Clinical Assessment and Treatment of Autistic Transgender and Gender-diverse Individuals: A Neurodiversity-affirming Approach

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ABSTRACT

Transgender and gender-diverse (TGD) individuals demonstrate higher autism prevalence compared with cisgender peers, yet face delayed diagnosis due to masking, assessment bias, and attribution of traits to minority stress. Autism assessment practices historically center cisgender white male presentations, creating systematic barriers for TGD individuals with more subtle presentations. This review examines the assessment and treatment of autistic TGD individuals without intellectual disability from a neurodiversity-affirming perspective. We synthesize current evidence and offer recommendations for selecting autism screening and diagnostic tools, conducting a clinical assessment of autism, counseling and providing psychoeducation about autism, weighing the risks and benefits of having a formal diagnosis, and adapting psychotherapeutic and psychopharmacologic interventions. A neurodiversity-affirming approach values the diversity of human minds, centers lived experience, supports authentic expression, prioritizes self-understanding, addresses co-occurring conditions, and advocates for necessary supports and accommodations. Clinicians should recognize that autism and gender diversity frequently co-exist, requiring specialized, affirming care approaches.

Transgender and gender-diverse (TGD) individuals are 3 to 6 times more likely to be autistic compared with cisgender individuals, with 6% to 26% of TGD populations meeting diagnostic criteria.[1,2] This overlap of autism and gender diversity reflects multiple potential mechanisms, such as reduced conformity to social norms, less susceptibility to the binary gender socialization process, sensory sensitivities intensifying gender dysphoria, and integrated experiences where gender is inseparable from autism (described as *autigender* or *gendervague*).[3-5]

AUTISM

Autism is a genetically based neurological variant characterized by distinct patterns of perception, cognition, and social communication.[6] Clinicians are likely to encounter autistic individuals: approximately 19% of adults in outpatient psychiatric clinics are autistic, with an additional 5% to 10% showing subthreshold traits, though most remain undiagnosed.[7] An estimated 60% to 76% of autistic people do not meet criteria for intellectual disability[8]; this popu-

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lation has elevated mental health risks, with 24% prevalence of suicide attempts and behavior.[9] Across clinical settings, practitioners frequently encounter unrecognized autistic patients seeking care for co-occurring conditions, often leading to diagnostic overshadowing.

Autism diagnosis and assessment tools remain constrained by significant methodological and demographic biases. Original studies on autism included few girls and likely no TGD participants, resulting in diagnostic criteria largely centered on boys. Reported ratios have varied, with estimates of 3:1 for boys to girls overall, though mathematical modeling suggest the true ratio may approach 3:4, as up to 80% of those assigned female at birth (AFAB) may be undiagnosed at age 18.[10] The Autism Diagnostic and Observation Schedule, 2nd edition (ADOS-2),[11] a "gold standard" autism assessment tool utilizing behavioral observation, was normed on cisgender white male samples, so may fail to capture the presentations of girls, women, TGD people, people of color, and those with co-occurring mental health conditions, particularly when autistic traits are camouflaged.[12] Furthermore, studies show that of people diagnosed in the community, only 81% of men and 50% of women met ADOS-2 research cutoff criteria, raising concern for possible systematic bias in the medical literature.[13] The female autism phenotype is a helpful concept to describe how autism may present differently in AFAB individuals, and may apply to TGD individuals.[14]

Autism and Gender Diversity

Challenges to autism diagnosis in TGD people include delayed diagnostic timing, with AFAB, gender-diverse, and high intelligence quotient (IQ) individuals diagnosed significantly later than assigned male at birth (AMAB), cisgender, and low IQ individuals, and nonbinary individuals diagnosed significantly later than those with binary genders (eg, man or woman); later autism diagnosis was correlated with increased mental health risk and suicidality.[15] In some cases, gender diversity may overshadow autism-related signs when social and behavioral differences are attributed to gender minority stress; however, neuroimaging supports true autism in this population.[16] Transgender youth with subthreshold autistic traits often experience clinically significant autism-related challenges and comparable levels of mental health concerns, such as internalizing symptoms, and increased suicidality.[17] Autistic TGD youth show distinct presentation patterns compared with non-autistic TGD youth, including higher social transition rates, greater body and voice dysphoria,[18] and higher rates of co-occurring mental health conditions (**Table A**). Autistic Black, Indigenous, or persons of color (BIPOC) TGD individuals often experience compounded marginalization, leading to higher masking and potentially less likelihood of autism recognition. However, in cultures that emphasize strict conformity to the gender binary, autistic traits may make more room for gender diversity; in a Chinese community sample, autistic traits were associated with greater gender diversity.[19]

Neurodiversity-affirming Care

The neurodiversity paradigm reframes autism as a natural human variation rather than pathology, aligning with the social model of disability that locates disability in societal barriers rather than individual impairments.[6,20] Autistic researcher Damian Milton's "double empathy problem" describes social communication challenges as mutual misunderstanding across neurotypes.[21] Autistic individuals communicate effectively with one another, challenging the notion of inherent social communication deficits,[22] but rather highlighting difficulties with cross-neurotype communication. Autistic individuals have many strengths, including sensory attunement, high integrity, direct communication, focused interests, cognitive diversity, perseverance, social justice sensitivity, and creativity.[23] (A note about language: we will use *autism* instead of *autism spectrum disorder* and identity-first language, eg, autistic individual).[24] **Table B** describes neurodiversity-affirming principles and strategies and **Table C** defines neurodiversity-related terminology. This review synthesizes neurodiversity-affirming approaches to autism assessment and treatment considerations for TGD individuals without intellectual disability, drawing upon the lead author's clinical experience with more than 100 autistic TGD youth and adults.

The authors note that this approach contrasts with the dominant medical model, which is rooted in the pathology paradigm and deficit-based framings of autism.[6]

AUTISM ASSESSMENT

Autism assessment and diagnosis are inaccessible for many individuals. Autism clinics often have long waitlists (sometimes up to 3 years long) and prioritize younger children over adolescents and adults. In addition, many communities lack easy access to autism clinics. Neuropsychologists who assess for autism may not be familiar with more subtle presentations of autism. To meet this need, mental health providers can receive additional training to assess and diagnose autism, which is a clinical diagnosis and does not require formal testing or use of any specific assessment tool. However, neuropsychological testing should be considered when questions are raised regarding intellectual disability, learning disorders, dyslexia, and cognitive capacities. Moreover, access to certain accommodations or services (eg, school accommodations) may require specific assessments to determine eligibility. Because of the inaccessibility of a formal autism diagnosis, self-diagnosis

is accepted by the autistic community; self-diagnosed autistic individuals report experiences and outcomes similar to those with formal diagnoses.[25]

Clinical Vignette: *Sammy is a 22-year-old nonbinary/transmasculine young adult (using they/them pronouns) with a history of depression, anxiety, and trauma, who presents asking for an autism assessment. Sammy's case will be used as an example throughout.*

Diagnosis

The diagnostic criteria for autism is described in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition, Text Revision (*DSM-5-TR*).[26] As the criteria are described using deficit-oriented language, we have reframed the criteria using neurodiversity-affirming language (**Table D**).

Screening and Assessment Tools

Standardized screening and assessment tools may aid in autism diagnosis by ensuring that diagnostically relevant information is available for clinical judgment. However, these tools should be utilized as cautious diagnostic aids rather than prerequisites to a formal diagnosis. No consensus exists regarding the optimal assessment tools; each have their strengths and limitations (**Table E**). Clinicians should consider an integrative, neurodiversity-affirming approach that combines screening and assessment tools with a comprehensive clinical interview prioritizing lived experience and functional impact over test scores.

Sammy completes a few self-report questionnaires, including the Ritvo Autism Asperger Diagnostic Scale-Revised (RAADS-R) (score 164, threshold score 65) and the Camouflaging Autistic Traits Questionnaire (CAT-Q) (score 126, threshold score 100).

Clinical Assessment

While screening and standardized questionnaires offer important data points, it is essential to conduct a clinical interview and understand the patient's internal experience of the diagnostic criteria. For example, a patient may appear to be making good eye contact but on further inquiry reveals that eye contact is uncomfortable and they are looking at the nose instead to give the appearance of making eye contact. Several resources exist to help clinicians better understand the diagnostic criteria and how they may present in individuals with more subtle presentations of autism.[27-30] Collateral information is also helpful, especially for youth under age 18, though we note that TGD people are at risk of strained relationships with their families and caregivers. This may present an opportunity to obtain collateral information from friends and "chosen family." Finally, assessment of co-occurring mental and physical health conditions in autistic TGD people is important to have the complete picture (**Table A**).

Sammy's clinician conducts a thorough clinical interview centered on Sammy's experience of the autism diagnostic criteria. ***Figure A*** *shows more details.*

Delivering and Counseling About the Diagnosis

If patients meet diagnostic criteria for autism, the next step is to deliver the diagnosis and provide counseling. Reviewing the criteria and how they apply to patients provides an opportunity for psychoeducation as well as clarification. **Table F** discusses neurodiversity-affirming counseling and education about autism. We note that counseling also involves discussing the benefits and drawbacks of listing a formal autism diagnosis in the medical record, which can confer validation and access to accommodations but also may leave a patient at risk for stigma and possible barriers to gender-related care. **Table G** shows further details regarding the pros and cons of having a formal autism diagnosis listed in the medical record. Patients should be given the opportunity to make an informed decision about whether they want a formal diagnosis and how visible they wish it to be. The impact of the autism diagnosis should not be understated:

> "The most powerful benefit of proper diagnosis of autism is the gift of non-judgmental self-understanding. Only an accurate and neurodiversity-affirmative self-understanding can free an individual from a lifetime of self-blame and shame." —Donna Henderson, PsyD.[27]

In addition, it is important to share resources with the patient (**Table H**).

Based on clinical interview and standardized measures, Sammy is diagnosed with autism. Sammy receives counseling and psychoeducation about autism from a neurodiversity-affirming perspective, including their strengths and challenges, as well as pros and cons of having a formal diagnosis listed in their medical record. Sammy is also given resources to learn more about autism and understand their unique brain and nervous system.

After being assessed for co-occurring conditions, Sammy is also diagnosed with major depressive disorder, social anxiety disorder, attention-deficit/hyperactivity disorder (ADHD), and avoidant/restrictive food intake disorder (ARFID).

TREATMENT

Psychotherapy

Clinicians are encouraged to critically re-examine traditional behavioral and psychotherapeutic interventions, which have historically aimed to change patients' behavior to fit neurotypical norms. Autistic adults have described the harms from common interventions such as Applied Behavioral Analysis (ABA) and social skills training (SST), which have led many to develop shame around authentic autistic ways of being and feel pressure to perform neurotypicality.[31,32] A neurodiversity-affirming approach to ABA might include behavioral interventions to improve functioning that are aligned with the goals and values of the autistic TGD individual,

rather than merely to appear neurotypical. Neurodiversity-affirming approaches to SST may include reframing neurotypical communication like cross-cultural communication, where an autistic individual may choose to learn certain neurotypical communication skills to facilitate desired interactions without feeling that their natural autistic ways of communicating are wrong.

Autistic individuals may respond less well to certain common therapeutic interventions, such as challenging thoughts and cognitive restructuring in Cognitive-Behavioral Therapy, or exposure therapy targeting sensory sensitivities; not only will this be ineffective, it may further traumatize the autistic TGD individual when their sensory sensitivities do not desensitize. There is a role for exposure therapy when targeting anxiety, and careful exposure interventions may be designed with the collaboration and consent of the autistic TGD individual. Distinguishing when to challenge around anxiety and when to accommodate around sensory sensitivity requires nuanced understanding of the underlying challenges and which interventions will ultimately be more supportive. Autistic TGD individuals may respond better to modalities such as Acceptance and Commitment Therapy and Internal Family Systems therapy. Core therapeutic goals may include supporting authentic and positive self-identity and self-expression, navigating sensory needs, and fostering effective communication skills. Affirming interventions may facilitate both gender identity and autistic identity development. Supporting the autonomy and agency of the autistic TGD individual to live a life aligned with their goals and values is paramount.

Sammy's sound sensitivity is affecting their work performance, so Sammy's clinician writes a letter to Sammy's employer requesting that Sammy has access to their noise-cancelling headphones at work. This request is approved and Sammy is able to more effectively complete their work. Separately, Sammy's clinician is working with them to develop exposure exercises targeting anxiety.

Psychopharmacology

Psychopharmacologic interventions in autistic TGD individuals remain common, with antipsychotics, mood stabilizers, and sleep medications frequently prescribed off-label to target co-occurring symptoms such as irritability, mood dysregulation, and insomnia. However, their use warrants continued reappraisal, as these medications may be prescribed to suppress behaviors divergent from neurotypical expectations, eg, treating "irritability" or "dysregulation" when underlying this may be overstimulation or communication barriers. A neurodiversity-affirming approach calls for careful functional assessment before pharmacologic intervention, prioritizing relief of risk or suffering rather than treating a behavior to a norm.

Autistic individuals often respond differently to psychotropic medications compared with neurotypical populations, with 30% to 50% of autistic patients not responding adequately to pharmacotherapy.[33] These differences include heightened side effects at low doses (eg, irritability, somnolence, movement disorders), rare or atypical adverse reactions, and paradoxical responses. The underlying mechanisms driving this difference are being investigated, but may include genetic differences in drug-metabolizing enzymes, genetic variants in pharmacodynamic genes (eg, serotonin receptor/transporter genes), and heightened sensory and physiological sensitivity. Though pharmacogenetic testing is not standard in routine clinical care, a small study of treatment-resistant autistic adults found that the testing improved outcomes in 93% of the sample.[34] Importantly, medications should not be used to treat autism itself, but rather to address co-occurring conditions.

Clinicians are advised to initiate treatment at low doses and titrate gradually, counsel patients regarding potential side effects, incorporate shared decision making when treating one condition may exacerbate another (eg, ADHD and eating disorder), and allow agency in dose titration with guidance.

With medication treatment and weekly individual psychotherapy, Sammy grew to better understand and affirm their autistic identity as well as receive appropriate accommodations. Sammy did not respond to or had significant side effects to the first two medications tried but did respond to the third medication. At a recent visit, Sammy's depression was greatly improved, and they reported no longer experiencing any suicidal thoughts, noting that this was the first time their mood had felt good in a long time.

Sammy has significant challenges with eating, exacerbated by co-occurring ADHD and ARFID. Sammy has sensory sensitivities with food texture and taste, low interoceptive awareness leading to not being aware of being hungry, and executive function challenges that make it hard to plan and cook a meal. Through shared decision making with their clinician, the decision was made to start a stimulant medication with close observation. On follow-up, Sammy's eating had improved, as they are more easily able to plan and make meals, and also able to function better at school and work.

Working With Autistic TGD Individuals Seeking Gender-related Care

Autistic TGD individuals have unique needs, particularly when seeking gender-related care. In fact, the leading international guidelines for the care of TGD people recommend understanding the unique elements of care that autistic TGD people may require.[35] **Table I** discusses clinical considerations and support strategies when working with autistic TGD individuals.

Sammy has difficulty wearing a binder or using binding tape due to sensory sensi-

tivities. They prioritize wearing loose clothing that hides their body shape. Sammy has unique gender-care goals, as they would like to pursue top surgery but are not interested in taking hormone therapy. They appreciate receiving additional help from their clinical team to navigate the various tasks and appointments needed to prepare for surgery. They advocated for receiving written and visual materials as they learn better through those media. Sammy was provided additional support to navigate the sensory aspects of surgical aftercare, including adhesive bandages, planning wound care, and having access to appropriate clothing. With this additional support, Sammy's recovery from surgery went smoothly.

CONCLUSION

TGD individuals have higher odds of being autistic. Existing autism assessment tools identify only a subset of the autistic population and are more likely to overlook AFAB and TGD individuals, people of color, and those without intellectual disability. TGD youth who score slightly subthreshold on common autism assessment tools show similar outcomes and worse suicidality, raising the question of the utility and accuracy of current tools in identifying autism in TGD individuals. Gender diversity is more common among autistic people, yet many TGD individuals, particularly those who are BIPOC, rely on masking strategies that reduce their visibility and lower the likelihood of meeting diagnostic thresholds on traditional tools.

Autism is a clinical diagnosis, which can be diagnosed via a clinical interview. Screening and assessment tools may be helpful in the diagnostic process but should not replace expert clinical judgment. Viewing autism through the neurodiversity paradigm and social model of disability can provide a more affirming framework for assessment and care for TGD individuals. Accurate, neurodiversity-affirming autism diagnosis can be life changing, and adapting psychotherapeutic and psychopharmacologic interventions accordingly increases their effectiveness. Assessing for and managing co-occurring mental and physical health conditions is essential. A neurodiversity-affirming approach advocates for accommodations when needed and helps individuals build skills that align with their own values, rather than coercing conformity to neurotypical norms. With proper supports, autistic TGD individuals can thrive and are rewarding to work with.

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Figure A: Clinical Vignette – "Sammy"

Sammy is a 22-year-old nonbinary/transmasculine young adult (they/them pronouns) with a history of depression, anxiety, and trauma who presents asking for an autism assessment.

Sammy learned about autism from social media and their peer group, many of whom have told Sammy that they may be autistic. When asked what it would mean if Sammy were to be diagnosed with autism, Sammy says "everything would make sense."

Sammy's clinician conducts a clinical interview, seeking to understand Sammy's experience of the autism diagnostic criteria.

Reciprocity:
Sammy strongly dislikes small talk. They have difficulty knowing what to say, and feel they are "really bad at it." They have difficulty with greetings, even with people they know, and have a few scripted intro lines for talking to people at college, such as "what's your major?" If the other person deviates from the script, Sammy does not know what to say next and feels stressed. Sammy has trouble knowing when it is their turn in conversation. They find themselves either talking too little or too much (especially if asked about anime). Sammy feels their social skills used to be terrible but are improving. Sammy still feels that there is a hidden social rule book that everyone else seems to get so easily that has been very hard for Sammy to decipher. Sammy has difficulty with sarcasm, jokes, and humor, often feeling hurt when not realizing their friends are joking.

Nonverbal communication:
Sammy appears to be giving good eye-contact; however, when asked about their experience of eye-contact, shares that it is extremely uncomfortable for them. Sammy has learned to look at a person's nose to give the appearance of giving eye-contact, since they have been told eye-contact is important. Sammy has difficulty reading the facial expressions and body language of other people, leading them to not know what other people are thinking or feeling. Sammy's facial expressions don't match their internal feelings – they are often asked if they are feeling angry when they are not.

Relationships:
Sammy currently has a close network of friends. On further inquiry, all of Sammy's friends are neurodivergent as well, many of whom are autistic and/or ADHD. Sammy shares that when they were younger, they had significant difficulty making friends because they were the "weird kid." It wasn't until college that Sammy finally found a peer group of friends, many sharing similar interests. Sammy has a history of being bullied due to not keeping up with the popular trends at the time. Sammy also has difficulty distinguishing when peers show romantic interest in them. They report several instances when peers were romantically interested in Sammy and Sammy did not pick up on those cues, which led to some awkward interactions, including when Sammy didn't realize they were on a date. Sammy has difficulty forming relationships with neurotypical individuals.

Repetition:
Sammy enjoys rocking, pacing, spinning, and crocheting, reporting that the rhythmic and repeated movements are relaxing and calming. Sammy also tends to listen to the same music playlist on repeat and has read their favorite book series 17 times. Sammy also enjoys "stimming" with fidget toys and has certain phrases they often repeat.

Sameness:
Sammy has extreme difficulty with last minute changes to plans. If a friend cancels plans that Sammy was looking forward to, they will feel dysregulated and need to be in a quiet, dark room rocking for an hour, and then will not feel like interacting with others for a few days. If anyone moves an item in Sammy's room, they will notice right away and feel upset. Transitions between classes are difficult, as there is not enough time for Sammy to adjust. When they get home, they often stay in the car for an additional 15 minutes before going inside the home.

Special interests:
Sammy loves anime, and sometimes spends hours researching the history of anime. They will also spend hours drawing their favorite anime characters, sometimes leading them to forget about eating, using the bathroom, or going to bed. They are also very interested in neurodivergence and disability rights and have done a lot of reading and research into these topics. Sammy feels passionately about social justice, especially climate change and the rights of LGBTQ+ communities.

Sensory experiences:
Sammy has extreme sensitivity to noise and sounds and can hear the "buzzing" of the light bulbs. They strongly dislike when there are discordant sounds, like when different music is playing at the same time, or if there are multiple conversations at the same time. The overhead fluorescent lighting is too bright and gives Sammy migraines. They also have significant sensory sensitivities to food taste and texture, leading them to be a very "picky eater" and limited diet. Sammy also experiences low-interoceptive awareness that manifests as alexithymia, or difficulty describing their emotions and feelings. Sammy reports that their sensory sensitivities have been present for as long as they can remember. They bring noise-cancelling headphones and sunglasses wherever they go to accommodate their sensory needs. They experience sensory enjoyment from hearing ASMR sounds and playing with textured fidget toys.

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; ASMR, autonomous sensory meridian response; LGBTQ+, lesbian, gay, bisexual, transgender, queer, and more.

Table A: Common Co-Occurring Health Conditions in Autistic Individuals

A1: Common Co-Occurring Neurodevelopmental and Psychiatric Conditions in Autistic TGD Individuals

Neurodevelopmental / Psychiatric Condition	Prevalence among autistic TGD individuals*
Attention-deficit/hyperactivity disorder (ADHD)†	50–83%[1,2]
Anxiety disorders	80–94%[3,4]
Depression	54–91%[3,4]
Eating disorders	10–52%[3,4]
Self-harm	17–85%[3,4]
Suicidality	33–57%[3,4]
Post-traumatic stress disorder (PTSD)	57%[4]
Psychotic spectrum disorders	51%[4]
Substance use disorders	41%[4]

* Prevalence rates reported among autistic transgender and gender-diverse (TGD) individuals unless otherwise noted.
† ADHD prevalence is reported among autistic individuals broadly; data specific to autistic TGD populations remain limited.

A2: Common Co-Occurring Chronic Health Conditions in Autistic & ADHD Adults[5]

Category	Examples
Connective tissue / hypermobility	Hypermobility spectrum disorder, hypermobile Ehlers-Danlos syndrome (hEDS)
Cardiovascular	Postural orthostatic tachycardia syndrome (POTS), dysautonomia
Allergy / Immunology	Mast cell activation syndrome (MCAS); autoimmune disease (e.g., Hashimoto's, Sjögren's, rheumatoid arthritis, lupus)
Post-infectious chronic illness	Long COVID, myalgic encephalomyelitis / chronic fatigue syndrome (ME/CFS)
Gastrointestinal disorders	Irritable bowel syndrome (IBS), celiac disease, food sensitivities / intolerances, gastric motility disorders
Pain syndromes	Fibromyalgia, chronic pain, migraines
Reproductive	Polycystic ovarian syndrome (PCOS), premenstrual dysphoric disorder (PMDD), endometriosis
Sleep disorders	Obstructive sleep apnea (OSA), upper airway resistance syndrome, restless leg syndrome

[1] Hours C, Recasens C, Baleyte JM. ASD and ADHD comorbidity: What are we talking about? *Front Psychiatry*. 2022;13:837424. doi:10.3389/fpsyt.2022.837424

[2] Joshi G, Petty C, Wozniak J, et al. The heavy burden of psychiatric comorbidity in youth with autism spectrum disorders: a large comparative study of a psychiatrically referred population. *J Autism Dev Disord*. 2010;40(11):1361-1370. doi:10.1007/s10803-010-0996-9

[3] Kahn NF, Sequeira GM, Reyes V, et al. Mental health of youth with autism spectrum disorder and gender dysphoria. *Pediatrics*. 2023;152(6):e2023063289. doi:10.1542/peds.2023-063289

[4] Strauss P, Lin A, Winter S, Watson V, Wright Toussaint D, Cook A. Mental health difficulties among trans and gender diverse young people with an experience of gender-affirming care: a national survey. *J Psychiatr Res*. 2021;136:82-88.

[5] Everything is Connected to Everything: Improving the Healthcare of Autistic & ADHD Adults. All Brains Belong VT. 2023. Accessed October 29, 2025. https://allbrainsbelong.org/all-the-things/

Table B: Neurodiversity-Affirming Principles and Strategies

Principles of Neurodiversity-Affirming Psychology Practice for Autistic Adult Clients[1]

- A commitment to continued learning about autism
- Providing safety to be one's autistic self
- Finding a way to communicate
- Authenticity and humility in practice
- Validation of autistic experiences
- Autistic-informed person-centered support
- Genuine acceptance and appreciation of autism

Ways to Be Neuro-Affirmative[2]

- Reframe autism from disorder to a neurotype
- Don't pathologize autistic ways of being
- Use supports and follow recommendations that target autistic people's needs and challenges and not their autistic ways of being
- The autistic voice should be at the center of everything you do
- Respect autistic culture and identity
- If you have the power, employ autistic and otherwise neurodivergent team members; if you don't have the power, advocate others to do so
- Recognize that there is immense value in diversity
- Recognize that there is value in living a disabled life
- All neurodivergent people (including those with significant intellectual disability and high support needs) have power, a place at the table, and are supported and advocated for
- Reject behavior-based compliance approaches
- Reject neurotypical social skills training
- Advocate for systems and environmental changes
- Fostering a positive autistic identity is a priority goal

Tips for Making Your Practice More Neurodiversity-Affirming

- Ask about accessibility needs ahead of time
- Ask about communication preferences (e.g., verbal, written)
- Adjust sensory environment, e.g., dim/adjust lights, get rid of overhead harsh lights
- Invite individual to do what they need to do to be comfortable, move, stim, not make eye contact
- Allow access to sensory/fidget toys
- Give heads-up about what to expect during the appointment
- Allow a support person to be there if requested
- Start with interests/passions to engage, if having difficulty with engagement
- Be direct and clear, avoid euphemisms
- Open-ended questions might be difficult, consider close-ended questions
- Offer breaks, get permission before talking about challenging topics
- Flexibly convert to telehealth, if unable to make it in person
- Check ableist language, use neurodiversity-affirming language

[1]Flower RL, Benn R, Bury S, et al. Defining Neurodiversity Affirming Psychology Practice for Autistic Adults: A Delphi Study Integrating Psychologist and Client Perspectives. *Autism in Adulthood*. Published online June 2, 2025:aut.2024.0305. doi:10.1089/aut.2024.0305

[2]Hartman D, O'Donnell-Killen T, Doyle JK, Kavanagh M, Day A, Azevedo J. *The Adult Autism Assessment Handbook: A Neurodiversity-Affirmative Approach*. Jessica Kingsley Publishers; 2023.

Table C: Neurodiversity Terminology

Term/Concept	Definition/Description
Neurodiversity	The diversity of human minds, the infinite variation in neurocognitive functioning within our species
Neurotype	One's style of neurocognitive functioning
Neurodivergent (ND)	Having a mind that functions in ways which diverge significantly from the dominant societal standards of "normal"
Neurotypical (NT)	Having a style of neurocognitive functioning that falls within the dominant societal standards of "normal"
Neurodiverse	Multiple neurocognitive styles are represented, including Neurodivergent and Neurotypical. Note: a single person is not diverse/neurodiverse (though individuals are free to self-identify how they wish)
Neuroqueer	The practice of queering (subverting, defying, disrupting, liberating) oneself from neuronormativity and heteronormativity simultaneously. May also be used as an identity label by those who are neurodivergent and queer
Ableism	Discrimination or prejudice against disabled individuals and disability itself
Disability	A person who has a physical or mental impairment that substantially limits one or more major life activity (ADA)
Pathology paradigm	Assumption there is one "right" style of neurocognitive functioning. Variations that diverge are framed as pathologies, deficits, disorders. There is a predominance of the pathology paradigm in medical literature
Neurodiversity paradigm	Neurodiversity is a natural and valuable form of human diversity. The idea that there is one "normal" or "healthy" type of brain or mind is a culturally constructed fiction, akin to the idea of one "correct" ethnicity, gender, or culture — and like those constructs, it may produce dynamics of social power inequity.
Medical model of disability	Disability is attributed to medicalized defects located within the disabled individual. Assumption that status quo societal norms are "right" and "natural." Having traits and needs that are incompatible with those norms constitutes a personal deficiency
Social model of disability	Disability is the result of failures of accommodation, societal attitudes, and systemic barriers, which conflict with the needs, traits, and abilities of specific groups and individuals
Universal design	An environment can be accessed, understood, and used to the greatest extent possible by all people regardless of their age, size, ability, or disability.

Abbreviation: ADA, American with Disabilities Act

Walker N. *Neuroqueer Heresies: Notes on the Neurodiversity Paradigm, Autistic Empowerment, and Postnormal Possibilities*. Autonomous Press; 2021.

Price D. *Unmasking Autism: Discovering the New Faces of Neurodiversity*. First edition. Harmony Books; 2022.

Table D. Autism Diagnostic Criteria A and B in the DSM-5-TR Reframed in Neurodiversity-Affirming Language

A. Social communication differences (all three, current or by history):

1. Reciprocity
2. Nonverbal communication
3. Relationships (developing, maintaining, and understanding relationships)

B. Specific patterns of behavior/experience (at least two, current or by history):

1. Repetition (repeating movements and behaviors that are soothing, calming, regulating, e.g. stimming)
2. Sameness (preference for routines and predictability, difficulty with change, flexibility, transitions)
3. Special interests and passions
4. Sensory experiences (hyper- or hypo-sensitivity across five senses, plus interoception, proprioception, vestibular)

Table E: Autism Screening and Assessment Tools

Proposed Screening Tools	Description	Strengths	Limitations
CATI-R (Revised Comprehensive Autistic Trait Inventory)	Self-report questionnaire for people age 16+ without intellectual disability. It has 42 items, each rated on a 5-point scale from definitely disagree to definitely agree), yielding a total score plus six subscales: Social Interactions, Communication, Masking, Repetitive Behaviors, Cognitive Rigidity, and Sensory Sensitivity. The score range is 42–210. Scores ≥147.5 suggesting elevated autistic traits consistent with autism.	Developed in collaboration with autistic community members to provide neurodiversity-affirming language. Designed with female and gender-diverse individuals in mind. Language is more accessible and less stigmatizing. Has a masking subscale.	No CATI-R specific cutoff scores have been developed. Thresholds are extrapolated from the original CATI. Newer tool with less external recognition
RAADS-R (Ritvo Autism Asperger Diagnostic Scale-Revised)	Self-report questionnaire for people age 16+ without intellectual disability. It has 80 questions, each having 4 choices (true now and when I was young, true now only, true only when I was younger than 16, never true). The score range is 0-240, with scores above 65 indicating likely autism	High sensitivity & specificity; Clinically popular	Lengthy; Vague, frustrating items; high cognitive burden to switch between present moment and childhood when answering questions
CAT-Q (Camouflaging Autistic Traits Questionnaire)	Self-report questionnaire of social camouflaging behavior in people age 16+ without intellectual disability. It has 25 statements, each with 7 answer choices ranging from strongly disagree to strongly agree. The score range is 25-175, with scores above 100 being significant. Of note, this questionnaire does not	Measures masking/compensation; Neurodiversity-affirming	Does not assess core autistic traits

	measure core autistic traits, but rather the camouflaging and compensation efforts that people engage in.		
SRS-2 (Social Responsiveness Scale, 2nd Ed.)	A highly regarded autism assessment that identifies social challenges associated with autism and quantifies its severity. It's sensitive enough to detect subtle symptoms, yet specific enough to differentiate clinical groups, both within the autism spectrum and between autism and other disorders. Raw scores are converted to gender-normed T scores, with a T-score of <59 designated as normal range, 60-75 considered mild-to-moderate, and a T-score of >75 indicating severe impairment. Recommend using with parents/caregivers of youth under age 18.	Online form; Instant scoring; Graphical reports; Parent/self-available.	Has language that is not neurodiversity-affirming; proprietary.
Additional Screening Tools	**Descriptions**	**Strengths**	**Limitations**
AQ (Autism Spectrum Quotient)	A self-administered questionnaire for people age 16+ without intellectual disability. It has 50 questions, each giving 4 choices (definitely agree, slightly agree, slightly disagree, definitely disagree). The score range is 0-50, with scores above 26 indicating possible autism. About 80% of autistic people score 32 or higher.	Covers multiple age groups; Available in various languages; Graduated answer choices	Some items outdated; Not neurodiversity-affirming; Lengthy

CARS-2 (Child Autism Rating Scale, 2nd Ed.)	A clinician rated tool that identifies autism severity in children across communication, social, emotional, and sensory domains.	Multi-informant (clinician, parent, teacher); Options for standard/HF	Scoring laborious; Bundles only
RBQ-2A (Adult Repetitive Behaviors Questionnaire-2)	Self-report tool capturing restricted interests, insistence on sameness, and repetitive behaviors in adults.	Short (20 Qs); Targets repetitive behaviors & sameness	Narrow focus; Limited scope

Assessment Tools	**Descriptions**	**Strengths**	**Limitations**
MIGDAS-2 (Monteiro Interview Guidelines)	Strength-based, conversational interview capturing qualitative patterns in communication, sensory processing, and behavior.	Neurodiversity-affirming; Begins with sensory & interests	Lengthy; Paper only; Some items outside DSM
ACIA (Autism Clinical Interview for Adults)	Adult-focused, semi-structured interview integrating developmental history and current presentation to distinguish autism from psychiatric overlap.	Structured semi-structured guide; Covers co-occurring conditions; Includes strengths & hopes	Strict order; Special interests last; Training UK-based
ADOS-2 (Autism Diagnostic Observation Schedule, 2nd Ed.)	Often considered "gold-standard," structured observation assessing communication, social interaction, and restricted behaviors across age and ability levels.	Standardized; Clear behavioral coding; helpful for young children with intellectual disability and/or language impairment	High cost for full testing kit; behavioral observation only, misses masked presentations; normed on cisgender white males, misses people not of that demographic; may feel awkward for adolescents and adults; does not inquire about lived experience.

Table F: Neurodiversity-Affirming Education and Counseling about Autism

- Autism is a difference in how an individuals' brain/nervous system are wired (not deficits)
    - Some things will be easier, e.g. passions & special interests. For some, this might align with a job that one can get paid for.
    - Some things will be more challenging, e.g. crowded situations requiring social interaction that are overwhelming from sensory standpoint
- Goal is to learn/attune to one's unique nervous system, learning its needs, and how to regulate it
    - Redesign life with sensory needs in mind, seek accommodations when necessary
    - Prepare a sensory kit, access before/during/after stressful experiences
    - Make time for special interests/sensory needs, which helps regulate nervous system
- Find opportunities to unmask, discover one's authentic self, develop positive identity
    - Make friends with other neurodivergent people, connect with the autistic community
    - Recognize that masking may be needed in some situations for safety reasons, however can leave individuals feeling exhausted/drained. Develop awareness/intentionality of when to mask, and have a plan for restoring energy afterward (e.g. through special interests/sensory needs)
- Celebrate and cultivate autistic strengths, including but not limited to:
    - Strong sense of morality, social justice
    - Ability to hyperfocus on areas of special interest
    - Clear and direct communication
    - Creativity and artistic talents

Table G: Pros and Cons of Formal Autism Diagnosis

Pros	Cons
• Medical record accurately reflects diagnosis, easier to share with other providers • May be easier to advocate for certain accommodations and supports • Some people may find the formal diagnosis to be validating	• Stigma within healthcare settings, as other healthcare providers may have a narrower understanding of what autism is (e.g. the cisgender boy stereotypical presentation) and may invalidate and/or take a deficit-oriented perspective. • There may be potential challenges with accessing certain types of medical care, such as gender-affirming care, in states that have restricted access • There are other risks that we are not able to fully predict: access to life insurance, immigration to some countries, legal risks, parental/reproductive rights, etc

Note: We can't predict all the potential consequences down the line, so we are trying to make the most informed choice we can with the available information we have right now.

Resources:

Price D. Seeking an Autism Diagnosis? Here's Why You Might Want to Rethink That. *Medium*. August 4, 2022. Accessed November 3, 2025. https://devonprice.medium.com/seeking-an-autism-diagnosis-heres-why-you-might-want-to-rethink-that-530e79c272a0

Table H: Resources

Autism-Related Resources for Patients

- Books
  - Price D. *Unmasking Autism: Discovering the New Faces of Neurodiversity*. First edition. Harmony Books; 2022.
    - Devon Price, PhD, is a trans autistic social psychologist, and also has a number or articles on Medium that are a good resource
  - Walker N. *Neuroqueer Heresies: Notes on the Neurodiversity Paradigm, Autistic Empowerment, and Postnormal Possibilities*. Autonomous Press; 2021.
    - Nick Walker, PhD, is an autistic trans professor of psychology
    - The chapters: "What is Autism" and "Neurodiversity: Some Basic Terms and Definitions" provide a good overview of autism and terminology. These are also accessible on the author's website
  - Neff MA. *Self-Care for Autistic People: 100+ Ways to Recharge, de-Stress, and Unmask!* 1st ed. Adams Media Corporation; 2024.
    - Megan Anna Neff, PsyD, an autistic & ADHD psychologist, offers 100+ ways to recharge, de-stress, and unmask.
  - Price D. *Unmasking for Life: The Autistic Person's Guide to Connecting, Loving, and Living Authentically*. 1st ed. Potter/Ten Speed/Harmony/Rodale; 2025.

- Divergent Conversations podcast: Podcast of Megan Neff and Patrick Casale, 2 autistic+ADHD therapists describing their experiences of autism and ADHD. Consider starting with "What is Autism?" Parts 1-4, episodes 48-51 (Apr 5-26, 2024), then check out the other episodes.
  - https://www.divergentpod.com/

- AASPIRE Health Care Toolkit:
  - A comprehensive resource designed to improve healthcare experiences for autistic adults developed by the Academic Autism Spectrum Partnership in Research and Education (AASPIRE)
  - https://autismandhealth.org/

- Neurodivergent Insights:
  - Website of an autistic + ADHD psychologist Megan Anna Neff, with helpful diagrams and tools
  - https://neurodivergentinsights.com/

- Healthy Relationships on the Autism Spectrum (HEARTS):
  - A 6-session online class that supports autistic adults looking to have healthy friendships and relationships. Classes are led by one autistic facilitator and one non-autistic facilitator. There is an opportunity to get paid for participating in research.
  - https://sites.bu.edu/hearts/

- Everything is Connected to Everything: intertwined health conditions
  - A helpful resource for the co-occurring health conditions that autistic adults may experience.
  - https://allbrainsbelong.org/all-the-things/

- Autistic strengths, skills, interests
  - https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2023.1264516/full

- Neuroclastic
  - A collective of autistic people responsive to the evolving needs and trajectory of the autistic community.
  - https://neuroclastic.com/

- Autistic Self-Advocacy Network (ASAN)
  - A nonprofit organization run by and for autistic people. ASAN is a national grassroots disability rights organization for the autistic community
  - https://autisticadvocacy.org/

- Autistic Women and Nonbinary Network (AWN)
  - A nonprofit organization that provides community support and resources for autistic women, girls, transfeminine and transmasculine nonbinary people, trans people of all genders, Two Spirit people, and all people of marginalized genders or of no gender
  - https://awnnetwork.org/

Autism-Related Resources for Clinicians

- Books
  - Price D. *Unmasking Autism: Discovering the New Faces of Neurodiversity*. First edition. Harmony Books; 2022.
  - Henderson DA, Wayland SC, White J. *Is This Autism? A Guide for Clinicians and Everyone Else*. Routledge; 2023.
  - Henderson DA, Wayland SC, White J. *Is This Autism? A Companion Guide for Diagnosing*. Routledge; 2023.
  - Hartman D, O'Donnell-Killen T, Doyle JK, Kavanagh M, Day A, Azevedo J. *The Adult Autism Assessment Handbook: A Neurodiversity-Affirmative Approach*. Jessica Kingsley Publishers; 2023.
  - Gratton FV. *Supporting Transgender Autistic Youth and Adults: A Guide for Professionals and Families*. Jessica Kingsley Publishers; 2020.
  - Walker N. *Neuroqueer Heresies: Notes on the Neurodiversity Paradigm, Autistic Empowerment, and Postnormal Possibilities*. Autonomous Press; 2021.

- Neurodivergent Insights:
  - Website of autistic + ADHD psychologist Megan Anna Neff, with helpful diagrams and tools. Consider joining the Learning Nook Clinician Community and consultation group.
  - https://neurodivergentinsights.com/

- Divergent Conversations podcast: Podcast of Megan Neff and Patrick Casale, 2 autistic+ADHD therapists describing their experiences of autism and ADHD. Consider starting with "What is Autism?" Parts 1-4, episodes 48-51 (Apr 5-26, 2024), then check out the other episodes.
  - https://www.divergentpod.com/

- Donna Henderson's podcast episode on Autism in Girls and Women
  - https://thetestingpsychologist.com/ttp-119-autism-in-girls-women-w-dr-donna-henderson/

- Finn Gratton's Neurodiversity-Affirming Consult Group
  - https://www.grattonpsychotherapy.com/consulting

- A. Ning Zhou's Gender Health Training Institute Workshop: Centering Empowerment and Self-Understanding: A Neurodiversity-Affirming Approach to Autism Assessment and Treatment Adaptation for Gender Diverse Adolescents and Adults without Intellectual Disability
  - https://www.genderhealthtraining.com/a-neurodiversity-affirming-approach/

Gender-Related Resources

- World Professional Association of Transgender Health – www.wpath.org
- National LGBTQIA Health Education Center – www.lgbtqiahealtheducation.org
- American Academy of Child and Adolescent Psychiatry Gender and Sexuality Resources – www.aacap.org/AACAP/Member_Resources/SOGIIC/SOGIIC.aspx
- The Trevor Project – www.thetrevorproject.org
- The Tyler Clementi Foundation- www.tylerclementi.org
- PFLAG – https://pflag.org
- Advocates for Trans Equality – www.transequality.org
- Trans Student Educational Resources – www.transstudent.org
- Gender Spectrum – www.genderspectrum.org
- Transhealth - https://transhealth.org/
- TransFamily Alliance - https://www.transfamilyalliance.com/
- Trans Health HQ - https://www.thhq.org/
- GLSEN – www.glsen.org
- Transgender Law Center - https://transgenderlawcenter.org/
- Lambda Legal - https://lambdalegal.org
- Human Rights Campaign - https://www.hrc.org/
- Lavender Phoenix - https://lavenderphoenix.org/
- GLMA - https://glma.org/

Table I: Clinical Considerations and Support Strategies for Working with Autistic TGD Youth and Adults Seeking Gender-Related Care

Clinical Considerations

- Do not assume that autistic TGD individuals do not know their gender and are unable to provide informed consent/assent about their treatment
    - Many have a lot of clarity around their gender identity and embodiment goals
    - Many are able to assent/consent. Assess for medical decision-making capacity as you would with other patients
- Communication and language differences do not mean an individual is unable to communicate clearly who they are
- Use a variety of strategies and approaches to assess and obtain information
- Collaborate with family/support system and other treatment providers when available
- Consider risks/benefits of both treatment and non-treatment. Non-treatment may not be neutral.
- Gender-related care should not be held merely because someone is autistic

Support Strategies

- Support communication and diverse learning needs
    - Inquire about communication needs ahead of time, e.g., preference for verbal, written, visual, and/or asynchronous formats
    - Present information in multiple formats according to communication preferences
    - Regularly check for understanding, in both directions (clinician to patient, and patient to clinician)
        - Clinician to patient: Clinician provides brief summary of what they heard from the patient, checking that they accurately understood what patient said, giving patient chance to provide clarification if needed
        - Patient to clinician: Patient "teaches back" what they learned from the clinician, allowing clinician to confirm that patient accurately understood the relevant medical information, providing clarification if needed.
- Support executive function needs related to medical tasks
    - e.g., attending appointments, following through with treatment recommendations and aftercare plans
- Support sensory experiences
    - Anticipate where sensory differences may intensify the patient experience of various interventions, and develop strategies to prepare for, cope with, or accommodate sensory needs.
    - Examples of interventions (not exhaustive) include:
        - Non-medical: binders, binding tape, tucking garments, makeup, wardrobe, etc.
        - Medical: navigating needles, bandages, adhesives, physical changes from endogenous or exogenous hormones (e.g., hair growth, chest tissue growth, skin becoming more oily), etc.
        - Surgical: wound care, drains, effects from anesthesia/pain meds, limited mobility, need for dilation, etc.

Abbreviation: TGD, transgender and gender diverse.