Girls and female adolescents diagnosed with autism spectrum disorder: A descriptive study

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ABSTRACT

Introduction. Autism spectrum disorder (ASD) presents challenges in social communication and behavior. It is more common in males (3:1). Girls receive alternative or delayed diagnoses due to better communication skills, atypical but less unusual interests, greater presence of internalizing behaviors, and camouflage strategies. This can lead to underdiagnosis and limit access to adequate support.

Objective. To describe the population of girls and female adolescents (GFA) with ASD being monitored at a tertiary hospital, comparing them according to age and clinical characteristics.

Population and methods. Descriptive, cross-sectional study with retrospective analysis of medical records of GFAs evaluated between 2002 and 2024. Data on development, physical examination, and sociodemographic variables were collected. The sample was divided into preschoolers and schoolchildren, and by the presence or absence of language at the time of diagnosis.

Results. A sample of 415 GFAs was obtained. Sixteen percent (n = 69) received a late diagnosis. In older girls, two profiles were identified: one compatible with the female phenotype of ASD (language present, lower intellectual disability, consultation for social difficulties) and another with characteristics of profound autism (no language, higher intellectual disability, epilepsy, regression, and greater severity). In preschoolers, cognitive impairment or failure to adapt to formal assessments predominated. A family history of ASD or an broader autism phenotype were present in 19.5% (n = 81) of cases.

Conclusion. We observed a high clinical variability, which requires greater diagnostic sensitivity and specific tools to facilitate adequate support.

Keywords: *autism spectrum disorder; phenotype; female; girls; adolescents.*

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INTRODUCTION

Autism spectrum disorder (ASD) refers to a diagnostic category within neurodevelopmental disorders characterized by challenges in social communication and repetitive and stereotyped behaviors.[1]

Classically, it has been described that the diagnosis is more frequent in males than in females, regardless of age (3:1).[2] This ratio decreases (2:1) in the presence of intellectual disability (ID) and is higher (10:1) in people with ASD with average or above-average intellectual ability.[3] Attempts to explain this discrepancy range from the extreme view that females have some protective genetic factor to explanations that focus on professional bias.[4]

Several publications show that conventional diagnostic tools have greater difficulty detecting women with ASD (gender bias), especially in the subgroup without ID.[5] For this reason, girls are consulted at a later age or receive inaccurate or different diagnoses, such as language, learning, anxiety, personality, or eating disorders.[6] It is estimated that approximately 80% of them are diagnosed after the age of 18.[7] Several authors argue that this is because the classic diagnostic criteria do not help identify this group. Under this assumption, they propose the identification of a specific behavioral phenotype for women with ASD. This female phenotype of ASD (FFA) maintains the core challenges of autism, but these characteristics are expressed in a different way than those traditionally described in autism in males.[3]

In pioneering work by Asperger and Atwood, differences between males and females are already evident, with females exhibiting better social imitation skills.[8] The FFA shows different traits in socialization, restricted types of interests, a greater presence of internalizing behaviors, and the phenomenon of camouflaging. Girls tend to exhibit better communication skills and greater persistence of sensory symptoms throughout their lives. They also show greater initiative in reciprocal conversation and are more motivated to initiate friendships, although their difficulties involve deficits in initiating, maintaining, and resolving problematic situations. On the other hand, the special and restricted interests they demonstrate tend to be less unusual but atypical in their intensity and quality.[9] Camouflaging is the use of strategies that compensate for the social challenges of ASD, but at the cost of great cognitive effort, stress, and emotional impact.[10]

On the other hand, the female protective effect hypothesis[9,11] posits that girls and women require a greater genetic burden or environmental impact than boys to develop ASD, either through differences related to sex chromosomes or the role attributed to fetal androgens (the "extreme male brain" hypothesis). Women would be more protected against the same risk factors.

It has also been suggested that there is underdiagnosis in women related to the use of diagnostic tools based on male stereotypes.[12] Underdiagnosis or late diagnosis, due to the unconventional presentation of the subgroup of girls and female adolescents (GFA) with ASD, will result in a lack of appropriate specific educational and therapeutic support and will have adverse effects on quality of life, education, functioning, and mental health.[13,14]

The objective of this study was to describe the population of GFAs diagnosed with ASD being monitored at the Interdisciplinary Neurodevelopmental Clinics Service (CIND, by its Spanish acronym) of the Hospital Garrahan, compare them according to age groups, and relate the characteristics of our population to those described in the literature.

POPULATION AND METHODS

A descriptive, cross-sectional study was conducted with retrospective analysis of medical records. Data were collected from the diagnostic evaluation of all girls and young women with ASD carried out at CIND from 2002 to 2024. Patients with an uncertain diagnosis or undergoing evaluation were excluded. All patients were evaluated simultaneously by multiple professionals, and in many cases, this evaluation took place over several meetings. The evaluation team consisted of developmental pediatricians, speech therapists, and educational psychologists with experience in evaluating and following up children and adolescents with ASD.

The diagnosis of ASD was made according to international recommendations through the clinical history of development, clinical observation, physical examination, and standardized complementary scales for assessing communication, social interaction, and behavior, such as the Autism Diagnostic Observation Schedule-2 (ADOS-2),[15] the Childhood Autism Rating Scale (CARS)[16] and based on the criteria of international reference manuals (DSM-IV[17] and DSM-5[18]). In relation to the developmental assessment, developmental quotients (DQs)

were obtained according to age using the CAT/CLAMS[19] or Bayley-III[20] Scales, and IQ scores were obtained using the Wechsler[21] or Stanford-Binet[22] scales. A score of less than 70 points was defined as a delay. The definition of discrepancy varied depending on the information provided by the test administered. It was recorded as "did not adapt" when, during the test administration, the patient was unable to complete it due to behavioral issues.

Regarding the physical examination, microcephaly was defined as a value below 2 standard deviations (SD) from the mean, and macrocephaly was defined as a value above 2 SD.

Regression was defined as the loss of words (more than 5 and used for at least 3 months) and/or loss of social interest (e.g., use of gestures, shared gaze, response to name) and absence of language as the functional use of fewer than 5 words, regardless of specific *mom* and *dad*.

The following population data were obtained: age, schooling, associated medical and developmental conditions, personal and family history, and socioeconomic indicators (unmet basic needs [UBN] and health insurance [HI]).

The population was divided into two groups based on school age (older and younger than 72 months) and the presence or absence of language at the time of diagnosis. The following variables were compared: DQ or IQ, history of regression, perinatal history, associated medical conditions, reasons for consultation, and CARS scale score.

Summary measures were described, including medians and ranges, as well as category frequencies. Pearson's chi-square test and Fisher's exact test were used.

Various forms of record-keeping were used over the 22 years, the most recent being REDCap, which began in 2019.

This research study has been approved by the Associate Director of Teaching and Research, the Research Review Committee, and the Hospital Ethics Committee, as well as the Administration of the Hospital de Pediatría S.A.M.I.C. Prof. Dr. Juan P. Garrahan under research protocol number 1167.

RESULTS

Of the 2183 patients with ASD treated during the study period, 415 were GFAs. Sociodemographic data are presented in *Table 1*.

The schooling of patients older than 36 months who consulted since 2021, the year in which face-to-face classes resumed after the COVID-19 pandemic, was analyzed (*Table 2*). The average age was 60.5 months, with a range of 36 to 172 months. Fifty-three percent (n = 34) attended regular school, and 29% (n = 19) were not enrolled in school; however, of the latter, 63.2% (n = 12) were between 36 and 48 months old at the time of consultation.

We highlight that, in relation to diagnosis, the most used tools were CARS, followed by ADOS-2 (*Table 3*). We also observe that 42% (n = 174) of the population experienced delays, and 30% (n = 117) did not adapt to formal assessments.

Epilepsy was the most common associated medical condition. Regarding perinatal history, the most common was prematurity (9.9%, n = 41).

Most of the population analyzed received a diagnosis before 72 months of age. In the younger group, 39% (n = 134) had language at the time of diagnosis, while among the older group, 76% (n = 53) had verbal language (p <0.001) (*Table 4*).

Regarding developmental coefficients, older children generally had IQs consistent with their age; however, younger children did not adapt to the assessments (p < 0.001). Girls with language skills were more likely to seek help for socialization challenges (p = 0.036). In contrast, girls without language skills were more likely to seek help for communication and language challenges (p <0.001).

In the group of older girls without language, a higher frequency of epilepsy (p = 0.004) and regression (p = 0.026) was observed, as well as a greater tendency toward the presence of syndromic conditions (p = 0.08) (*Table 4*).

About family history of ASD or broader autism phenotype, it was positive in 19.5% (n = 81) of cases, among which 41.6% were siblings (n = 35). The group with the highest percentage of family history is that of older girls with language (*Table 1*).

DISCUSSION

As described in the literature,[2] in our population, the diagnosis of ASD is more frequent in males (4.25:1).

Kasee et al.[23] describe epilepsy as the medical condition most frequently associated with autism in girls and women, highlighting its stronger association with intellectual disability, older age, language difficulties, and severity. We have obtained the same data from our population, both in general and specifically from the nonverbal

Table 1. General sociodemographic and clinical characteristics of the sample (n = 415)

Characteristic	n (%)
Age: median (range) in months	46 (18-172)
Origin	
CABA	55 (13.2)
Suburbs	206 (49.6)
Province of Buenos Aires	44 (10.6)
Other provinces	30 (7.2)
Other country	1 (0.2)
Data missing	79 (19)
UBN, n (%)	
Yes	42 (10.1)
No	373 (89.9)
Social welfare	
Yes	223 (53.7)
No	170 (41)
Data missing	22 (5.3)
Medication*	
Not receiving	326 (78.5)
Anticonvulsants	48 (11.6)
Melatonin	7 (1.7)
Risperidone	23 (5.5)
Methylphenidate	5 (1.2)
Others	29 (7)
Head circumference	
Normal	290 (69.9)
Macrocephaly	27 (6.5)
Microcephaly	16 (3.9)
Not listed	82 (19.7)
Medical conditions**	
Epilepsy	43 (10.4)
Sleep disorder	41 (9.9)
Syndromic	35 (8.4)
Other	34 (8.2)
UDD (non-ID)	22 (5.3)
Feeding challenges	20 (4.8)
Obesity	17 (4.1)
Autoimmune diseases	14 (3.4)
Tumors	4 (0.9)
Gastrointestinal disorders	2 (0.5)
Perinatal history	
Yes	84 (20.2)
No	221 (53.3)
Not listed	110 (26.5)
Family history***	
ASD/BAP** siblings	35 (8.4)
ASD/BAP** non-siblings	46 (11.1)
Other UDD	140 (33.7)

ASD: autism spectrum disorder; BAP: broader autism phenotype; CABA: Autonomous City of Buenos Aires (by its Spanish acronym); ID: intellectual disability; UBN: unmet basic needs; UDD: unspecified developmental disorders.

**Some patients received more than one medication simultaneously.*

***Some patients had more than one medical condition at the same time.*

****Some patients had more than one family member with a history of the condition.*

Table 2. Educational achievement of participants since 2021 (n = 65)

Education	n (%)
Regular school	30 (46.1)
IEP/NTPA	4 (6.1)
Special school	9 (13.8)
Educational-therapeutic center	2 (3.1)
Not enrolled in school	19 (29.2)
Data missing	1 (1.5)

IEP/NTPA: individual educational project/non-teaching personal assistant.

Table 3. Complementary tools used and their results

Evaluation	n (%)
CARS	361 (87)
Mild (30-36.5)	94 (22.6)
Moderate-severe (37-60)	232 (55.9)
No score	13 (3.1)
Not listed	22 (5.3)
ADOS	148 (35.7)
Autism	91 (21.9)
Spectrum	45 (10.8)
No score	1 (0.2)
T* module	
Moderate-severe concern	6 (1.4)
Little to no concern	1 (0.2)
Not listed	4 (0.9)
SCQ	60 (14.5)
Scores	44 (10.5)
No score	16 (3.9)
ADI-R	19 (4.6)

** Toddler module of the ADOS-2, used to assess young children (12-30 months) who do not yet use verbal language consistently. ADI-R: Autism Diagnostic Interview-Revised; ADOS-2: Autism Diagnostic Observation Schedule-2; CARS: Childhood Autism Rating Scale; SCQ: Social Communication Questionnaire.*

GFAs group.

Regarding the age at diagnosis of our patients, 16% (n = 69) had a late diagnosis (LD), i.e., after 72 months, a slightly higher percentage than that described in the general population in developed countries.[13]

Among girls older than 72 months, we found two different groups: those with no language skills and those with language skills at the time of diagnosis. The group without language shows a greater association with intellectual disability and moderate-severe scores on the CARS. As shown in the results, this is also evident in relation to regression,[23, 24] comorbidities such as epilepsy, and a tendency to associate syndromic conditions. When reviewing the developmental trajectory of this group, in general, they first received a diagnosis of global developmental delay or ID, or their etiological diagnosis prevailed. Hence, the diagnosis of ASD came later, in a second instance. This coincides with what was described by Young[25] (2018), who suggests that physicians are more likely to disregard the diagnosis of ASD in the presence of another condition, particularly intellectual disability, focusing solely on the latter diagnosis. These findings are consistent with what is currently described as profound autism.[26]

The other group of older girls is the one that could correspond to the FFA. As they possess language skills and a lower percentage of ID, they may employ more camouflage strategies and delay their diagnosis.[27] Camouflaging involves social learning skills and behavioral variation that depend on the environment. The conscious or unconscious use of strategies, learned explicitly or developed implicitly, that tend to reduce the characteristics of autism in social encounters, presenting a “more socially

Table 4. Comparison by age group and presence of language

Variable	Younger (<72 months) Without language n (%)	Younger (<72 months) With language n (%)	Older (≥72 months) Without language n (%)	Older (≥72 months) With language n (%)	*p*-value
Language	212 (61.3)	134 (38.7)	16 (23.2)	53 (76.8)	<0.001*
a) DQ/IQ					<0.001*
Accord	3 (1.4)	21 (15.7)	0 (0)	20 (37.7)	
Delay	96 (45.3)	50 (37.3)	11 (68.8)	17 (32.1)	
Discrepant	14 (6.6)	13 (9.7)	0 (0)	5 (9.4)	
Did not adapt	83 (39.2)	30 (22.4)	4 (25)	0 (0)	
Not performed	16 (7.5)	20 (14.9)	1 (6.3)	11 (20.8)	
Regression	21 (9.9)	4 (3.0)	4 (25)	1 (1.9)	Younger: 0.014** / Older: 0.026**
b) Medical conditions					
Epilepsy	20 (9.4)	14 (10.4)	5 (31.3)	1 (1.9)	0.004**
Syndromic condition	19 (8.9)	9 (6.7)	5 (31.3)	2 (3.8)	0.08**
Sleep disorder	27 (12.7)	9 (6.7)	1 (6.3)	4 (7.6)	Ns
Food challenges	11 (5.2)	2 (1.5)	1 (6.3)	6 (11.3)	Ns
Perinatal history	50 (23.6)	18 (13.4)	3 (18.8)	13 (24.5)	Ns
c) Reason for consultation					<0.001**
Communication and language	129 (60.9)	64 (47.8)	10 (62.5)	14 (26.4)	
Socialization	26 (12.3)	18 (13.4)	4 (25)	22 (41.5)	
Behavior	72 (34.0)	43 (32.1)	3 (18.8)	22 (41.5)	
d) CARS scale					<0.001*
Mild	25 (11.8)	52 (38.8)	1 (6.3)	17 (32.1)	
Moderate-severe	155 (73.1)	50 (37.3)	13 (81.3)	14 (26.4)	
No score	0 (0)	7 (5.2)	0 (0)	6 (11.3)	
Not administered	32 (15.1)	25 (18.7)	2 (12.5)	16 (30.2)	

CARS: Childhood Autism Rating Scale; DQ/IQ: developmental quotient/intelligence quotient.
**p: chi-square test. **p: Fisher's exact test.*
Ns: not significant.

acceptable" facet, or compensating for these challenges.[3] In autobiographical descriptions of GFAs with ASD, the process of camouflaging can generate internalizing symptoms and challenges in the development of one's own identity, requiring prolonged periods of solitude to recover.[10] It should be noted that this is the only group in which the main reason for consultation was socialization, unlike the others, in which it was communication and language. Although research suggests that girls have greater social motivation than boys, it also indicates that they find it more challenging to maintain long-term relationships, whether in friendships or romantic partnerships.[3,10] This group also has the highest percentage of relatives diagnosed with ASD or the broad-spectrum disorder. The presence of a family history may have been a contributing factor to the diagnosis in this population, which, although late, was still earlier than in adulthood, as reported in the literature.[5,7] In addition, these adolescent girls and young women had the highest percentage of eating challenges (mainly due to sensory processing difficulties), which is significant given the high prevalence of eating disorders in adult and adolescent women.[10,28]

The terms "female phenotype of ASD" and "profound autism" are operational and do not correspond to new diagnostic categories. However, they contribute to the description of the different functional profiles of our sample within the same diagnosis.

In relation to younger girls, regardless of language, the vast majority were associated with cognitive impairment or did not adapt to formal developmental assessments. This coincides with the description by Hervas,[10] who states that at these ages, delays are evident, and autism is more likely to be identified and diagnosed in addition to other associated developmental delays. In addition, they had similar rates of epilepsy and syndromic conditions. However, it is noteworthy that girls without language had a much higher rate of regression and, for the most

part, scored for severe autism on the CARS scale, unlike girls with language, who scored mild or did not score.

We acknowledge the limitations of this study, as it is conducted in a high-complexity hospital, which may introduce a referral bias due to the greater clinical comorbidities that patients tend to present. In addition, changes in databases over the years, while improving record-keeping and reliability, may have led to a loss of data. Another limitation is that we have not collected specific data on the deep interests and comorbidities in mental health of the GFAs who were followed up at CIND. It would also be enriching to have data on the experience of the diagnostic process for both families and patients themselves. This information would provide a more comprehensive view and serve as a starting point for future research aimed at improving the quality of life for GFAs.

Timely diagnosis would facilitate access to specific educational and therapeutic support. This should be structured within a rights framework that not only minimizes the challenges and obstacles described in the literature but also guarantees the functioning, full community participation, and quality of life of GFAs.

CONCLUSION

This study described the population of GFAs with ASD being monitored at CIND, showing relevant differences according to age group and presence of language. In younger children, cognitive impairment predominated, with greater regression and severity in those without language.

In those who receive a later diagnosis, there is both the presence of health comorbidities and cognitive impairment at one extreme and the presence of communicative strengths typical of the so-called female phenotype at the other.

A timely diagnosis would facilitate access to specific educational and therapeutic support, ensuring the functioning, full community participation, and quality of life of GFAs. ■

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