalence of ASDs in such settings. One study (Scragg and Shah, 1994) found 1.5 per cent of patients had a diagnosis of Asperger's syndrome (higher than the general population) in a UK high secure forensic psychiatric hospital. The Royal College's Report draws on the lack of community studies and that the specialist nature of these settings prohibits extrapolation to other more generalised settings such as prisons. A more recent study in Scottish prisons highlights the difficulty in identifying individuals with autism, let alone estimating its prevalence (Robinson *et al.*, 2012).

One systematic review (King and Murphy, 2014) found that whilst there is emerging literature on the link between ASD and offending, people with ASD do not seem to be disproportionately over-represented in the criminal justice system. The review also found a lack of evidence on the presence of co-morbid psychiatric diagnoses amongst offenders with ASD, and a lack of certain types of crimes. It is important to note in this context the difficulty in distinguishing personality disorder from ASDs, which is an issue that has been receiving attention for many years (Fitzgerald and Corvin, 2001).

One national study carried out in Sweden (Langstrom *et al.*, 2009) examined longitudinal registers for 422 patients hospitalised with ASD. 7 per cent had been convicted of violent, non-sexual offences and 2 per cent with sexual offences. Violent individuals were more likely to be diagnosed with Asperger's syndrome rather than ASD. Individuals with substance misuse and co-morbid psychotic illness were more likely to have a history of violent offending.

Gender dysphoria

Gender dysphoria/gender identity disorder refers to individuals who experience significant dysphoria (discontent) with the sex and gender they were assigned at birth. It is classified as a medical disorder, in accordance with ICD-10 (World Health Organisation, 1992) and DSM-5 (American Psychiatric Association, 2013). However, there is controversy surrounding this diagnosis due to the notion that it pathologises gender variance, and in turn increases stigma. It is hoped that the terminology of "gender dysphoria" rather than "gender identity disorder" in DSM-5 may help resolve some of these issues, because the term then applies only to the distress experienced by individuals with gender identity problems (Newman, 2002).

The prevalence of gender dysphoria/gender identity disorder ranges from 0.05 to 0.5 per cent, based on people who identify themselves as transgender. It is estimated that about 0.005-0.014 per cent of males and 0.002-0.003 per cent of females would be diagnosed with gender dysphoria, based on current diagnostic criteria (Coleman *et al.*, 2012).

Much of the research on gender dysphoria/gender identity disorder is focused on whether this is linked with psychiatric co-morbidity. This is because the relationship between this disorder and psychiatric co-morbidity is known to have major negative prognostic features for the outcome of gender reassignment surgery (Meyer-Bahlburg, 2010). Of the available literature on gender identity disorders and criminal offending, much is focused on the vulnerability of these individuals to abuse and bullying, as well as ethical and moral dilemmas placed on prison services and mental health services to manage this appropriately. The prevalence of offending amongst patients with gender identity disorders/gender dysphoria has yet to be extensively studied.

Associations between ASDs and gender dysphoria

A possible association between gender identity disorder/gender dysphoria and ASDs has yet to be evaluated in great depth. The literature available is limited to case series.

One of the first epidemiological studies to highlight this co-occurrence assessed rates of ASD in 204 children and adolescents referred to a gender identity clinic (De Vries *et al.*, 2010). This revealed a co-occurrence of both diagnoses at 7.8 per cent, which is four times the rate within the general population. The study acknowledged that of the 16 children/adolescents who presented with both gender disorders and ASD, only five persisted with both at follow-up. The report suggested this co-morbidity may indicate a phenomenon of childhood.

Further research into the adult population has been undertaken, by assessing autistic traits using interview and questionnaire methods in a sample of adults with a confirmed diagnosis of transsexualism (Paterski *et al.*, 2014). The study showed five of 16 patients persisted with a co-morbid diagnosis of ASD, four of whom were adolescents.

A different study notes that the "extreme male brain" theory suggests females with ASD are hyper-masculinised in certain aspects of behaviour (Jones *et al.*, 2012). This study found that genetic females with gender dysphoria have an increased number of autistic traits compared to the general population. They also had significantly more autistic traits than control men. Six of 198 participants (3 per cent) had a diagnosis of ASD in the trans women group. Transmen had an 11-fold increase in the rate of "narrow autistic phenotype" relative to typical males.

The case presented in this paper highlights how diagnostic complexity and co-morbidity across these domains can become associated with offending. Difficulty providing appropriate treatment to help bring about and demonstrate reductions of risk is explored. Approaches for healthcare providers to manage this important patient group are put forward.

Case presentation

Ms CB is a 52-year-old white British woman, from a former industrial town in the north of England.

There are no known mental health problems amongst family members. She is from a fairly traditional working class environment. She has described her childhood being fairly happy and she has maintained close links with her family throughout.

She was born biologically male but had symptoms of gender dysphoria from the age of seven. She was bullied extensively at school in part due to this, but also as she had a marked speech impediment (for which she received speech therapy) and was quite bookish in demeanour. She left school with no formal qualifications.

She underwent a period of time working as a labourer, with occasional time spent in receipt of state benefits. She would tend to feel guilty about receiving these, placing a high value on contributing to society. She subsequently worked on a farm with her father. She then did some office work from her mid-20s.

She underwent gender reassignment surgery in her mid-30s but felt discriminated against at work and decided to move to London, where she thought there would be more tolerance due to the city's diversity. She lived in London for four years prior to the offending that led her into custody. During her time in London she worked in a stationery store, managing to become a shop manager.

She had no significant intimate relationships prior to her gender reassignment. Her decision to move to London was in part based on a plan to meet a man she had met via dating magazines for trans people. Unfortunately the relationship was not a happy one, with her account being of domestic violence, controlling behaviour, infidelity and theft by her partner. She was eventually made homeless by the partner.

Her psychiatric history is fairly brief, other than her involvement with gender dysphoria services prior to her reassignment. Initially they referred her to the local community mental health team for social support due to her shy and sensitive demeanour, although some histrionic and dependent personality traits were also thought relevant. By the age of 33, however, it had been agreed she should have gender reassignment. Prior to the operation there were a number of overdoses and episodes of self-harm by cutting, however. She was being treated with antidepressants prior to the operation.

There is no history of significant substance misuse and she has no physical health problems.

Offending

She had never been in contact with the police prior to the offence that led her into prolonged imprisonment, which took place when she was in her early-40s. She has subsequently reported feeling violent when living as a man, and has also described preoccupation and fascination with

knives. She would carry them to feel relaxed and grip them if she felt uneasy. She would occasionally fantasise about killing people who were reliant on state support. She also described sexual excitement from knives.

The offence was committed at the local unit designed to assist homeless people with their housing needs, located in an inner city part of London. She had expected that the state would be able to provide her with immediate housing. On finding this was not the case, and being unable to accept that their response had been adequate, she brought out two knives and showed them to staff. Although she did not threaten violence directly, she refused to give up the knives and the police were contacted. That children were present in the unit was considered an aggravating factor of the incident.

She was arrested and convicted of Possession of Offensive Weapons, for which she received a four-year prison sentence. She appealed against the severity of the sentence but her presentation in Court was of concern, with her threatening to blow up the Court and to kill her ex-partner. An Indeterminate Sentence for Public Protection (IPP) was imposed, with a minimum tariff of one year. This form of sentencing was only available between 2005 and 2012 before being abolished, but those sentenced under its provisions remain subject to it. Thus, although her length of sentence had been nominally reduced, she would not be released from prison until she could demonstrate to the Parole Board that she no longer posed an undue risk in the community. Sentencing under an IPP is therefore not dissimilar to receiving a life sentence.

Prison

On her reception into prison she was seen by a forensic psychiatrist. They noted Borderline traits in her personality, including uncertain self-image, emotional impulsivity and ongoing thoughts and acts of self-harm. Narcissistic traits were also thought evident, such as her lack of empathy, grandiose self-importance and envy of others. She was not felt ready to do psychological work on this, which would anyway be available to her in prison.

She spent four years in the ordinary prison estate. At times she experienced bullying and there were also infrequent assaults and threats. There was little progress made and she was not felt any closer to a recommendation for release. A referral was made to the Dangerous and Severe Personality Disorder (DSPD) unit within the prison service.

Her assessment by this unit included a range of rating scales. They revealed narcissistic and anankastic personality traits, with some psychopathic traits evident. She was accepted by the DSPD unit. Whilst there she reliably engaged in a full range of psychological groups. She did more than 80 sessions of a Life Minus Violence group but was still felt to need more work on her fantasising, interpersonal skills and emotion management. She tended towards avoidance as a coping strategy.

She then did some offence-focused work on a Cognitive Behavioural Therapy framework. She did this for more than a year. Whilst there was some improvement in her rigid style of thinking, she continued to show little ability to generalise her learning or to identify positive strategies to avoid violence. Her interest in knives had shifted towards books and she had not self-harmed for a number of years. She repeatedly failed to be released by the parole board due to concerns that gains made would not be generalised in the community.

It was when staff underwent some training on Asperger disorder that a novel way of thinking about CB's difficulties came about. An opinion from a specialist was sought who reframed some of the symptoms previously considered part of a personality disorder as being consistent with an ASD. They noted the lifelong difficulties in social communication and relationships. She was felt to lack a central coherence, in which context could help her guide her future behaviour. She was not felt to have a textbook case of Asperger syndrome and the diagnostic and management confusion staff experienced was thought to reflect this. It was concluded an environment where her problems could be better understood would be appropriate and she was referred for hospital admission.

It is important to note that by this point there was the evidence of several years of intensive support and supervision by the DSPD unit, and no criticism of the initial psychiatric formulations is intended.

Hospital

Due to her legal situation, CB required treatment at a medium-level of security. In England, Regional Secure Units exist around the country to provide this care, with most patients suffering from psychotic illness, with a lower number having affective disorders or primary personality disorder. Co-morbidity of mental illness with personality disorders and substance use disorders is common in the patients admitted to these units. The great majority of patients in such units are men, which has allowed some development of specialist services for male service users, e.g. for personality disorder, intensive care and rehabilitation. Fewer specialist services are available for women, although that has enabled services to become adept at managing different patient groups within mixed-need environments.

CB was transferred from prison to a medium-secure ward for women. The Mental Health Act allows such transfers to take place, whilst the patient remains legally a serving prisoner.

There were some anxieties about how she would settle amidst the occasional chaos of an environment with severely psychotic patients, but extensive efforts were made by the staff, in conjunction with CB, to develop structures and routines that would help her to manage the environment.

Her treatment has emphasised developing prosocial interests and skills, which it is hoped she will be able to gradually transfer into the community. She is also developing an understanding of her interpersonal styles and challenges using a Cognitive Analytic Framework, in individual sessions, which she has been able to engage with well.

An extended ASD assessment was completed following her admission to hospital. This incorporated the autism diagnostic observation schedule (ADOS) (Lord *et al.*, 1989) and the adult asperger assessment (AAA) (Baron-Cohen *et al.*, 2005) using information from multiple sources.

The ADOS produced a score of 3 on the communication domain (meeting the threshold for autism) and of 4 on the social interaction domain (meeting the threshold for ASD but not autism *per se*). Thus the ADOS was suggestive of ASD.

The AAA incorporated two self-report questionnaires (relating to empathy and autism quotient). The self-report questionnaires did not meet the thresholds for ASDs, although some important characteristics were self-identified. Information was then obtained from two different immediate family members and a discussion was also held with members of the clinical team who had observed CB for many months in hospital. CB was observed to have three of five symptoms in the social interaction domain, three of five in the routines/interest domain, four of five in the communication domain and two of five in the imagination domain, as well as five of five in the prerequisites domain. This met the necessary cut-off for diagnosing ASD.

Her progress in hospital, when contrasted with her experience in prison, is strongly supportive of managing her complex needs through the healthcare route. The formulation that was developed from the ADOS/AAA assessment further enabled healthcare professionals to adapt their management approaches to CB's particular needs in a generic environment with no specific prior experience of working with people with ASDs.

CB has taken on service-user representative roles, which has enhanced her confidence. She has begun to cautiously use leave from the hospital, which was challenging for her initially, but which she has developed to include regular sessions at a local library and a community work placement. She works in the hospital's service-user led café, where she has also taken on a managerial role. Transferring these gains into the community through increased use of leave is the next step for her.

Through developing such a programme and managing sometimes difficult situations in the ward environment, it is anticipated that she will be able to demonstrate to the parole board in due course that her risk has reduced, enabling her to live a meaningful and safe life in the community.

Conclusions

Most clinicians in mental health services have only limited experience of diagnosing and managing ASDs, and yet it is inevitable that generic services will be responsible for providing care and treatment to the majority of people with such disorders who develop significant problems as a result of them.

Distinguishing ASDs from personality disorders is challenging, especially for clinicians very experienced in diagnosing the latter. It is even more challenging when co-morbidity with personality disorder and/or mental illness exists and where additional complexity such as gender dysphoria is relevant.

CB's case also demonstrates the importance for those preparing expert reports for the Courts to consider the possible diagnosis of ASD, and the potential ways in which this might link to offending behaviour, even when the diagnosis is not immediately obvious.

People with ASDs will usually struggle to demonstrate progress in environments where resources are not tailored towards their needs. On the other hand, even in generic services, it is possible to individualise care for people with these presentations and to be optimistic about outcomes.

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