

Clinical Case Rounds in Child and Adolescent Psychiatry

When Attachment Disorder Presents With Symptoms of Gender Identity Disorder: Case Discussion

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This report describes the case of a seven-year-old boy, who presents with symptoms of both gender identity disorder (GID) and attachment disorder (AD). Thus many aspects of his symptomatology could not be attributed exclusively to either disorder. Although attachment problems are linked to GID (Zucker & Bradley, 1995), the scientific literature has not assessed to date whether these disorders might impact each other.

The seven-year-old boy was adopted at the age of 16 months in an Asian region of Russia. Although his perinatal history is unknown, his adoptive parents stated that they had no reason to believe it had caused developmental delays in the child. They said that they had no preference concerning the sex of the child they wished to adopt. They noted that the boy found it difficult to integrate into his new family. During the initial months with his adoptive family, he was hesitant to form relationships with others—in particular with male figures of all kinds, including his adoptive father, who remained committed to the boy during this period. Marked opposition, and behaviours reflecting an intense and persistent identification with the opposite sex, also emerged several months after adoption, at around the age of four or five. Most of the children in the boy's social circle were female. He wore makeup and his mother's clothing and jewellery, and asked that his penis be removed in order that he might have a vulva. He exhibited a passion for female activities, such as gymnastics, drawing, dancing and singing. Although his adoptive parents did not encourage this behaviour, they did tolerate it. During this time, the child expressed ongoing confusion about his sex at birth, and regularly asked his parents if he were a girl or a boy. Although he now con-

siders himself to be a boy, he says that he is unsure if he will remain a boy in the future. He does not, however, display a marked sense of inadequacy about his current sexual orientation. He also has typical male fantasies, such as the desire to one day be a firefighter or police officer. The boy was calm and pleasant during the interview. He was intelligent and aware of what was being said, and he also looked for his mother's approval on a semi-constant basis. The mother was attentive and reassuring. It was observed, however, that she put the problems and needs of her son before her own. She also called him by an affectionate nickname that would have been more appropriate for a younger child of the female sex. The father was attentive to the needs of his son, but seemed, nevertheless, to be withdrawn from the family. He participated only slightly in the interactions. No sign of insecure attachment was observed. Moreover, there was no indication of marital discord or unresolved grief or trauma by the parents. They were committed to the child and did not provide distorted or insufficient information.

When the boy was approximately three years old and then again when he was five years old, the parents had consulted psychologists about the serious behaviour problems exhibited by their son. During his early years, he had exhibited an ongoing inability to engage in, and respond appropriately to, social situations, due to significant relationship inhibition, but this problem had nearly disappeared. He had become, however, highly oppositional. For example, he exhibited low tolerance for frustration, argued, refused to follow rules, and had intense temper tantrums. During the first psychological assessment, he was diagnosed with AD. The intervention that had been proposed to

the parents to address the oppositional behaviour of the child had been somewhat successful. But certain aspects of his disturbed behaviour, such as a low tolerance for frustration, were still evident at home and at school, where the child began to be ostracised by his peers. These problems motivated his parents to once again seek psychological help, although the conclusions and recommendations they received remained, for the most part, unchanged.

Upon completion of its evaluation, the consulting team reaffirmed the diagnosis of non-specific GID. The initial intervention had employed psychoeducation to stabilize and positively reinforce the sexual identity of the child. Clearly, psychoeducation will also be eventually required to address the residual symptoms of AD. Certain symptoms of anxiety were also present during the evaluation. But these symptoms were judged, at that time, to fall within the scope of the two other disorders, rather than indicating the presence of a primary anxiety disorder. It was noted that the child has not been re-evaluated since this meeting; therefore, the consulting team had no longitudinal data.

Discussion

GID and AD do not occur frequently. The exact prevalence of GID is unknown. The prevalence of AD is estimated to be less than one percent of the population (Sadock & Sadock, 2007). Therefore, it might be possible, though very rare, for these two disorders to co-exist.

A lack of progressive patient care, responsible for the AD behaviour problems, is presumed to be a factor in this diagnosis. This deprivation can be caused by a repeated change in caregivers for the child, which would hinder the development of secure relationships (American Psychiatric Association, 2000). This situation is frequently found in longitudinal studies of adopted children, who are at greater risk of developing AD (Zeanah, 2000).

Since there is an overrepresentation of

adopted children being referred to clinics for GID (Zucker & Bradley, 1998), one can postulate that GID is more common in this population. One can also postulate that AD, in certain cases, is a symptom of GID. Therefore, one could argue – although data does not seem to be available on this point (probably because these disorders are uncommon and rarely studied)—that AD and GID co-exist when maternal sensibilities play a major role. (Marantz & Coates, 1991) (Moran et al, 2008).

Although this report suggests possible comorbidity between GID and AD, it also indicates the possibility of overlap (at least in terms of symptoms) between these clinical disorders.

Acknowledgements / Conflicts of Interest

The authors have no financial connections or conflicts to disclose.

References

- American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR). Washington, DC: American Psychiatric Association.
- Marantz, S. & Coates, S. (1991). Mothers of boys with gender identity disorder: a comparison of matched controls. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30 (2), 310–5.
- Moran, G., Forbes, L., Evans, E., Tarabulsy, G. M., & Madigan, S. (2008). Both maternal sensitivity and atypical maternal behaviour independently predict attachment security and disorganization in adolescent mother-infant relationships. *Infant Behavior and Development*, 31(2), 321–5.
- Sadock, B. J. & Sadock, V. A. (2007). Reactive Attachment Disorder of Infancy or Early Childhood. In: Synopsis of psychiatry, *Behavioral Science/Clinical Psychiatry*, 10th ed. Williams & Wilkin, p. 1250.
- Zeanah, C. H. (2000). Disturbances of attachment in young children adopted from institutions. *Journal of Developmental and Behavioral Pediatrics*, 21, 230–236.
- Zucker, K. J. & Bradley, S. J. (1995). Etiology: Psychosocial Research. In: *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*, 1st ed. New York: Guilford, p. 226–230.
- Zucker, K. J. & Bradley, S. J. (1998). Adoptee overrepresentation among clinic-referred boys with gender identity disorder. *Canadian Journal of Psychiatry*, 43, 1040–1043.