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Feminist Therapy at The Intersection of Gender Diversity and Neurodiversity

Elizabeth A. McConnell and Reese Minshew

Palo Alto University, Palo Alto, CA, USA

ABSTRACT

There has been growing awareness of the overlap between transgender, nonbinary, and gender expansive (TNBGE) and neurodivergent identities in recent years. However, many clinicians do not receive adequate training around either gender diversity or neurodiversity, much less their intersection. Further, the ubiquity of the pathology paradigm contributes to practices that further marginalize TNBGE autistic clients. We illustrate how feminist therapy's four realms of power provides a valuable framework for empowering clinical work with autistic TNBGE clients, with an aim toward centering the experiences of TNBGE autistic people. We also provide recommendations for clinical practice and systems-level change.

KEYWORDS

Autism; empowerment; feminist therapy; gender diversity; LGBTQ; neurodiversity; psychotherapy; transgender

Transgender, nonbinary, or gender expansive (TNGBE) people are more likely to be autistic,[1] and autistic people are more likely to be TNBGE. Autism rates are 1–2% in the general population, but range from 2.2% to 23.1% in studies of TNBGE people. Accurate estimates of TNBGE identities are harder to come by: they range from 0.002% to 7.3% in the general population, but from 0.7% to 22% in studies of autistic people (Sparrow, 2020). These numbers indicate a high degree of overlap of gender diversity and neurodiversity[2] at the population level. Further, TNBGE autistic people experience high rates of depression and anxiety (Murphy et al., 2020; Strang et al., 2023), likely due to high minority stress exposure (Botha, 2021; Meyer, 2003; Testa et al., 2015), and may thus be more likely to seek mental health care. These patterns are also borne out observationally, with growing recognition from clinicians who work with TNBGE individuals that many of our clients are also autistic, those who work with autistic people noting greater gender diversity in their client populations, and many beginning to note the impact of multiple forms of minority stress on TNBGE autistic people. Thus, clinicians who work with neurodiverse populations and clinicians who work with gender diverse populations

CONTACT Elizabeth A. McConnell emcconnell@paloaltou.edu Palo Alto University.

must build our comfort and capacity for work at the intersection of neurodiversity and gender diversity.

Although greater representation and visibility of both gender diversity and neurodiversity are leading to an increasing number of "own voice" representations of these experiences (e.g., scholarship and narratives by and for autistic TNBGE people), the dominant psychological discourses regarding these aspects of identity revolve primarily around a medicalized model characterized by cisgenderism[3] and ableism[4] (Botha, 2021; Gratton, 2020; Shapira & Granek, 2019; Walker & Raymaker, 2021). Moreover, the narratives of gender diversity and neurodiversity have not progressed at the same pace: while the last 30 years have seen significant movement toward understanding TNBGE identities from an affirmative lens, the pathologization of neurodivergence, and particularly autism, remains widespread. In this article, we provide an overview of scholarship relevant to TNBGE autistic experiences, including parallels in histories of oppression and intervention. Further, we explore how feminist therapy can support liberatory practice with autistic TNBGE people using the four realms of power as an organizing framework and provide recommendations for clinical practice and systems change informed by diversity-affirmative and feminist therapy paradigms. To our knowledge, this is the first discussion of feminist therapy in clinical practice with TNBGE autistic people.

Methods

Author Positionality and Reflexivity

The principles of feminist therapy insist that those who would stand in the role of clinicians explore our biases in order to deliberatively reduce the harm these biases inflict. The authors of this paper share several identities that have informed our thinking about neurodiversity and gender diversity. First and foremost, we are both allistic,[5] which has conferred numerous social and professional advantages in an allistic-centered society, including facilitating our navigation of clinical psychology doctoral programs. Moreover, we have not had the experience of being unable to verbally communicate our needs and wishes. As clinicians, our field centers verbal communication, specifically of complex emotional states, so this means that in therapy, as in day-to-day life, non-verbal autistic people have fewer opportunities to communicate their internal states and have these states attended to.

Although we do not have personal experiences with navigating allistic-centered systems as autistic people, we do have experience navigating cisheteronormative systems as TNBGE people: one of us is nonbinary and the other genderqueer. We share a specific experience of being TNBGE in that

we are both White, masculine of center, and have worked in the realms of LGBTQ and TNBGE health for many years. One of us is disabled, although invisibly so, which confers its own set of challenges and privileges in navigating health structures. These identity factors and elements of our histories are fundamental to our training and the ways we think about gender diversity, neurodiversity, and language use, as well as sickness, health, and ability.

Another experience we discussed in writing this manuscript is that neither of us has been in therapy with a TNBGE provider (that we are aware of). Thus, we have done much of our gender exploration with cisgender providers. We have had powerful, and powerfully affirming, experiences with cisgender providers. And there have been times in which nuances of our gender identities have been missed or tacitly rejected. We mention this to remind ourselves that, as much as we aim for radical inclusion in our provision of therapy with autistic TNBGE people, there will be ways in which we implicitly center allistic TNBGE experiences when discussing TNBGE health.

Use of Narratives

As allistic clinicians commenting on therapy with autistic people, we wanted to be careful about how we utilized the narratives of autistic people, while also recognizing that there is nothing more powerful than autistic expression for representing autistic experiences. We were inclined to draw from "own voice" narratives in published anthologies, as presumably the authors want these words to be read. On the other hand, citation does not function as a form of compensation for personal narratives the same way it does for academic texts. We opted to include strategic themes from "own voices" material, as they informed our thinking about neurodiversity generally and autism specifically, and hope readers will access TNBGE autistic narratives in their efforts to become more affirmative of TNBGE autistic clients.

Within the realm of academic writing, we were fortunate to have access to work by TNBGE autistic scholars and clinicians through published work, training attendance (Liz), and membership in a supervision group on building competence in working with TNBGE and autistic clients (Reese). We also drew from our own experiences of being TNBGE consumers of mental health services working with cisgender clinicians. Finally, although feminist therapy is an organizing framework for both of us, we revisited feminist psychotherapy through academic reading and personal communication with expert clinicians.

Pathologization of TNBGE & Autistic Identities

Historical Parallels of Oppression

From our perspective, the histories of gender diversity and neurodiversity in the United States have a number of striking parallels. We want to start by acknowledging that both gender diversity and neurodiversity are entirely predictable phenomena from a biological perspective. Individual difference allows a species to survive at the population level and is fundamental to the process of evolution. However, systems of medicine were founded with the explicit intention of pathologizing some forms of variation. Thus, intrinsically value-neutral experiences, including TNBGE identity and/or neurodivergence, become diagnosable "conditions" or problems to be solved. Also, both autism and gender incongruence have long been considered to exist only in specific bodies and present only in specific ways. White people who were assigned male at birth (AMAB) are much more likely to be screened for and diagnosed with autism than Black, Indigenous, and other People of Color (BIPOC) AMAB people, White people assigned female at birth (AFAB), or BIPOC AFAB people (see Jones et al., 2020, for a thoughtful discussion of this form of gendered medical racism). White AMAB people have also been centered in the dialogue around gender identity and expression.

Understanding parallels in the diagnostic trajectories of one form of gender diversity (specifically, gender incongruence) and one form of neurodiversity (specifically, autism) can help us locate contemporary conceptualizations of these experiences. What was then called infantile autism was diagnostically decoupled from childhood schizophrenia in 1980, with the publication of the Diagnostic and Statistical Manual-III (American Psychiatric Association, 1980). These diagnostic criteria were an improvement over the prevailing theory of autism in the 1950s and 60s, which was that autism was a psychiatric illness induced by "refrigerator parents," particularly icy mothers who did not love their children adequately (Silberman, 2015). The DSM-III also introduced a new diagnosis, then called transsexualism, reflecting the rise (and painful fall) of the gender clinics in the 60s and 70s, which were intended to be gender affirming (within a tightly controlled, binary model of gender affirmation). Although the diagnosis of transsexualism and the first wave of gender clinics had their limitations, they were an improvement over early theories of gender development (One particularly head-scratching example was the theory that transgender girls were especially cute, and thus treated as girls, and so then became girls. Transgender boys, this theory argued, were too unattractive to be girls and thus had to make do with being boys; see Fridell et al., 1996; Stoller, 1976).

The diagnoses that describe some experiences of neurodiversity and gender diversity act as shorthand for beliefs that these less common forms of experience are innately pathological. What the International Classification of Disease, 11th Edition (ICD-11), now calls Autism Spectrum Disorder (and we refer to as autism) is categorized as a neurodevelopmental disorder and defined as "persistent deficits" in social interaction and communication, coupled with repetitive movement patterns and "clearly atypical" fixed interests (World Health Organization, 2020). What the ICD-11 now calls Gender Incongruence is classified as a condition related to sexual health and defined as "a marked and persistent incongruence between an individual's experienced gender and defined sex" (World Health Organization, 2020).

We understand this history in the context of a disability psychology framework, which asserts that there are three models for understanding disability: the moral model, the medical model, and the social model. The moral model views disability as a function of a moral failing or transgression or sometimes as a "cross to bear." The medical model, which is congruent with the guiding principles of the field of psychological medicine, views disability as something to be fixed or changed. The social model views disability as socially constructed and identifies things in the environment that might change to better facilitate the goals of the disabled person (see Dirth & Branscombe, 2018; Olkin, 2002). Additional considerations at the intersection of sex assigned at birth, socioeconomic status, and race (see Nabors & Pettee, 2003; Schalk & Kim, 2020; Wendell, 1997) highlight the ways in which "appropriate" roles for specific bodies are socially constructed, and when our bodies thwart social expectations, the bodies in question are pathologized and shamed. As Wendell (1997) describes it, gender and disability (and we would add race and other identity factors) are socially constructed from biological reality.

Due to the work of trans activists and allies, the diagnosis of gender incongruence has grown somewhat less pathologizing over the past decade. Simply being a transgender person is no longer diagnosable; diagnosis is reserved for people who are seeking interventions to change primary or secondary sexual characteristics. Autistic activists and allies make a similar argument regarding diagnostic language, insisting that autism should not be considered a disorder, but rather simply part of a spectrum of diversity, and should only be "diagnosed" as is useful for helping autistic people access appropriate resources. While these debates mirror larger debates in feminist therapy regarding the diagnostic framework writ large, autism and gender incongruence share a particular contested space: they are experiences that, if held and accepted in community, simply reflect difference, but when pathologized and located within individuals represent problems the individual must "solve" for the comfort of those around them.

In another parallel, professional organizations focused on the needs of TNBGE and autistic people have limited representation of their constituencies at the highest levels of organizational governance. The World Professional Association of Transgender Health (WPATH) is the largest, oldest, and most prominent professional organization for gender-affirming medicine and behavioral health practitioners. Although founded in 1979, there was no transgender president of WPATH until Stephen Whittle in 2007 (World Professional Association for Transgender Health, 2021). Autism Speaks, the autism organization with the greatest name recognition and largest budget, focuses on finding a "cure" for autism rather than identifying supports and resources that autistic people need or advocating for an autism-inclusive society. This organization has also been robustly criticized for a long history of excluding autistic people from leadership positions within the organization. The first autistic board member, John Elder Robison, resigned, citing the organization's anti-autism stance and focus on research related to basic genetics rather than improving the lives of autistic people (see Robison, 2020). In 2016, the Autistic Self-Advocacy Network, the National Center for Transgender Equality, and the National LGBTQ Task Force issued a joint statement on the rights of TNBGE autistic people that called for "the full inclusion of transgender and gender nonconforming autistic people in both autistic and transgender spaces, services, and movements" (p. 2), highlighting the importance of centering the voices and leadership of those with lived experience of this intersection.

Parallels in Intervention

The "solutions" for autism and gender incongruence also share some parallels. It has been tagged by autistic people and discussed widely in community forums that Applied Behavior Analysis (ABA), the primary behavioral intervention used with autistic children, was partially co-created by the originator of conversion therapy for sexual minority individuals (Silberman, 2015). In both cases, the goal is to teach and enforce behavioral norms that increase the comfort of others at the expense of the person seeking treatment. Although autism advocates have been warning of the dangers of ABA for some time, these ethical concerns have not impacted widespread use of ABA (Wilkenfeld & McCarthy, 2020). While conversion therapy is now banned for minors in twenty states (Movement Advancement Project, 2022), ABA is considered the standard of care for autistic children and sometimes is the only behavioral health intervention for autism covered by insurance, despite some evidence it contributes to low self-esteem and increased dependency (Sandoval-Norton et al., 2019) or even posttraumatic stress disorder (Kupferstein, 2018) in autistic individuals. The majority of

interventions for autism focus on behavior modification, with treatment success defined through metrics such as language use or increased capacity to play with allistic children (see Sandbank et al., 2020, for a meta-analysis). While these outcomes may make parents and teachers more comfortable with autistic children, they do not necessarily indicate greater health on the part of the autistic child. Indeed, the success of these interventions is often measured by the caregivers of autistic individuals, depriving the autistic people who are actually engaging in these treatments of even the autonomy of self-evaluation. Families with autistic children may not have the bandwidth or resources to seek other treatment options or know such options exist. They might also fear for the safety of their autistic child if that child is incapable of "masking," or disguising autistic characteristics, and thus choose ABA for safety-related reasons.

The treatment literature for autistic adults centers medication and Cognitive Behavioral Therapy to increase social skills and reduce social anxiety, with mood and distress sometimes included as secondary outcomes (e.g., Bemmer et al., 2021). This implicitly asserts that an individual's ability to mask their autistic identity is the greatest indicator of treatment success (Botha, 2021), which is a key characteristic of the pathology paradigm.

Alternatives to the Pathology Paradigm

The Neurodiversity Paradigm

Autistic scholar-activists have articulated several alternatives to the pathology paradigm. Most prominently, the neurodiversity paradigm articulates how diversity among human minds is similar to other forms of human diversity and is thus subject to the same impacts from systems of oppression (Walker & Raymaker, 2021). This perspective has gained traction in the past several decades, encouraging a shift in focus from autistic people's perceived deficits to their strengths, and from interventions aimed at "curing" or "treating" autism to changing the systems that create barriers to autistic people's wellbeing (Lewin & Akhtar, 2021). This paradigm shift facilitates greater attention to the impacts of minority stress on disparities in TNBGE autistic people's mental health and wellbeing (as opposed to viewing psychological distress as a reflection of the inherently pathological nature of TNBGE autistic people's identities; Botha, 2021; Testa et al., 2015). An emerging field of neurodiversity studies is beginning to take shape (Rosqvist et al., 2020) and references to neurodiversity are becoming more common in both the popular media (Lewin & Akhtar, 2021) and academic scholarship, particularly in the humanities (Walker & Raymaker, 2021). Recent work by Botha (2021) provides a first-hand account of the ways in which academic autism research is hostile toward researchers who

are autistic, thereby contributing to the continuation of the pathology paradigm.

TNBGE Autistic Representation

In 2016, Strang and colleagues developed the only published guidelines for clinical work with TNBGE autistic adolescents, which were based on input from (presumably allistic) expert clinicians. However, Strang et al. (2021) recently published additional clinical recommendations based on participatory research with TNBGE autistic youth, their parents, and TNBGE/autistic self-advocates (alongside expert clinicians), and some research is beginning to speak to the lived experiences of TNBGE autistic people (Hull et al., 2017; Kapp et al., 2019; Kirby et al., 2021; Strang et al., 2018) and their parents (Kuvalanka et al., 2018). There are important differences in the recommendations provided by these groups; for example, clinicians emphasize an extended assessment and diagnosis process for both autism and gender dysphoria (Strang et al., 2016) while TNBGE autistic youth underscored the urgency of accessing gender-affirmative care and resources (Strang et al., 2018, 2021).

Academic research has largely been actively mistrustful of, and hostile toward, autistic perspectives (Botha, 2021), and representation of TNBGE autistic people in published texts still lags behind the discourse happening among TNBGE autistic people in online spaces. A narrative study identified a schism between published academic case studies of TNBGE autistic people by allistic clinician-researchers (which were characterized by the pathology paradigm and cisgenderism) and online writings by TNBGE autistic people (which both engaged with and challenged the medical discourse around autism; Shapira & Granek, 2019). Additionally, the experiences of White people dominate representation of both trans (Glover, 2016) and autistic (Onaiwu, 2020) narratives. However, online communities can provide important spaces for BIPOC trans and autistic people to share their stories (Botha, 2021; Kirby et al., 2021).

Outside of academic journals, there has been an exciting proliferation of recent work. Multiple volumes (most edited by TNBGE autistic people) provide first-person narratives about autistic TNBGE experiences, including creative writing (Sparrow, 2020) and interview-based case studies (Adams & Liang, 2020; Mendes & Maroney, 2019). A recent self-help guide (Purkis & Lawson, 2021) and guide for clinicians (Gratton, 2020) (both authored by TNBGE autistic people) provide valuable resources for clinical work. Alongside contributions from queer and trans autistic scholar-activists (e.g., Brown, 2017; Walker & Raymaker, 2021; Yergeau, 2018), these texts have heightened the visibility of discourse around TNBGE autistic experiences.

Feminist Therapy

Feminist therapy focuses on elucidating the links between individual difficulties and systems of oppression, fostering an egalitarian relationship in order to promote the empowerment of marginalized groups across a variety of domains (discussed further below; Brown, 2018; Evans et al., 2011). It is organized around the understanding that marginalized people are the experts of their own experiences, and that centering these voices (and decentering the voices of culturally appointed experts) has powerful potential to promote transformational change and liberation (Brown, 2018). Further, feminist therapy problematizes the dominant myth of therapist neutrality, articulating that therapists bring our own relationships to power into our work with clients and that psychotherapy practiced uncritically reinforces hierarchies of dominance and subjugation. Feminist therapy is characterized by collaborative subversion, using the tools of psychotherapy to undermine both internalized and external systems of oppression that create distress and suffering (Brown, 2018). In practice, many feminist therapists use a variety of therapeutic techniques from different theoretical orientations; however, they do so in ways that align with the underlying beliefs and principles of feminist therapy (Evans et al., 2011).

Feminist therapy is rooted in and evolved alongside feminism as a social movement and thus reflects some of its key concepts, histories, and biases. Given its origin in the 1970s during feminism's second wave, key foundational principles included gender as a social construct and "the personal is political," which communicates the understanding that individual experiences reflect broader social and political systems. Feminist therapy takes a non-pathologizing stance toward problems experienced at the individual level, instead viewing symptoms as resilience strategies for coping and surviving within oppressive social systems. At the same time, feminist therapy mirrored second wave feminism's focus on White, cisgender, middle-class, abled women's experiences (Enns, 2004; Evans et al., 2011). In the 1980s, women of color made significant contributions to challenging and broadening this lens: Walker (1983) introduced the term "womanist" to center the experiences of feminists of color; this framework was developing alongside legal theory suggesting Black women might have different experiences in the workplace than either Black men or White women due to intersecting systems of patriarchy and White supremacy (hence the term intersectionality; Crenshaw,1989). Womanist therapy then developed as an approach grounded in the needs and experiences of Black women (Nabors & Pettee, 2003; Sanchez-Hucles, 2016).

During feminism's third wave in the 1990s and early 2000s, Koyama (2003) and other trans activists challenged feminism to be more inclusive of transgender women and other gender minorities, signifying the emergence of the

transfeminist movement. Around the same time, disability advocates and scholars articulated the need for feminist disability studies (Garland-Thomson, 1994; Wendell, 1997); more recently, feminist-of-color disability studies has emerged as an important field addressing the intersections of race, gender, and ability (Nabors & Pettee, 2003; Schalk & Kim, 2020). Although the experiences of White, abled, cisgender, middle-class women are still often centered in feminist therapy, the theory grapples with power structures and issues of systemic oppression in concrete and visible ways.

TNBGE Autistic Experiences and Feminist Therapy's Four Realms of Power

Within a Biopsychosocial/Spiritual-Existential Model, four domains of power are possible sites for liberatory moves in the context of feminist therapy (Brown, 2018; summarized in Table 1). We now discuss the experiences of TNBGE autistic people as they relate to each of these four realms of power, integrating recommendations for clinical practice within each realm.

Somatic and Biological Power

All bodies have some spaces that represent empowerment and some that represent disempowerment. This is both specific to the particular body and a function of larger systems that police, reject, or disenfranchize some bodies (based on characteristics like skin color, size, and ability status) while creating resources for and celebrating others. Authentic gender expression is one form of somatic empowerment, and many TNBGE people report increased contact with and enjoyment of their bodies as dysphoria decreases. Conversely, choosing to conceal gender—either by not disclosing TNBGE identity and thus not receiving outside gender affirmation or transitioning to present as another gender and not disclosing sex assigned at birth—can also be forms of empowerment. Further, the recognition that some people want to change their bodies and that this can be a form of empowerment rather than a surrender to patriarchy and the gender binary can be a powerful intervention, although this has been a contested assertion in the domain of feminist therapy. Feminist therapists can help clients identify forms of gender expression and affirmation that increase safe contact with somatic experience and engage in radical acceptance of clients' gendered choices, including getting conversant with writing letters of support for hormones and surgeries and building relationships with medical providers that are inclusive of trans and neurodiverse experiences.

The body's relationship to sensation and perception may be another salient aspect of somatic power for TNBGE autistic people. Autistic people commonly report hypersensitivity or hyposensitivity to sensory stimuli,

Table 1. Feminist Therapy's four realms of power and potential TNGBE autistic sites of empowerment.

Somatic and biological power	Intrapersonal and intrapsychic power
Includes: • Connection to one's body • Understanding bodily sensations such as hunger/thirst, sexual arousal, nervous system activation, energy level, and need for rest • Experience of body as a "safe-enough place" • Not predicated on bodies being a particular shape/size, having specific abilities, being physically strong, or being free of pain or illness	Includes: • Knowing what one thinks and feel • Ability to examine thinking patterns in ways that are both critical and flexible • Experiencing and using present-moment feelings as a source of knowledge • Self-soothing in ways that are not harmful to self or others
TNBGE Autistic Sites of Empowerment: • Decisions around gender expression and transition (if relevant) • Negotiating responses to sensory stimuli, creating sensory diets • Context-specific decisions around stimming • Navigating interactions with medical providers	TNBGE Autistic Sites of Empowerment: • Clarifying self-knowledge, including experiences of gender, autism, and other intersecting identities • Exploring autistic ways of "doing gender" • Challenging TNBGE and autistic stereotypes, undoing shame, and internalized stigma • Highlighting and embracing TNBGE autistic strengths • Expanding menu for congruent self- expression and regulation
Interpersonal and social-contextual power	**Spiritual and existential power**
Includes: • A general pattern of interpersonal effectiveness (including having desired effects on others) • Flexible and differentiated boundaries • Boundaries not rooted in control or dominance • Ability to form, maintain, and exit relationships with other individuals, groups, and larger systems from a position of choice and intention (rather than from a sense of scarcity or perception of low self-worth)	Includes: • Internal and external access to inclusive systems of meaning-making • Systems of meaning-making provide comfort and assist with responding to existential challenges • Awareness of social context, culture, and heritage • Accessing creative capacity and fantasy in ways that are balanced with reality
TNBGE Autistic Sites of Empowerment: • Context-specific decisions around masking, managing energy demands around masking (if applicable) • Supporting self-advocacy and strategic neurodiversity and gender diversity affirmative relationship building • Minimizing pressure to perform neurotypicality in therapy • Connection with other autistic and/or TNBGE people and communities	TNBGE Autistic Sites of Empowerment: • Celebration of TNBGE autistic ways of being • Exploration of TNBGE autistic forms of fantasy and creative expression, including special interests • Connection to affirmative faith community • Working through grief and loss related to oppression • Exploring values-congruent actions across life domains • Participation in advocacy and social change efforts

including both internal (e.g., interoception, proprioception) and external (e.g., sound, touch) experiences. Autistic people often develop patterns of suppressing sensory hyperreactivity in order to avoid negative responses from others to the extent that dissociation from hyperreactive responses may underlie most hyporeactive or non-reactive sensory responses (Gratton, 2020). A non-suppressive way of dealing with sensory or emotional overwhelm might be to stim, which autistic people describe as a helpful self-regulatory mechanism, albeit one that is often met with social judgment and negative attention from others (Kapp et al., 2019).

Stimming may be received differently based on the social context and biases related to the autistic person's phenotype. Empowering choices might be to choose environments with fewer difficult stimuli, to advocate for environmental changes, or to use noise-blocking headphones and sunglasses when those environments are unavoidable. Another empowering choice might be to identify stims that are more easily disguised in public (fidget cubes or spinners, for instance). Yet another might be to mask if possible; this might be the most empowering choice available to an individual based on both individual context and systemic oppression (We want to be especially mindful of the ways in which other aspects of identity might influence these decisions. It may be safe enough for a White autistic cisgender woman to stim in public, for instance, while the same stimming from a Black autistic mask person could end in state-sanctioned murder at the hands of the police). Finally, a powerful choice might be to primarily spend time with people who recognize stimming as coping and do not ask that the autistic individual mask for their comfort. Clinicians can also support clients in developing sensory diets (i.e., routines that minimize sensory overload and maximize meeting sensory needs; Gratton, 2020) and engaging in somatic treatment and/or soothing self-touch.

TNBGE autistic people are more likely than allistic cisgender people to experience physical health concerns and less likely to receive medical treatment, either due to lack of access (which is closely linked with economic injustice related to employment discrimination) or out of fear of negative interactions with medical providers (which commonly occur; Gratton, 2020). There are important reasons why TNBGE autistic people may benefit from or want to engage with medical providers, including access to gender-affirming services and treatment of health conditions that cause discomfort, including those related to chronic stress. Empowering choices in this domain may include self-advocating by providing information on how to meet their needs, navigating healthcare systems to identify non-harmful or affirmative providers, and thinking through powerful choice points in advance in order to facilitate greater regulation in potentially dysregulating contexts. Finally, feminist therapists must recognize that clients with all kinds of bodies may struggle with biological functions, including eating, sleeping, eliminating waste, and making decisions about sexual activity and touch. Bodies are generally a neglected domain in conventional talk therapy, but destigmatizing bodily experiences is a liberatory practice that feminist therapists can help facilitate.

Intrapersonal and Intrapsychic Power

Traditional psychotherapy is perhaps most congruent with this realm of power, given its focus on individual self-awareness and behavior change.

Working with clients to increase awareness of and flexibility in patterns of thinking, feeling, and acting, make safe contact with powerful emotion, and learn strategies for coping and affect regulation are all familiar tools in a therapist's skillset. However, most therapists (including ourselves) received little to no training in their graduate programs on how to adapt these interventions when working with TNBGE or autistic clients, and literature on these adaptations is still relatively scarce (e.g., Balsam et al., 2019; Dyson et al., 2019; Pickard et al., 2020). Clinicians can adopt an attitude of cultural humility and take a collaborative stance in identifying intrapersonal interventions that work well for individual clients, keeping in mind the incredible heterogeneity of experiences included in both the autistic and TNBGE umbrellas (Botha, 2021; Gratton, 2020; Sparrow, 2020).

Both TNBGE and autistic people may experience a fundamental conflict across the lifespan between their internal experience or sense of self and the messages they receive from people in their lives and the world at large about who or how they should be. Thus, although TNBGE autistic people may have a clear internal sense of themselves from an early age, this self-knowledge may become clouded, suppressed, or managed to avoid negative consequences and reactions from others. TNBGE autistic people who are less likely to see their experiences reflected in narratives of what it means to be TNBGE and/or autistic (e.g., AFAB, BIPOC, and nonbinary people) face additional barriers to this self-knowledge. Across intersecting identities, clinicians can play a depathologizing role by helping clients draw connections between minority stress and psychological distress, thus naming and destigmatizing the impacts of oppression.

Many autistic TNBGE people describe their experiences of autism and gender as fundamentally interconnected, including uniquely autistic ways of "doing gender." Liberatory expressions might include identifying as agender or neutrois, disidentification with allistic gendered scripts, experiencing oneself as both male and female based on honest self-assessment absent allistic pressures to conform to gender role expectations, or identifying with specific neurogenders, such as gender related to fandoms or the natural world (Mendes & Maroney, 2019; Sparrow, 2020). Additional liberatory moves in the domain of intrapersonal power that feminist therapists might facilitate include undoing shame and internalized stigma about TNBGE autistic ways of being, challenging stereotypes of autistic people as lacking emotion or empathy, identifying and engaging in congruent forms of self-connection and expression, embracing special interests and other TNBGE autistic strengths, and expanding one's menu of options for self-soothing and emotion regulation.

Interpersonal and Social-Contextual Power

A central tension many TNBGE autistic people experience in this realm is how to manage interactions with allistic people. Many autistic people report learning and performing allistic scripts—a process often referred to as masking—as a strategy for negotiating this tension. For those who can and choose to mask autistic traits and/or to conceal TNBGE gender identity or expression, these strategic choices can be viewed as a resilience strategy akin to code switching and may thus constitute a powerful choice. For those who do not wish to conceal their TNBGE or autistic identities and traits, who are not able to mask, or who feel mentally exhausted or unduly burdened by compulsive or intensive concealment demands, movement toward interpersonal power might include developing a broader repertoire of options (Hull et al., 2017; Kapp et al., 2019). These can include educating others and self-advocacy, leaning into autistic strengths (even those that might be pathologized or misunderstood), and strategically building relationships with people and settings who are supportive of neurodiverse and gender diverse expression. Including and valuing relationships with animals, others with shared interests, and satisfying interactions with strangers may also be helpful (Gratton, 2020; Mendes & Maroney, 2019). Feminist therapists can also expand our own comfort with a range of verbal and nonverbal communication styles in order to minimize the extent to which autistic clients feel a pressure to mask or perform neurotypically in therapy. This can include examining our own assumptions about communication, noticing and talking about strategies that are more and less effective in meeting a client, and directly addressing ruptures and misses when they occur (Gratton, 2020).

Building connections with others who share TNBGE autistic experiences is another important potential source of interpersonal power. There is an incredible diversity of ways to experience both TNBGE identity and autism, so connecting with others at this intersection by no means indicates that one's specific identities and experiences will be shared. However, many TNBGE people report being able to identify with common themes of experience (e.g., minority stress, masking, autistic ways of doing gender, frustration with allistic norms and social scripts) that can be incredibly validating to share with others, and many describe TNBGE autistic community as vital to their interpersonal wellbeing (Botha, 2021; Gratton, 2020; Mendes & Maroney, 2019; Sparrow, 2020). Movement toward power in this respect may include accessing TNBGE autistic narratives, participation in TNBGE autistic online spaces, and building relationships with other TNBGE autistic people both offline and online. These community connections may be especially important for BIPOC TNBGE autistic people and

others whose experiences are underrepresented in dominant narratives and community spaces.

Spiritual and Existential Power

For TNBGE autistic people, empowerment in this domain might involve movement from internalized cisnormativity and neurotypicality toward celebration of TNGBE autistic ways of being. The concept of neuroqueerness—which explicitly identifies and subverts the performance of neurotypicality (Walker & Raymaker, 2021)—may be particularly valuable in this kind of liberatory movement. Accessing spaces and ways to express one's creative capacity may constitute another important source of liberatory movement for TNBGE autistic people. Autistic people might identify as having special interests, which can function as incredible arenas for building expertise, engaging autistic strengths, and creative self-expression. TNBGE autistic people may participate in gaming, cosplay, fandom, and/or kink/BDSM communities as special interests in ways that support expansive gender expression and other forms of engagement with fantasy and creative expression. Feminist therapists can support this liberatory movement by directly asking clients about their interests as well as highlighting participation in these (often stigmatized) communities and forms of creative self-expression as strengths.

Spiritual and existential empowerment may also take the literal form of empowerment in the context of a religious or spiritual community. Many TNBGE individuals report rejection by faith communities and may feel uncomfortable in religious spaces; however, gender-affirming faith communities can be a powerful protective factor. Clinicians can potentially be helpful by interfacing with faith leaders in our communities and developing relationships with pastors, rabbis, and imams who lead gender-affirming congregations. This is also a domain for advocacy around various forms of worship and autism. Autistic TNBGE people may find typical services overstimulating, but appreciate the opportunity to attend (virtually or in-person) services that are shorter, have less sensory stimulation, or take a different format (a small study group, for instance) while still being included in the larger community. For people who do not feel comfortable with traditional services or formal religious communities, there may be expansive, existential, community-based ways to connect with the natural world. In our clinical experience, some autistic TNBGE clients report an affinity for neo-pagan communities and metaphysical ways of connecting with a larger sense of spirit or community through things like Tarot and astrology. Spiritual communities may also be involved in direct action

around social justice, providing another potentially congruent opportunity for engagement for TNBGE autistic people.

Other liberatory moves in the domain of spiritual and existential power might include working through feelings of grief and loss related to oppressive experiences in a world that is often hostile toward TNBGE autistic people, including for older clients who may be coming into identify affirmation later in life. For BIPOC and other multiply marginalized TNBGE autistic people, it may be powerful to draw connections between experiences of oppression as well as histories of resilience, resistance, and social change related to different minoritized identities. Clinicians can also encourage values clarification and values congruent action as a means of supporting clients in prioritizing the domains of living and ways of being that matter to them and participation in advocacy and social change efforts as a form of meaning making.

Systems-Level Recommendations for Clinical Practice

Given that the pathology paradigm is encoded into current diagnostic systems, clinicians can advocate for neurodiversity and gender diversity affirmative diagnostic systems. Within the current system, clinicians should recognize the power imbalances inherent in diagnostic authority (including gatekeeping of affirmative services) and the complex relationships clients may have with diagnosis. Clinicians should work from a collaborative stance and honor the validity of self-identification with both TNBGE and autistic identities. Some clients may desire a more formal autism assessment process or find expert diagnosis validating; clinicians can provide a formal diagnosis themselves, refer to affirmative providers for assessment and diagnosis, and/or talk with clients about the limitations of expert diagnosis (e.g., pathology paradigm, lack of autism assessment protocols for adults and gender minorities, underdiagnosis of autism among people with other minoritized identities), depending on client needs and priorities.

Clinicians can also be accomplices to TNBGE and autistic communities by advocating for systems-level changes, including de-implementation of harmful practices, increasing TNBGE and autistic representation in the organizations that represent these groups and in research and practice communities, encouraging uptake of the neurodiversity paradigm, and making settings more accessible and affirmative for TNBGE and autistic people (Botha, 2021; Kirby et al., 2021). Setting-level changes may include inclusive forms and paperwork, access to gender inclusive bathrooms, TNBGE and autistic staff representation, supporting pronoun and chosen name disclosure, reducing sensory stimulation in waiting rooms and other agency spaces, providing teletherapy and online options for scheduling and

communication, including information about what to expect in a visit online, talking with autistic clients about their sensory preferences, and having tools available for stimming in therapy spaces (Gratton, 2020).

As with many aspects of human diversity, clinicians should engage in ongoing self-education to balance both cultural competence and humility with attention to ever-evolving language, knowledge, and community spaces. Consistent with feminist therapy principles, clinicians should center the experiences and voices of TNBGE autistic people themselves rather than culturally sanctioned sources of "expert" knowledge. Clinicians can improve their skills with this population and directly support TNBGE autistic communities by paying for training and consultation from TNBGE and/or autistic people. Organizations can provide support for staff to receive training in these areas and can pay TNBGE autistic people to provide feedback about helpful systems-level changes and actually implement these changes.

What has become clear to us in the course of our careers and has been reified in the course of writing this article is that systems-level intervention is most urgently needed. If, for instance, providers who work in gender clinics were trained to assess for autism and providers who specialize in working with neurodivergent populations were trained to ask about gender, this could help identify people who might benefit from additional supports related to both gender diversity and neurodiversity. Research on culturally appropriate ways to evaluate for autism in a gender diverse population, and gender diversity in an autistic population, has the potential to be transformative for autistic TNBGE people who might not know they are neurodivergent and/or transgender, or who feel they could not disclose these identities. Additionally, interventions aimed at reducing anti-autism bias as well as anti-trans bias in the medical community could be helpful to TNBGE autistic people, their families, and their treatment providers. Thus, we add our voices to the many calling for psychological interventions that operate on the systems-level rather than focusing on individual change.

Conclusion

Feminist therapy offers valuable theoretical guidelines that have potential for therapeutic intervention with TNBGE autistic people within a gender- and neurodiversity-affirming framework. Feminist therapy's attention to broader systems of power, privilege, and oppression is intended to shift the focus of intervention to broken *systems* that individuals can choose to work on navigating or deconstructing, rather than suggesting the individuals in those systems are broken. Feminist therapy, like neurodiversity models and gender-affirming models, centers autonomy, empowerment, and self-

identification, reducing hierarchical disparities between clinicians and clients. To this end, we believe it provides an invaluable theoretical orientation and set of tools for those of us who would aim to be supportive and useful to TNBGE autistic people as they move toward greater healing, resilience, and empowerment.

Notes

1. There is debate over whether person-centered (person of transgender experience; person with autism) or identity-centered (autistic person; transgender person) is preferable. Following an "own voices" overview (Robison, 2020), we use identity-centered language throughout (although for a data-driven analysis of the complexity see Bury et al., 2023).
2. We use the term neurodiversity to refer to groups of people in which there is a range of cognitive variation, including more and less typically occurring. We use the term neurodivergent to refer to individuals with cognitive variation that is less typically occurring. We use the term neurotypical to describe groups and individuals with cognitive variation that is more typically occurring. For people whose neurodivergence is consistent with autism, we use the term autistic. For more about these terms and their usage see https://neuroqueer.com/neurodiversity-terms-and-definitions/
3. We use the term cisgenderism to reflect the centering of cisgender (that is, not transgender) experiences and identities, rather than an expansive view of gender that locates equal value in all experiences of gender.
4. We use the term ableism to reflect the centering of abled (that is, not disabled) experiences and identities rather than an expansive view of dis/ability that locates equal value in all experiences of the ability spectrum.
5. We use the term allistic to refer to people who are not autistic. Allistic individuals may be neurotypical or experience a form of neurodivergence that is not autism.

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ORCID

Elizabeth A. McConnell http://orcid.org/0000-0001-5792-9791
Reese Minshew http://orcid.org/0000-0001-5330-1630

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