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Gender Incongruence, Depression and School Refusal: Clinical and Psychological Approach to A Case in an Adolescent Girl

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Abstract

Gender incongruence in adolescents is an increasingly common clinical problem in child psychiatry, often associated with significant psychological distress. When accompanied by depressive symptoms and school refusal, it poses a considerable diagnostic and therapeutic challenge. This article presents the case of a 14-year-old adolescent girl, seen for school withdrawal and mood disorder, in whom persistent gender incongruity was identified. The proposed clinical analysis aimed to explore the psycho-pathological links between gender identity, depression and dropping out of school, and discussed the clinical and ethical implications. In this context, care raises many questions around consent, the temporality of decisions, and the potential psychiatrization of the adolescent journey. It is essential to provide a space for free speech, without any specific direction. The role of caregivers is to enable a safe exploration of identity, while avoiding premature medical projections.

Keywords: Gender, identity, incongruence, depression, adolescent, school refusal.

INTRODUCTION

Adolescence is a pivotal period of development, marked by physical, psychological and social upheavals. Mental health issues are common and can be indicative of gender incongruity [1].

The latter is defined as a discordance between the assigned gender and the felt gender. It is recognized by the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the 11th revision of the International Classification of Diseases (ICD-11) as a clinical entity that can be a source of significant suffering [2, 3].

Several studies have highlighted an increased prevalence of anxiety-depressive disorders in young people expressing such incongruence [4, 5].

This association raises clinical questions about its nature: is depression a consequence of stigma or a factor contributing to an incomplete sense of identity?

This article offers a clinical reading through the case of an adolescent girl, discussing ethical and therapeutic perspectives in a developmental approach.

OBSERVATION

- Socio-demographic data and family context

This is Eve (first name used for anonymity), aged 14 and in 5th grade. She was the only child of the parental couple, living with her mother since moving 6 months before the day of the first meeting. The parents had been divorced for 3 years, but maintained cordial relations. She spent every other weekend at her father's house. The latter had gotten back together and was living with his new partner and her children.

Intrafamily relationships were described as generally cordial, although a certain withdrawal had been noted in Eve over the past year. She was described as distant from her father. The latter explained this by a disagreement over a proposed name change. There was no family history of psychiatric follow-up, although anxious vulnerability was described in the mother. The parents reported a notion of psychological follow-up for

Eve, for the past three years due to anxious school refusal.

- Reasons for consultation

Eve had come for a consultation for the purpose of continuing her follow-up at the medical psychological center after the move. Her parents had accompanied her for an initial meeting. They said they were beginning to worry following repeated absenteeism. According to them, Eve had not attended school for about two months, citing abdominal pain and a general feeling of malaise. The parents reported persistent sadness, social withdrawal, loss of appetite, and repeated thoughts of death. The refusal to go to school seemed linked to significant anxiety about being exposed to the gaze of others, particularly since the first signs of puberty.

- Developmental and identity anamnesis

According to her parents, Eve was the result of a planned pregnancy and the delivery went well. Her psychomotor development was described as uneventful. Since early childhood, she showed a consistent preference for activities, clothing, and games socially associated with the male gender. From the age of 9, she expressed discomfort with feminine bodily characteristics, particularly her long hair and so-called "feminine" clothing. She asked to be called by a male name within the family, a request that was met with some perplexity but without outright opposition. The onset of puberty, with the development of secondary sexual characteristics and the onset of menstruation, was experienced as a bodily trauma. According to the parents, this period coincided with the beginning of social withdrawal. The mother added that Eve had suicidal thoughts, saying she wanted to remove her uterus with a knife to stop menstruating.

- Clinical evaluation

It consisted of clinical observations collected during consultations that took place at the adolescent medical-psychological center. The care team consisted of child psychiatrists, nurses, and psychologists. They welcomed adolescents from 12 to 18 years old. Each patient had a referring nurse and a doctor or psychologist who was the treatment director.

The team implemented individualized diagnostic and therapeutic interventions.

She provided support based on a partnership with national education, school medicine, pediatrics, the reference hospital center, justice, etc.

In our case, the assessment consisted of semi-structured interviews with Eve and her two parents. The collection of anamnestic data and direct clinical observations (appearance, attitude, emotional expression, thoughts, judgment, perception, instinctual and social behaviors), were part of an exploratory approach whose purpose was to make a qualitative analysis of psychological and contextual symptoms.
No standardized psychometric tools were used during these consultations.

- Clinical results

The first interview highlighted a cold contact, a body and clothing presentation with loose clothing (t-shirt and wide pants). The facial expressions were not very mobile, expressing anxiety. Eve was calm, the parents did not report any behavioral problems. Her sleep was of poor quality; she had difficulty falling asleep at night and had repeated nightmares. The diet was not reduced. She had refused to go to school for 4 months, kept herself apart from the peer group and did not go out during breaks. She explained this by the discomfort linked to the persistent use of her birth name by teachers and her classmates.

Indeed, Eve expressed a strong desire to be called "Fred", the first name she had chosen, and wanted to initiate administrative procedures to change her civil status.

Her depressive mood was associated with self-deprecating speech and social anxiety. Eve reported feeling uneasy about her body and experiencing painful inner conflict. She used the term "gender dysphoria" to describe her psychological state. In this sense, she described growing unease at school, reinforced by gendered remarks from some classmates. "*Why do they tell me I have girl's hands? How can limbs be gendered? I'm fed up and want to crush them when they tell me I look like a girl. Plus, they get my first name wrong and can't understand that my name is Fred, and neither can the teachers when they take the roll and publish my grades!*"

She described anxiety attacks when confronted with the mirror, exacerbated during menstruation. She could go five days without taking a bath; if necessary, she would keep her T-shirt and shorts on in the shower. This technique allowed her to avoid seeing her body even underwater, she said.

The parents reported their helplessness in the face of their daughter's request for identity. The father expressed reluctance and sought the psychiatrist's opinion on whether or not to grant parental authorization to initiate the administrative process for a name change. He expressed concern about the influence of social media and a desire to delay. "*Doctor, tell me what I should do. I don't think I should make this big decision that will change her life. I would have preferred her to wait until she was an adult, that way she could do what she wanted.*" said the father.

The mother seemed more inclined to go along with the name change project, although she expressed fears about their child's academic future.

- Monitoring and support

Eve attended the appointment regularly, every week at first, then every month. She was accompanied most of the time by her mother. Given the anxio-depressive disorder with the presence of suicidal thoughts, antidepressant treatment was introduced with associated psychological monitoring. After 5 months, her mood had stabilized, and she reported fewer dark and suicidal thoughts. However, showering and menstrual periods were still anxiety-provoking. There were moments of increased anxiety during altercations with her father when Eve went to his house on weekends. She blamed him for not taking her suffering into account.

"*I have gender dysphoria! And my father refuses to sign the paperwork for the administrative procedures. What didn't he understand?*". This is the wording she used to express her pain during interviews.

After 7 months of follow-up, the father finally agreed to give his consent so that Eve could begin the administrative procedures. She felt relieved, complained less and less of anxiety, and the suicidal thoughts had completely disappeared. However, her sleep was still disturbed with difficulty falling asleep. Regarding schooling, a return to school was not considered. Fred instead planned to continue classes with the National Center for Distance Education. A referral letter was written for specialized care in a support structure for trans-identities for parallel follow-up.

DISCUSSION

- Limitations of the study

The article aims above all to open a clinical and ethical reflection, more than to produce quantitative results. This is an illustrative case and not a study that can be generalized to all adolescents presenting gender incongruence or school refusal. Then, the results are limited by the absence of psychometric assessments such as the Wechlser Intelligent Scale for Children (WISC) which would provide insights into the overall cognitive functioning of the adolescent and reduce bias during the diagnostic discussion. The administration of this test could not be carried out by psychologists in the sector during the study period, given their waiting lists with delays of approximately 6 months. Finally, the information on school dynamics (position of the establishment) remains ambiguous. This reduces the overall understanding of the refusal to return to middle school.

- Psychopathological understanding of the case

Fred's case highlights the complexity of the links between gender incongruence and mood disorders. Symptoms appear to be organized around a pathogenic core consisting of gender-related discomfort. Depression appears here as an effect of this unverbalized identity suffering. The literature shows an increased risk of anxiety and depressive disorders among young people experiencing gender incongruence [6, 7].

Indeed, the non-recognition of the felt identity is an aggravating factor of psychological distress, while the social acceptance of the chosen first name appears to be a protective factor against depression and the risk of suicide [8, 9].

Although it is not yet clearly understood, studies indicating the link between autism and transgender identities are increasingly numerous. In addition, current results suggest the presence of low empathy and a reduced theory of mind in them. In our observation, atypical clinical elements could raise the possibility of an autism spectrum disorder. Even if the developmental trajectory does not provide any guidance in this direction, it will also be necessary to be vigilant regarding the occurrence of a possible dissociative component.

- Adolescent specificities

Adolescence is a period of intense psychological transition, where identity markers are being fully constructed. Thus, bodily transformation imposes a biological reality that is sometimes in contradiction with subjective experience [11, 12].

In Fred's case, puberty acted as a major trigger, making the probably latent identity conflict intolerable and speaking thus by his difficulties in looking at himself in the mirror. Rautio's work allows us to interpret this conflict as the expression of suffering linked to pubertal bodily perceptions [13].

Furthermore, confrontation with the gaze of peers, particularly prevalent in the school environment, increases anxiety and accentuates isolation [14].

This would explain Fred's school refusal. His attitude can be understood as an attempt at defensive withdrawal in the face of an environment perceived as persecutory, non-inclusive or malicious. For example, the persistent use of the birth name by teachers and classmates is a major trigger for anxiety. Russel in his study had shown that the use of the chosen first name considerably reduces depressive symptoms and suicidal thoughts [15, 16].

- Family and ethical issues

Family involvement in symptom dynamics and care is essential. Parental support is identified as a protective factor in the journeys of young transgender people. In Fred's situation, the divergence of parental positions generates a climate of latent tension which, without being directly conflictual, would fuel his feeling of ambivalence according to the study by **Durwood** *et al.,* [17].

Ethically, the psychiatrist was in a delicate position, having to maintain a certain neutrality. He was building a therapeutic alliance with Fred, avoiding taking on the role of legal arbiter in the request for

administrative change. Indeed, international recommendations insist on clinical prudence allowing for psychological maturation [18].

This therapist's position allows the adolescent to be supported in exploring their gender identity while supporting the family in the process of understanding and acceptance; without freezing or denying the reality of the identity experience [19].

- Practical guidelines according to the literature

The therapeutic arsenal was based on a trans-disciplinary approach, relieving anxieties and gradually reintegrating the adolescent into a secure social environment. Fred's psychotherapy was focused on welcoming identity speech and tolerating uncertainty. Parental support would have helped to promote dialogue, reduce parent-child tensions and redefine places [20].

Clinical monitoring was provided during follow-up appointments. It aimed at a regular assessment of suicide risk. The latter was common in this type of situation. However, there was no action on the part of Fred, which could be explained by the reassuring maternal support [21].

Specialized support would make it possible to put in place specific care based on the desire for social, hormonal or surgical transition [19]. In our case, Fred was looking forward to his 16th birthday before making the decision to start hormone therapy.

Finally, consultation with the school team would have created the conditions for a gradual return, while respecting the gender experience and the use of the chosen first name [14, 15].

This was lacking in our care. Therapeutic coordination involving educational partners was difficult to establish. Consultation schedules left little room for efficient collaboration to organize school meetings.

CONCLUSION

The picture presented by Fred reflects a multidimensional suffering where intra-psychic, familial and institutional issues are interwoven. Depression and school refusal must be understood as warning signals expressing a psychological impasse. It seems clear that the issue cannot be addressed unequivocally. So, far from calling for a normative response, this type of situation imposes on the clinician a stance of listening and caution. His role consists less in deciding on administrative procedures than in supporting the subject in his identity symbolization. The authors declare that they have no conflict of interest.

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