5-2022

'There is No Cause, There is No Effect': Experiences at the Intersection of Transgender and Neurodivergent Identities

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‘THERE IS NO CAUSE, THERE IS NO EFFECT’: EXPERIENCES AT THE INTERSECTION OF TRANSGENDER AND NEURODIVERGENT IDENTITIES

by

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Presented to the Graduate School of

The University of Southern Maine

in Partial Fulfillment

of the Requirements

for the Degree of

MASTER OF SOCIAL WORK

May 2022

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Acknowledgements

This work represents the culmination of what unexpectedly became the focus of my MSW. During my first-year internship, I had the opportunity to work with a creative, kind, and humorous client who became very near to my heart. This client was a neurodivergent young adult living in a rural community. During our work together, she shared with me that she was exploring her gender identity and was interested in pursuing gender-affirming medical care. As I learned more about her, I became curious about this intersection of identities and what resources were available for social workers supporting neurodivergent clients during gender exploration and transition. That initial inquiry turned into an 18-month process of researching and writing that has radically shifted my perspective on neurodivergence, mental health, and disability. Our relationship and the resultant research have had a profound effect on my social work practice, and I am so grateful for the opportunity to learn from her. Thank you!

I would also like to thank all the participants who took part in this study for sharing their stories and incredible insights with me. Thank you as well to my thesis advisor, Dr. Caroline Shanti, for your encouragement, partnership in thought, and tireless editing. Thank you to the other members of my committee, Dr. Rachel Casey and Dr. Heather Shattuck-Heidorn, I so appreciate your affirmations and thought-provoking questions. Thank you to my partner, Allie. Your encouragement, care, and joy in endless discussions about my learning sustained me during this writing process and throughout this program. Finally, thank you to all my friends in the USM MSW program– we did it!

April 28, 2022

Abstract

‘THERE IS NO CAUSE, THERE IS NO EFFECT’: EXPERIENCES AT THE INTERSECTION OF TRANSGENDER AND NEURODIVERGENT IDENTITIES

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The University of Southern Maine, 2022

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A significant body of clinical research has demonstrated that neurodivergent individuals are more likely than neurotypical individuals to have transgender and/or gender expansive identities (Janssen et al., 2016; Strang et al., 2014; Warrier et al., 2020). Within this body of research, neurodivergence and transgender identities are commonly mutually pathologized. Existent medico-psychiatric literature has been found to describe neurodivergence and transgender identities as “co-morbidities” and hypothesizes neurodivergence as a “cause” of transgender identity (Shapira & Granek, 2019, p. 506). A small but growing body of clinical, sociological, and theoretical scholarship has demonstrated the importance of non-pathologizing approaches to mental and physical healthcare for this population, the complexity of neurodivergent and transgender identity construction, and the importance of intra-community solidarity (Egner, 2019; Oswald et al., 2021; Strang et al., 2020). However, little is known about individuals’ internal experience of this phenomenon.

The present study utilizes hermeneutic and queer phenomenology to explore transgender and neurodivergent individuals' experiences and understandings of gender identity and neurodivergence, connections drawn between gender identity and neurodivergence, experiences within broader LGBTQ+ community, and experiences accessing gender-affirming, medical, and mental healthcare. Participants who identify as both transgender and neurodivergent were recruited via social media and 13 individuals took part in the hour-long semi-structured interview process. Five essential themes emerged from the data: (1) fluid and expansive identities, (2) relationality and identity development, (3) connections between gender and neurodivergence, (4) diverse experiences within LGBTQ+ community, and (5) experiences within the healthcare system. Participant gender and neurodivergent identities were found to be fluid, and identity development and expression were found to be informed by relationships and social dynamics. All participants drew at least some connections between their gender identities and neurodivergence. Participant experiences within the broader LGBTQ community included both those of inclusion and exclusion. Finally, participants did not report ableist discrimination in gender-affirming care settings. However, all participants reported experiencing transphobia in healthcare settings. Implications for social work education and practice are presented as well as directions for future research.

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Chapter 1: Background

Introduction

Neurodivergent populations, particularly autistic individuals and those with ADHD, have been found to be more likely than neurotypical populations to hold transgender and/or gender diverse identities (Janssen et al., 2016; Strang et al., 2014; Warrier et al., 2020). This phenomenon has been well documented in clinical research studies dating back to the late 1990s (Nobili et al., 2018) and is also understood anecdotally among transgender and neurodivergent communities (Brown, 2016). Existent clinical research has focused primarily on the elevated rates of transgender identities among neurodivergent individuals and has characterized both identities within a medical model of pathology; transgender and neurodivergent identities are commonly described in the literature as "co-morbidities," and neurodivergence has been assumed to "cause" transgender identity (Shapira & Granek, 2019, p. 506). To date, minimal attention has been given within clinical research to this population's own experiences and perspectives.

Within the last ten years, a growing body of clinical and sociological scholarship has demonstrated the importance of non-pathologizing approaches to gender-affirming healthcare that address the unique needs, insights, and experiences of structural discrimination faced by individuals at the intersection of these identities (Dubois & Shattuck-Heidorn, 2021; Shumer & Tishelman, 2015; Strang et al., 2020; National LGBT Health Center, 2020). This body of research has found significant disparities in health outcomes as well as in access to gender-affirming medical and mental health care for neurodivergent and transgender populations. One notable barrier to accessing gender-

affirming care, particularly for youth, is a pervasive belief among medical and mental health providers that transgender identity is a ‘symptom’ of neurodivergence (Kuvalanka et al., 2018; Shapira & Granek, 2019; Jackson-Perry, 2020). This assumption of causality frequently results in undermining the validity of neurodivergent individuals’ gender identities, which can contribute to denial of gender-affirming care (Shapira & Granek, 2019).

Sociological research and first-person narratives have provided rich descriptions of the importance of community solidarity and mutual aid among transgender and neurodivergent populations. For young people, participating in neurodivergent and transgender community spaces has been linked to better mental health outcomes (Strang et al., 2020), developing meaningful friendships, and opportunities to explore gender identity in a non-judgmental space (Oswald et al., 2021). For both youth and adults, internet-based community spaces are particularly salient (Oswald et al., 2021 & Egner, 2019). These spaces may provide freedom from surveillance by families and medical or educational institutions as well as opportunities for identity construction that exists outside of cisgender and neurotypical paradigms (Oswald et al., 2021 & Egner, 2019).

A growing body of 'neuroqueer' theory has created a novel framework for deconstructing gender and neurological binaries of normal and abnormal (Egner, 2019; Roscigno, 2019; Walker & Raymaker, 2020). Neuroqueer praxis conceptualizes gender, bodies, and minds in ways that are not rooted in a pathology, but instead allow for fluid and expansive forms of expression and identity-construction that are resistant to “assimilationist rhetoric” (Egner, 2019, p. 142). Understood through this theoretical lens,

the question of why there is a significant overlap between neurodivergent and transgender identities becomes less important. Through a neuroqueer lens, neurodivergent understandings and experiences of gender, mind, and embodiment can be recognized not as symptoms of comorbid pathologies, but as valuable insight into the phenomenon of gender. In fact, neurodivergent understandings and experiences of gender may provide far richer sites of analysis than theorizing the causality of the 'co-occurrence'.

However, though neuroqueer projects provide groundbreaking insight into a phenomenon that has historically been understood primarily in pathological terms, the majority of scholarship remains theoretical in nature. The paucity of original research informed by neuroqueer orientations speaks to the need for greater understanding of transgender and neurodivergent individuals' experiences and understandings of gender and neurodivergence, particularly those who are not active in neuroqueer community spaces. The present study attempts to contribute to these gaps in knowledge across both medico-psychological scholarship and critical theory through phenomenological research focused on the experiences of individuals at the intersection of these identities. This section serves to orient the reader to the project through providing terminology and language, contextualizing the experiences of transgender and neurodivergent people in the social environment, and establishing the guiding theoretical frameworks of the research.

Terminology & Language

Gender diversity is an expansive phenomenon that is inclusive of innumerable identities and experiences. The definition of transgender varies widely across fields of

study, community settings, and among individuals. In order to offer an inclusive definition, this research will define transgender identities as those that differ "from what is associated with the gender [an individual was] thought to be at birth" (James et al., 2016, p. 40). The definition of transgender employed in this research is inclusive of transgender men and women, non-binary people (those who identify outside of or in some combination of male and female categories), those who are questioning or exploring their gender identity, and anyone who identifies as otherwise not cisgender. This research uses both the word transgender and the abbreviated term 'trans,' which is considered to be "widely accepted amongst transgender people" (James et al., 2016, p. 40).

It is also important to contextualize the terms gender identity, gender, and sex in this research. Gender identity describes an individual's "internal" experience of their gender and how they communicate that experience to others (Wirtz et al., 2020, p. 230). Whereas gender refers to "culturally contextualized social and structural experiences as well as expressions of identity" and sex describes "biological characteristics generally related to reproductive anatomy or physiology" (Dubois & Shattuck-Heidorn, 2021, p. 3). However, it is also important to note that a growing body of scholarship has critiqued both the very concept of a sex binary and the ways in which assumptions surrounding this binary can work to "mask variation in physiology, as well as sociocultural contributions to human biology" (Dubois & Shattuck-Heidorn, 2021, p. 4).

Neurodiversity refers to the biological fact that a diversity of brains and neurotypes exists among human beings (Tumlin, 2019). The meaning of the term

neurodiversity is similar to racial diversity or religious diversity, in that these phrases describe a variety of experiences among a population. While it would be inaccurate to describe an individual as neurodiverse, a group of people may be described as neurodiverse if the group includes multiple neurotypes (Tumlin, 2019). That is, neurodiversity describes a facet of human diversity that is not unlike race, religion, sexual orientation, or gender identity.

Neurodivergence as a phenomenon is somewhat more difficult to operationalize. Not unlike the term transgender, definitions of neurodivergence vary significantly across disciplines and within the neurodivergent community. In its most narrow definition, neurodivergence refers to cognitive styles that are typically categorized in terms of neurodevelopmental differences such as autism and attention deficit hyperactivity disorder (ADHD), neurological conditions such as epilepsy and Tourette's Syndrome, and learning differences such as dyslexia (Tumlin, 2019). Neurodivergence can be biologically occurring, the result of a brain-altering experience, or a combination of the two (Tumlin, 2019). However, among neurodiversity scholars, the term has come to encompass a broader range of experiences, including those that have traditionally been categorized as mental health conditions, such as obsessive-compulsive disorder and bipolar disorder, among others (Tumlin, 2019). Neuroqueer theorists interpret the concept of neurodivergence in an intentionally expansive and evolving manner that is inclusive of any person whose "neurocognitive functioning diverges from dominant societal norms" (Walker, 2014, Neurodivergent and Neurodivergence section, para. 3). In the context of neuroqueer theory, the concept of neurodivergence is less focused on discrete diagnoses

and is instead centered on deconstructing normative ideas about neurocognitive processes. Within neurodivergent community discourses, the definition has also evolved in recent years. Today, in some neurodivergent community spaces, neurodivergence comprises an expansive range of experiences, inclusive of schizophrenia, down syndrome, and C-PTSD (complex post-traumatic stress disorder) among many others (Wise, 2021). Neither current scholarship nor intra-community first-person narratives offer precise or consistent definitions of neurodivergence. Further, the tension between the movement to embrace neurodiversity and individual experiences of desire for relief of 'symptoms' is minimally addressed in the literature. For the purpose of this research, neurodivergence is then situated as a term that participants may use to describe their neurological, cognitive, emotional, or social experiences.

The word neurodivergent is used as a descriptor for an individual (Tumlin, 2019). The word neurodivergent was created by Kassiane Asasumasu in the early part of the 2000s (Walker & Raymaker, 2020). Conversely, the term neurotypical refers to individuals whose cognitive style fits within societal norms and expectations. While participants may or may not embrace the language of their diagnoses, this research will use the term neurodivergence (or neurodivergent when referring to an individual) to resist pathologizing and deficiency-based understandings of certain neurotypes. While the word neurodivergence can serve as a useful shorthand for describing a broad range of experiences, it is also important to note that not unlike gender, the binary of neurotypical and neurodivergent is socially constructed. Thus, it is insufficient in its ability to fully describe cognitive, emotional, or social experiences. Further, these definitions represent

the research and theoretical orientation of the researcher and all individual choices related to self-identification should be recognized as valid and appropriate. The limitations of the categories of neurodivergent and neurotypical to describe individual experiences will continue to be interrogated throughout this work.

This research will also utilize identity-first rather than person-first language in regard to discussing autism (e.g., an autistic person rather than a person with autism). This choice is in order to reflect "autistic politics of self-affirmation" (Shapira & Granek, 2019, p. 496) and to align with the neurodiversity paradigm principle that identifies neurodivergence as a valuable aspect of human diversity. When neurodivergence is conceptualized as a disorder or condition, it seems appropriate to use a phrase such as 'person *with* autism.' However, the neurodiversity paradigm recognizes neurodivergence as a salient aspect of identity, not unlike race, sexual orientation, or religion. Identity-first language articulates an understanding of neurodivergence as a facet of diversity rather than a deficit against which an individual's humanity must be rearticulated. As Walker & Raymaker (2020) write, a "phrase like 'individuals with autism' should register with us as inappropriate in the same way that we intuitively recognize that there's something wrong with the phrase 'individuals with homosexuality'" (p. 3).

Contextualizing Transgender Experiences: Social, Economic, and Health Disparities

Global Epidemic of Violence

In order to contextualize the experiences of transgender communities, it is imperative to recognize the impact of institutional, political, and interpersonal cissexism and transphobia. Globally, transgender people are at significant risk of violence and

murder, with trans women and femmes[1], sex workers, and migrants facing the greatest rates of fatal violence (Transgender Europe, 2021). The year 2021 represented the deadliest year on record for transgender people in the United States, with 47 known murders (Human Rights Campaign, 2021). In the United States, the highest rates of violence are experienced by trans women and Black, Indigenous, and trans people of color, as compared to their White and trans men/masculine peers (Human Rights Campaign, 2021). In 2021, Black trans women represented the greatest proportion of transgender people murdered in the United States (Human Rights Campaign, 2021). However, these numbers are understood to likely provide an underrepresentation of the phenomenon as "there are no national surveillance systems that track murders of trans people and…trans victims of violence are often misgendered by police and news media" (Wirtz et al., 2020, pp. 227-230).

Transgender people have also been found to experience gender-based violence, or "physical, sexual, or other emotional violence perpetrated on the basis of socially ascribed gender differences," at rates ranging from 7% to 89% of the U.S. trans population (Wirtz et al., 2020, p. 227). The notable range in these percentages come from "nascent epidemiologic and behavioral data" (Wirtz et al., 2020, p. 227) and represent studies concerning both a variety of demographics within the transgender community and types of gender-based violence. Such experiences of gender-based violence occur across a variety of developmental, social, and relational contexts (Wirtz et al, 2020). Examples

[1] Femme is a queer and trans gender identity/expression term that refers to an experience of femininity that does not necessitate a cis/female identity (Blair & Hoskin, 2015).

of these contexts include during phases of gender "recognition and transition," in school systems, in the workplace, in healthcare settings, in interactions with law enforcement, and within intimate relationships (Wirtz et al., 2020, p. 230-231).

Economic Inequities

In addition to interpersonal violence, transgender populations face social exclusion, discrimination, and structural barriers that limit access to resources (Johnson & Rogers, 2019). The effects of structural and interpersonal cissexism and transphobia are recognizable in the economic inequality faced by transgender people in the United States (James et al., 2016). The 2015 U.S. Transgender Survey (USTS) provides the most recent and comprehensive data on the lived experiences of transgender people in the United States. In 2015, this study found that nearly one third of transgender people were living in poverty, as compared to 12% of the general population (James et al., 2016). Transgender people were also found to experience an unemployment rate three times the rate of the general population. Among Black, Indigenous, and trans people of color, the rate was four times the general population (James et al., 2016). In July 2020, when the general unemployment rate jumped from 6.5% to 10.2% due to the COVID-19 pandemic, transgender people were found to be disproportionately impacted with an unemployment rate of 29.8% (Kidd et. al, 2021).

In addition to elevated rates of poverty and unemployment, access to housing represents a significant disparity for transgender populations. Home ownership rates among transgender individuals have been found to be substantially lower than that of their cisgender peers at 16 percent versus 63 percent (James et al., 2016). USTS 2015

survey data also revealed that 30% of participants had experienced homelessness at some point in their lifetime and 12% reported experiencing homelessness that was connected to being transgender within the last year (James et al., 2016). Although the 2022 U.S. Transgender Survey is still forthcoming, the National Alliance to End Homelessness (2020) reported data from the Point-In-Time Count that found that the number of transgender adults experiencing homelessness had grown 88 percent between 2016 and 2020 and 113 percent among those experiencing unsheltered homelessness in the same time period.

It is critical to contextualize these statistics within the political climate. Against this backdrop of social and economic marginalization, the year 2021 set a new record for "anti-transgender legislation being introduced and enacted" (Human Rights Campaign, 2021, p. 4). In 2021, 33 states introduced over 100 bills disenfranchising transgender individuals' civil rights (Krishnakumar, 2021). Moreover, the majority of these bills impact minors, including youth's access to gender-affirming care, participation in sports, and curriculum bans on education related to gender identity and sexual orientation (Krishnakumar, 2021). Other restrictions include trans individuals' ability to update identification and to utilize bathrooms that reflect their gender identity (Krishnakumar, 2021). This increase in anti-trans legislation can be understood, in part, as political backlash following the legalization of same gender marriage in 2015 (Holzman, 2022). After 2015, conservative movements in the U.S. shifted focus away from lesbian, gay, and bisexual marriage equality and toward transgender civil rights and LGBTQ+ issues within educational settings (Holzman, 2022). This shift is evident in the dramatic increase

in anti-LGBTQ bills introduced across the country in the last four years (Lavietes & Ramos, 2022). In 2018, 41 bills intended to curb the civil rights of LGBTQ individuals were introduced nation-wide (Lavietes & Ramos, 2022). As of the first three months of 2022, the number of bills increased to 238, half of which were specifically intended to limit transgender civil rights (Lavietes & Ramos, 2022).

Disparities in Mental Health & Access to Care

Transgender communities have also been found to experience elevated rates of mental health challenges (James et al, 2016, Johnson & Rogers, 2019, Kidd, 2021, van der Miesen et al, 2020). However, these experiences do not occur by happenstance. Rather, the disparities in mental health among this population can be described as a result of minority stress. Minority stress is a concept that describes the "excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position" (Meyer, 2003, p. 3). Minority stress theory was originally posited as a conceptual framework to understand the link between elevated rates of mental health challenges among lesbian, gay, and bisexual (LGB) individuals and social conditions of prejudice and stigma (Meyer, 2003). Meyer (2003) describes three processes of minority stress that are relevant to LGB individuals, including external stressful events and conditions, the expectation of these events and resulting vigilance, and the internalization of "negative societal attitudes" (p. 5). While minority stress theory will be further explored on page 18, it is important to situate this phenomenon of disparity within its sociopolitical context. That is, the following information should be understood as, at least in part, connected to living in a climate of structural and interpersonal transphobia.

Particularly salient mental health challenges for trans populations have been found to include depression, anxiety, suicidal ideation, suicidal behaviors, and self-harm (Kidd, 2021). Among respondents in the 2015 USTS, 39% reported experiencing "serious psychological stress in the month prior," as compared to 5 percent of the general U.S. population (James et al., 2016, p. 3). Further, 40% of respondents indicated that they had attempted suicide at some point in their lives (James et al., 2016). Of course, the political, social, and economic climate has changed significantly since 2015, perhaps most notably in the effects of the COVID-19 pandemic. In 2020, an existent longitudinal cohort study focused on the lived experiences of transgender and non-binary (TGNB) people was leveraged to compare data on rates of psychological distress among TGNB people before and after the onset of the pandemic (Kidd et al., 2021). Survey data from this study revealed that the number of participants who met the criteria for "clinically significant psychological distress" during the pandemic rose to 41.8% of participants from 31.7% of participants prior to the pandemic (Kidd et al., 2021, p. 598). Additionally, more than half of participants reported a reduction in access to LGBTQ/TGNB community support (Kidd et al., 2021). This loss was associated with greater psychological distress, even when controlling for pre-pandemic mental health symptoms (Kidd et al., 2021). The authors emphasize the importance of understanding these findings within a pre-COVID "context of an elevated baseline level of distress" and mental health disparities among TGNB populations (Kidd et al., 2021, p. 604).

It is also worth noting the tenuous distinction between the previously described experiences and the concept of neurodivergence. As discussed in the section on

terminology, neurodivergence can be inclusive of any experience that is outside of dominant constructs of what it means to think, feel, and behave in a normative manner. Therefore, a precise boundary between "psychological distress" (Kidd et al., 2021, p. 598) and neurodivergence is difficult to draw. However, minority stress theory may offer a clarifying framework to navigate this murkiness. Minority stress theory's thesis that structural and interpersonal marginalization can impact individual mental well-being points to an understanding that depression, anxiety, or suicidality are socially influenced and not indicative of individual pathology. Moreover, this framework also allows for a recognition that these experiences can be profoundly painful and unwanted. That is, while these experiences are not evident of intrinsic deficiencies or disorders, they nevertheless represent an important health inequity faced by this population that is rooted in forces of structural oppression.

In addition to disparities in mental health, transgender populations experience socioeconomic and sociocultural barriers to accessing mental health care (Johnson & Rogers, 2019). Trans people are disproportionately likely to be uninsured or under-insured and often must pay out-of-pocket to access mental health services (Johnson & Rogers, 2019). In addition to economic barriers, access to gender-affirming and competent care remains a salient issue for transgender people seeking mental health care (Johnson & Rogers, 2019). Transgender people have been found to experience stigma and discrimination from mental healthcare providers, including exclusionary and outdated terminology on in-take forms and health insurance paperwork, unwelcoming office environments, lack of provider knowledge and ethics in providing gender-

affirming care, and issues surrounding pathologization and diagnosis (Johnson & Rogers, 2019).

Access to Gender-Affirming Medical & Mental Health Care

Gender-affirming care is inclusive of mental healthcare (therapeutic supports) and medical care such as hormone replacement therapy (HRT) and surgical interventions to change the appearance of various physical traits (Spencer et al., 2017). Dhejne et al.'s 2016 review of longitudinal studies on the experiences of transgender people who desire gender-affirming medical interventions found that access to these resources significantly improve mental health (Dhejne et al., 2016). Moreover, a majority of studies reviewed found that after receiving gender-affirming treatments, assessments of participants' psychological well-being were similar to those of the general population (Dhejne et al., 2016). Deprivation of gender-affirming care can also have significant short-term and long-term impacts, such as an increase in self-medicating with gender-affirming hormones as well as worsening mental health symptoms (van der Miesen et al., 2020).

However, the process to gain access to gender-affirming surgery can be particularly arduous. The World Professional Association for Transgender Health (WPATH) endorses four general criteria for individuals seeking gender-affirming surgery (El-Hadi et al., 2018). Individuals must be able to demonstrate that they experience "persistent, well-documented gender dysphoria," have the "capacity to make a fully informed decision and to consent for treatment," be of the age of consent in a given country, and if "significant medical or mental health concerns are present, they must be reasonably well controlled" (El-Hadi et al., 2018, p. 264). Given the emphasis on mental

health and cognitive ability, these criteria are particularly fraught for the intersection of identities considered in this project. The experiences of neurodivergent and transgender individuals seeking gender-affirming care will be further explored in the literature review. In addition to these initial criteria, there are often further requirements depending on the procedure and an individual's sex assigned at birth. For example, in order to access a hysterectomy (removal of the uterus), salpingo oophorectomy (removal of ovaries and fallopian tubes), or orchiectomy (removal of testicles), individuals will often need to have undergone 12 months of continuous hormone therapy (El-Hadi et al., 2018). Individuals seeking vaginoplasty or phalloplasty must be able to demonstrate "12 continuous months of living in a gender role that is congruent with their gender identity," a requirement that is commonly referred to as "real-life experience" (El-Hadi et al., 2018, p. 264). Further, documentation of this criteria typically requires letters from multiple mental and physical health professionals (Tabacc et al., 2020). This process can be further complicated by ambiguity around assessing an individual's "psychological health" and formally diagnosing gender dysphoria (Tabacc et al., 2020, p. 2).

In addition to navigating a multitude of medical system requirements, transgender people must also contend with complex health insurance processes and may face barriers such as long wait-times for treatment, strict participation protocols, and lack of transportation (van der Miesen et al., 2020). During this process, experiences of discrimination, misgendering, and even denial of care are common (Puckett et al., 2018). The 2015 USTS found one in four respondents had experienced a problem with their health insurance related to being transgender, including insurers refusing to change name

and gender markers on record, denial of gender-affirming healthcare, denial of procedures deemed to be gender-specific such as pap smears, and even denial of routine care (James et al., 2016). Among transgender people seeking health insurance coverage for transition-related surgeries, 55% report being denied (James et al., 2016). For those seeking HRT, 25% reported being denied coverage (James et al., 2016). The survey also found that while 78% of respondents reported a desire to pursue HRT at some point in their lifetime, only 49% reported that they were able to receive it, a finding that suggests that insurance coverage is far from the only barrier to access (James et al., 2016). Similarly, over three quarters of respondents (77%) indicated that they desired counseling related to gender identity or transition, yet only 58% reported being able to access counseling resources (James et al., 2016).

Additionally, medical providers have been found to be minimally informed about trans experiences and may hold limiting beliefs about identity and expression, such as only allowing "binary trans people to start Hormone Replacement Therapy" (Puckett et al., 2018, p. 54). It is important to note that binary here refers to transgender men and women, rather than non-binary individuals. This lack of accurate information can place the burden on patients to self-advocate and educate providers (Puckett et al., 2018). The onset of the COVID-19 pandemic in 2020 further impacted access to gender-affirming care (Angelo et al., 2021, van der Miesen et al., 2020). Early findings suggest that the pandemic not only deferred previously scheduled surgeries and intakes but will likely continue to delay access to gender-affirming care for the next several years (van der Miesen et al., 2020). However, one study on the experiences of transgender men

accessing gender-affirming care during the pandemic found that despite interruptions in care, most participants were able to maintain testosterone prescriptions and that the increase in telehealth services represented a positive development in care (Angelo et al., 2021).

In addition to economic and institutional barriers to accessing care, transgender individuals are often burdened with proving their gender identity to providers in order to receive gender-affirming care (Shapira & Granek, 2019). Such metrics of validity may include "prolonged mental health evaluations and 'real life tests' (i.e., living fulltime in one's self-identified gender)" (Reisner et al., 2015, p. 586). That is, transgender individuals seeking gender-affirming medical interventions must demonstrate a history of cognitions and behaviors that match the medical system's definition of transgender identity. The psychiatric category of gender disphoria (GD) is the current standard used to classify transgender identity (Shapira & Granek, 2019). The contemporary diagnosis of GD was constructed in 2013 in the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) and was intended to be less pathologizing of transgender people than prior diagnoses (Shapira & Granek, 2019). Yet, for some transgender people the requirement for a 'diagnosis' to receive gender-affirming care can itself be alienating and pathologizing (Shapira & Granek, 2019). Informed consent models are used in some medical settings to circumvent the requirement for a GD diagnosis for individuals seeking HRT (Reisner et al., 2015). Informed consent models are those that assess patients' hormone readiness without requiring them to undergo counseling related to gender identity (Reisner et al., 2015). In the case of Boston-based LGBT health center,

Fenway Health, implementing an informed consent model resulted in a significant increase in transgender patients served (Reisner et al., 2015).

Contextualizing Neurodivergent Experiences: Interpersonal Violence, Medical, Social & Epistemic Injustice

In comparison to transgender communities, far less has been written about the experiences of neurodivergent populations in the social environment. In theorizing possible causes for the paucity of information, it is important to note that the social category of neurodivergent is relatively new (as will be further explored in the discussion of theoretical frameworks). Prior to the advent of the neurodiversity movement, the cognitive styles/diagnoses represented by the term 'neurodivergent' had not been considered together. Therefore, a broader scope of research is necessary in order to contextualize the experiences of this population. This scope is inclusive of experiences of disabled people more broadly and people categorized as having mental illnesses. Further, scholarship on the social and relational experiences of autistic people and people with other developmental differences was found to be more robust than research concerning individuals who have ADHD or those with learning differences.

Elevated Risk of Interpersonal Violence

Disabled individuals have been found to be at greater risk for sexual, physical, and non-physical (inclusive of emotional and financial) violence than non-disabled individuals (Dammeyer & Chapman, 2018). Within this population, individuals categorized as having 'mental disabilities' are more likely than those with physical disabilities to experience all types of violence (Dammeyer & Chapman, 2018). In relation

to this project, it is also important to note that among people categorized as having mental disabilities, those with personality disorders, ADHD, autistic individuals, and individuals with schizophrenia and/or experiences of psychosis reported higher levels of violence than people with other types of mental disabilities (Dammeyer & Chapman, 2018). In a study comparing experiences of victimization and violence among autistic people and non-autistic people, rates of abuse were found to be significantly higher for autistic individuals (Weiss & Fardella, 2018). Autistic people were found to be four times more likely to report experiencing physical and emotional abuse from adults during childhood and 7.3 times more likely to experience sexual abuse by a peer (Weiss & Fardella, 2018). Additionally, autistic people reported significantly higher rates of polyvictimization in childhood than non-autistic people (Weiss & Fardella, 2018). As adults, autistic individuals also reported elevated rates of sexual assault, rape, and intimate partner violence as compared to non-autistic individuals (Weiss & Fardella, 2018).

These findings contribute an important counter-narrative to contemporary societal perceptions of an "inextricably linked" relationship between mental illness and violence (Rueve & Welton, 2008 p. 36). Concerning autism in particular, there exists a persistent stereotype in both social and medical discourses that autistic people are "fundamentally asocial" and unconcerned with both interpersonal connection and social acceptance (Catala et al., 2020, p. 9014). In the United States, popular and political discourses following mass shootings often link mental illness and gun violence (Metzl & MacLeish, 2014). This narrative link persists despite the fact that people with mental illnesses are estimated to be responsible for fewer than 1 percent of incidents of gun violence (Green,

2020, p. 2). Rather, people with mental illnesses are not only more likely to be victims of interpersonal violence, but they are also at greater risk of violence from law enforcement. Between 2015 and 2020, people with mental illnesses represented 23% of all fatalities caused by police officers, despite representing only 18.9%of the general population (Rohrer, 2021). People with mental illnesses have also been found to be 16 times more likely to be killed in a police encounter than the general population (Rohrer, 2021).

Applied Behavior Analysis & Medico-Psychiatric Injustice

Within the medico-psychiatric community, neurodivergence is typically understood within a framework of disorder, and as such treatment models are typically built around attempts to "recover normal functioning" (Gibson & Douglas, 2018, p. 20). This focus on recovery is particularly salient in the medical and psychiatric discourse surrounding autism. Among medical and behavioral health professionals, parents, and policymakers, "the imperative to take desperate measures to treat autistic behaviors through early intervention" remains unquestioned (Gibson & Douglas, 2018, p. 20). Subsequently, autistic youth and adults are frequently subject to interventions that seek to 'normalize' behaviors, including patterns of speech, body movements, and social interactions (Autistic Self Advocacy Network, National Center for Transgender Equality, National LGBTQ Task Force, 2016).

Perhaps most notable among these interventions is Applied Behavior Analysis (ABA). ABA is a therapeutic and pedagogical practice that is designed to shape behavior using operant conditioning (Roscigno, 2019). ABA was founded by Ole Ivar Lovaas, a psychologist whose work focused on treating "disturbed" children through operant

conditioning (Gibson & Douglas, 2018). Lovaas' treatment approaches included the use of both positive reinforcement and violent aversives (Gibson & Douglas, 2018). While contemporary ABA techniques typically focus on positive reinforcement, Lovaas' aversive tactics persist in some facilities. One of the most notorious among these is the Judge Rotenberg Center, a Massachusetts residential facility and day school for neurodivergent children (Roscigno, 2019). This program has continued to use electric shock as a punishment for children despite human rights campaigns to #StoptheShock led by autistic activists and allies (Roscigno, 2019).

Disability scholars have authored "substantive critiques" of the use of ABA with autistic children, the primary focus of which is the intervention's emphasis on "normalization" and the "erosion of self-determination" (Roscigno, 2019, p. 406). While ABA was designed to be used with autistic children and autism continues to be the primary diagnosis addressed by the intervention, ABA practitioners also work with otherwise neurodivergent individuals, such as those categorized as having "cognitive disorders, behavioral problems, developmental delays" (Cione-Kroeschel, 2021, p. 1). However, intrinsic to the philosophy of ABA is the construct of "recovery from autism" (Broderick, 2009, p. 264). As Broderick (2009) articulates, the concept of recovery is rooted in a belief that adopting neurotypical ways of thinking, emoting, and behaving is possible and desirable for neurodivergent people. Moreover, conceptualization of "autism as an identity" or "way of experiencing" is absent from the recovery rhetoric that informs ABA (Broderick, 2009, p. 266). While the history of ABA will be discussed further in the

Literature Review, the following paragraphs will offer a brief overview of contemporary critiques of ABA from the perspective of autistic education scholars and practitioners.

In their inquiry into the impact of ABA therapy among autistic individuals, Sandoval-Norton and Shkedy (2019) posit that long-term exposure to ABA can constitute abuse. The authors identify several primary issues with the efficacy and ethics of the model. First, the efficacy of ABA has not been adequately studied among non-verbal autistic individuals, yet the treatment continues to be used with this population for extended periods of time, as students never reach "mastery of tasks" (Sandoval-Norton & Shkedy, 2019, p. 2). Second, after years of ABA-based operant conditioning, individuals have been found to have high-compliance, low intrinsic motivation, and limited independent functioning (Sandoval-Norton & Shkedy, 2019). That is, recipients of ABA may tend to follow directions regardless of personal cost, experience limited internal motivation for making choices, and develop limited skills for engaging in life on one's own terms. Compliance, in particular, has been linked to lower self-esteem as well as "denial and behavior disengagement," coping skills through which an individual attempts to withdraw from or "reject the reality of a stressful event" (Sandoval-Norton & Shkedy, 2019, pp. 3-4). Compliance-related difficulties have also been found to impact the relational lives of so-called "high-functioning" autistic adults who underwent ABA therapy as children (Sandoval-Norton & Shkedy, 2019). Finally, ABA interventions frequently focus on extinguishing self-soothing or "stimming" behaviors in autistic individuals as well as developing the ability to maintain eye contact (Sandoval-Norton & Shkedy, 2019 p. 4). Yet, the function of stimming as an autistic tool to reduce anxiety is

not well understood among ABA practitioners and often arbitrary distinctions are drawn between acceptable and pathological behaviors (Sandoval-Norton & Shkedy, 2019). As Sandoval-North and Shkedy (2019) write:

> A lifetime of being punished for certain movements, and being forced to engage in eye contact despite the physiological pain and discomfort of doing so, is psychological and physical abuse…With such drastic methods of conditioning, it is heartbreaking but not surprising to learn that the odds of being a victim of a violent crime is doubled among individuals with disabilities, and individuals with cognitive disabilities have the highest risk of violent victimization (Harrell & Rand, 2010). Additionally, individuals with disabilities are sexually assaulted at nearly three times the rate of those without disabilities (Disabled World, 2012). So how much compliance is too much compliance? (pp. 4-5)

Social Injustice

In order to contextualize the experiences of neurodivergent people in the social environment, it is critical to consider the impact of structural and interpersonal ableism. A national survey of disabled Danish adults examined participants' experiences of discrimination in educational, employment, and service settings (Dammeyer & Chapman, 2018). Among those surveyed, individuals described as having mental disabilities were significantly more likely to report experiences of ableist discrimination in all three settings than those with physical disabilities (Dammeyer & Chapman, 2018). Within that population, autistic people and people diagnosed with schizophrenia/psychosis endorsed the highest level discrinination in all three settings (Dammeyer & Chapman, 2018).

Individuals with ADHD were significantly more likely to report experiences of discrimination in educational and employment settings than individuals with other mental disabilities (Dammeyer & Chapman, 2018).

In addition to structural and institutional discrimination, neurodivergent people (and disabled people more broadly) experience social and relational ableist discrimination. For example, a 2017 study considered neurotypical peoples' first impressions of and willingness to interact with autistic adults and children (Sasson et al., 2017). Researchers found that neurotypical participants' first impressions of autistic adults and children were significantly less favorable than their impressions of other neurotypical people (Sasson et al., 2017). These social impressions included perceived social competence (decreased), likeability (decreased), attractiveness (decreased), and submissiveness (increased) (Sasson et al., 2017). However, these negative impressions were found only to occur when participants were provided with audio and/or visual presentations of autistic people, and not when transcripts of autistic people's speech content were provided (Sasson et al., 2017). As the authors theorize, these findings suggest that it is social presentation rather than social content that informs neurotypical peoples' negative perceptions of autistic people. That is, neurotypical people are likely to perceive autistic physical and behavioral differences as undesirable even when individuals follow socioemotional and relational norms. These findings provide an important counterpoint to the pervasive stereotype that autistic people are asocial (Catala et al., 2020) and instead suggest that neurotypical biases may create a challenging social landscape for neurodivergent people to navigate.

Epistemic Injustice

Finally, in addition to structural and interpersonal injustice, there exists a level of rhetorical injustice that may be somewhat unique to the disabled community. The historic disability rights mantra, 'nothing about us without us,' speaks to resistance to policies, practices, and social narratives that are constructed about disabled people without leadership or expertise from the community (Catala et al., 2020). The neurodiversity movement (to be discussed further in the following section) works in part to disrupt medical and sociocultural narratives that describe neurodivergence in terms of deficiency and disorder (e.g., the idea that autistic people should aspire to 'recover' from autism (Broderick, 2009)). These narratives reflect what Catala et al. (2020) call 'neuronormativity,' or the "assumptions, norms, and practices that construe neurotypicality as the sole acceptable or superior mode of cognition" and renders neurodivergent "modes of cognition as deviant or inferior" (p. 9016). Pervasive neuronormativity leads to what the authors describe as "epistemic injustice" (Catala et al., 2020, p. 9017).

Epistemic injustice refers to the forces that constrict an individual's ability to "produce, use, or transmit knowledge - including knowledge regarding their personal or social experience" (Catala et al., 2020, p. 9017). As Catala et al. (2020) describe, epistemic injustice occurs in two main types - testimonial and hermeneutical. Testimonial injustice refers to "an undue credibility deficit" (Catala et al., 2020, p. 9018), in which the speaker is discredited by the hearer based on biases held about the speaker's membership in a stigmatized group. Hermeneutical injustice describes an "undue intelligibility deficit"

in which the content of the speaker's message is not understood due to "conceptual biases in mainstream or collective hermeneutical resources" (Catala et al., 2020, p. 9020). That is, the message is not understood because the content does not fit into existing knowledge schemas.

Epistemic injustice provides a framework to understand the paradoxical nature of the narratives surrounding neurodivergence. Dynamics of testimonial and hermeneutical injustice are evident in the ways in which social and medical discourses of neurodivergence are developed without input from the community. Neurodivergent people are denied the epistemic agency to describe their own cognitive, emotional, behavioral, and social realities and instead mainstream discourses of neurodivergence are determined by neurotypical 'experts.' One such example is the social and political power of the organization, Autism Speaks. Autism Speaks operates within a "cure paradigm" and does not include autistic people in leadership, yet it is the "largest and most well-funded autism advocacy organization in the United States" (Saunders, 2018, p. 4). When community-based critiques of pathology and cure discourses are raised, they are discredited on the basis of assumptions that neurodivergent people are cognitively inferior (testimonial injustice) and/or misunderstood, as a conceptualization of neurodivergence outside of the medical model is unimaginable (hermeneutical injustice) (Catala et al., 2020). The insidious nature of epistemic injustice creates a uniquely challenging social and academic climate to research the lived experiences of neurodivergent people, as the validity of the resultant insights is continually questioned.

The recognition of this phenomenon and a desire to contribute to epistemic justice serve as a driving force in this project.

Mental Health of Transgender and Neurodivergent People & Minority Stress Theory

Elevated rates of mental health challenges among neurodivergent populations are similar to those seen among transgender communities. For example, among autistic adults, more than half have been found to struggle with mental health challenges, most commonly depression and anxiety (Maddox et al., 2020). Yet providers are often inadequately trained in treating anxiety in autistic people and subsequently these issues are often left unaddressed (Maddox et al., 2020). For individuals at the intersection of trans and neurodivergent identities, depression and anxiety rates have been found to be higher than for cisgender neurodivergent people or transgender neurotypical people (Murphy et al., 2020).

As previously discussed, minority stress theory provides a framework for identifying the role of social, political, and economic marginalization in transgender and neurodivergent individuals' mental health. For transgender people, this may include "workplace harassment, discrimination, and physical or sexual violence" among other factors (Lefevor et al., 2019, p. 386). Similarly, the elevated rates of anxiety and depression among neurodivergent populations can be connected to the oppressive forces of structural and interpersonal ableism. For neurodivergent individuals experiencing social anxiety, this condition can be understood as "a symptom of the extensive social trauma that neurotypical society inflicts" upon neurodivergent people across the lifespan

(Walker & Raymayker, 2020, p. 4). It also provides a theoretical lens through which scholars and practitioners can resist drawing pathologizing conclusions about a potential link between transgender identities and mental illness, which will be critical to understanding the experiences and perspectives of neurodivergent and transgender individuals.

Theoretical Frameworks: Social Model of Disability, Crip Theory, & the Neurodiversity Paradigm

In order to situate the theoretical framework of this research, it is important to first present a brief history of sociocultural conceptualizations of disability and major questions raised by the field of disability studies. This project is informed by disability scholarship, crip theory, the neurodiversity paradigm, and neuroqueer theory. In the following section, the relationships and tensions between these four interrelated paradigms will be explored. The neurodiversity paradigm and neuroqueer praxis are offered as theoretical orientations that incorporate foundational aspects of the social model of disability and crip theory and offer novel insight into both conceptualizations of neurodivergence and disability more broadly.

Medical & Social Models of Disability

In the Western world, paradigms of disability have shifted significantly in the last several centuries (Tumlin, 2019). Throughout this timeframe, four primary models of disability have emerged: "disability as divine punishment; disability as divine gift; disability as a medical defect possessed by an individual; and disability as a social and cultural construction" (Tumlin, 2019, p. 12). While the first two models have largely

dissipated from popular consciousness in the West, the third and fourth models remain relevant and represent contemporary tensions between disability studies and the fields of medicine and psychiatry. The third model arose during the Enlightenment era and is now described as the medical model of disability (Tumlin, 2019). Currently, the medical model is perhaps the best known and socially accepted framework for understanding the diversity of human bodies and minds. The medical model understands disability in terms of disorder and deficits of a body and/or mind. Within this framework, disability exists within the individual and requires fixing, treatment, or long-term accommodation in order for the individual to live a productive life within society (Goering, 2015). The goal of the medical model is then "normalization, ideally through a cure" (Tumlin, 2019, p. 12).

However, for many disabled people "the main disadvantage they experience does not stem directly from their bodies, but rather from their welcome reception in the world, in terms of how physical structures, institutional norms, and social attitudes exclude and/or denigrate them" (Goering, 2015, p. 134). In response to the inadequacies of the medical model, disability scholars and activists articulated a social model of disability. The social model of disability was born from the Disability Rights movement and draws on discourses from other liberation movements (Tumlin, 2019). Within this model, differentiation is made between impairment and disability. Impairment refers to a non-normative and problematic state of the body/mind and disability is the structural disadvantage and discrimination faced by people with impairments (Goering, 2015). Understood through this framework, it is societal conditions that are disabling rather than the functioning of one's body or mind. This paradigm is quite similar to "social-relational

models of disability" in which not only structural marginalization, but "social barriers and ableist norms" are considered to cause "disablement and distress" (Chapman, 2021 p. 1361).

Critiques of the Concept of Impairment

While the articulation of structural ableism as a marginalizing force is critical to understanding experiences of disability, scholars have called into question the ways in which the social model of disability "maintain[s] impairment to be a biological fact" (McWade et al., 2015, p. 306). Within the field of disability studies, questions of impairment represent a significant source of scholarly debate. This debate raises fundamental questions of whether divergences from normative ideals of a 'healthy' body or mind truly represent physiological/psychological limitations or malfunctions or if they can be better understood as naturally occurring forms of human diversity. The social model has also been described as "fail[ng] to recognise the sociality of medicine," or the ways in which approaches to treatment are informed by socially constructed norms and values (McWade et al., 2015, p. 306). The debate surrounding impairment may be particularly salient for those who identify as mentally ill or mad (McWade et al., 2015). Within what is known as the psychiatric survivors movement, medical conceptualization of distress is rejected in favor of acceptance of diverse forms of perceiving, thinking, and feeling. Thus, those who are politically aligned with this movement may reject the notion that they are "psychologically impaired" (McWade et al., 2015, p. 306).

Crip Theory & Criticism from Disability Studies

Crip theory is a branch of disability scholarship that has taken up these questions of a concept of impairment that is distinct from disability. It has been described as a theoretical framework that builds on groundwork laid by queer theory and related queer liberation movements (Lofgren-Martenson, 2013). Not unlike queer theory, crip theory offers a "radical critique of the concept of normativity" (Lofgren-Martenson, 2013, p. 414). Crip theory evolved in response to critiques that the field of disability studies has excluded BIPOC communities, LGBTQ communities, and women (Egner, 2019). Crip theory developed through the work of feminist and sexuality scholars considering "questions of the body through a purposeful amalgamation of disability studies and queer theory" (Egner, 2019, p. 127). Not unlike the theoretical use of the word queer, the word 'crip' is intentionally "provocative" (Lofgren-Martenson, 2013, p. 414). Crip is a shortened version of the word cripple, an historically strongly derogatory term to refer to disabled people (Lofgren-Martenson, 2013, p. 414). Within crip theory academic and activist communities, the word crip is used to "experience pride" in a disabled body (Lofgren-Martenson, 2013, p. 414). Crip/ping as both a theoretical practice and identity term does not seek "tolerance" but instead seeks to "embrace and actively appropriate the stigma" (Lofgren-Martenson, 2013, p. 414).

Crip theory problematizes the narrative of health as aspirational and desirable and disrupts binaries of normality and abnormality (Egner, 2019). Foundational crip theory scholar, Robert McRuer, identifies how "compulsory-heterosexuality and compulsory-ablebodiedness similarly work to create an ideal citizen-subject and push queer/disabled people to a periphery" (Jenks, 2019, p. 456). It is then the existence of compulsory-

ablebodiedness that *produces* disability as a social category (Lofgren-Martenson, 2013). From this standpoint, impairment exists only in contrast to an able-bodied norm, not as an innate truth of the body (Lofgren-Martenson, 2013). However, some scholars within the field of disability studies take issue with crip theory's radical rejection of impairment and maintain that a concept of impairment is necessary to describe the material conditions of disabled lives (Bone, 2016; Jenks, 2019). As Jenks (2019) writes,

> The social deconstructionist nature of articulations of disability based on crip theory has the potential to obfuscate disability politics. This is not a debate over semantics, as the lives of people with disabilities are affected by their impairments. These impairments and their effects remain, in many cases, the basis for how law subjugates people with disabilities and labels them as second-class citizens, allowing for government and expert control over their bodies. (p. 466)

In this sense, the expression of impairments as a tangible reality is what allows for the importance of accessibility to be articulated. As Jenks (2019) cites, the need for healthcare and accessible public transportation are "impairment-based claim[s]" (p. 466).

This project does not take an either/or stance between crip theory and the social model of disability. Rather, this research strives to be simultaneously oriented toward a critical disability lens and to recognize the role of sociopolitical conditions in transgender and neurodivergent lives. It is also important to note that both the social models of disability and crip theory have paid limited attention to the phenomenon of "able-mindedness," or the structural, cultural, and interpersonal privileging of so-called healthy minds and marginalization of those whose psychological and neurocognitive styles exist

outside of those norms (Egner, 2019, p. 129). Instead crip theory and disability scholarship have focused primarily on experiences of physical disabilities and as such scholarship theorizing the experiences of those who identify as mad or mentally ill, termed 'mad studies,' has been isolated from the broader field of disability studies (McWade et al., 2015). In order to address the limitations of the concept of impairment, the need to recognize the sociopolitical implications of disability, and the exclusion of neurodivergent, mad, and mentally ill narratives from disability studies and crip theory, this research is informed by the neurodiversity paradigm and neuroqueer praxis.

Neurodiversity Paradigm

The neurodiversity paradigm is a framework for understanding neurodivergence outside of the medical model, or what is in this context referred to as the 'pathology paradigm.' The term 'neurodiversity' was originated in the late 1990s by sociologist and autistic self-advocate, Judy Singer. The term was informed by what was then a novel conceptualization of autism as a cluster of different but related "disorders," a realization that allowed Dr. Singer to recognize autism in herself (Tumlin, 2019, p. 10). As Singer (1999, as cited in Tumlin, 2019) writes:

> The rise of Neurodiversity takes postmodern fragmentation one step further. Just as the postmodern era sees every once-too-solid belief melt into thin air, even our most taken-for-granted assumptions: that we all more or less see, feel, touch, hear, smell, and sort information, in more or less the same way, (unless visibly disabled) are being dissolved. (p. 10)

In the decades since the first articulation of neurodiversity, the concept has evolved into what is now both a social movement and paradigmatic approach to understanding neurodivergence (Tumlin, 2019). Nick Walker, a queer, transgender, and autistic psychologist and preeminent neurodiversity scholar, identifies three core principles of this framework. First, neurodiversity is a normal and naturally occurring aspect of human diversity (Walker, 2014). Second, the idea that there is a universal healthy or normal brain is socially constructed and harmful to neurodivergent individuals (Walker, 2014). Finally, neurodivergent individuals experience systemic oppression and social inequity in ways that are similar to other marginalized identities (Walker, 2014). The neurodiversity paradigm also resists a bifurcated understanding of body and brain. As Walker and Raymaker (2020) describe, "mind is an embodied phenomenon…Mind, brain, and embodiment are intricately entwined in a single complex system. We're not minds riding around in bodies, we're bodyminds" (p. 2).

Through identifying the importance of the diversity of human bodyminds, the neurodiversity paradigm problematizes the idea of 'impairments' and rejects the social narrative that all disabled people would prefer to be able bodied/minded (Egner, 2019). In its emphasis on the interconnected nature of body and mind, the neurodiversity paradigm may also be able to dissolve the separation between critical analyses of able-bodiedness and able-mindedness, reaching toward a more inclusive and collective politic of resistance. As Graby (2015) writes, "the neurodiversity movement is particularly well placed to bring together broader categories of marginalised people(s)...under a broad banner of 'anti-normalisation' and challenges to supposedly 'universal' assumptions

about ‘human nature’ that privilege majority and historically dominant groups” (p. 241). However, the neurodiversity paradigm also allows for nuance in its rejection of pathologization of neurodivergence. The neurodiversity movement articulates the importance of consensual medical treatment to address physiological experiences that are “not core to personhood” (Tumlin, 2019, p. 11). As Tumlin (2019) describes there is an important distinction between “epileptics would like to be rid of seizures” and the reality that “many autistics do not want to be rid of their autism” (p. 11).

Neuroqueer Theory

Use of the term neuroqueer/ing has recently begun to emerge within academic literature, however, a precise definition of the concept is difficult to find (Egner, 2019). The term ‘neuroqueer’ was originally developed by scholars, M. Remi Yergeau, Athena Lynn Michaels-Dillon, and Nick Walker (Walker & Raymaker, 2020). Following the tradition of queer theory, the meanings and intentions of neuroqueer projects and discourse are intentionally slippery—embracing fluidity and rejecting categorization. Neuroqueer has been used as an identity term, as a means to explore the intersection between neurodiversity and LGBTQ+ identity, and as a theoretical approach (Egner, 2019). It can function simultaneously as an “identity,” “practice,” or “politic” of deconstructing normative categories of identity (Egner, 2019, p. 134).

In regard to its use as a theoretical approach, neuroqueer theory draws from queer, feminist, and critical disability studies and seeks to disrupt gender and neurological binaries of normal and abnormal (Egner, 2019; Roscigno, 2019; Walker & Raymaker, 2020). Unsurprisingly given its theoretical origins, neuroqueer theory situates both

gender and neurotype in terms of performance, where certain performances of gender, behavior, body movements, and social interactions are deemed acceptable and others deviant (Walker & Raymaker, 2020). Neuorqueer theory offers an understanding of the parallels between the ways in which cultural forces prescribe heteronormative gender and sexual performances and the ways in which individuals are pushed into the "embodied performance of neurotypicality" (Walker & Raymaker, 2020, p. 5). Walker and Raymaker (2020) identify the act of neuroqueering or the state of being neuroqueer as a subversion of prescribed neurotypicality. Further, they posit that neurotypicality and heteronormativity are inextricably linked, and "to queer one is inevitably to queer the other to some degree" (Walker & Raymaker, 2020, p. 5).

Egner (2019) conceptualizes neuroqueering as "neurologically and mind-based crip theory" (p. 129). Neuroqueer theory draws on crip theory's rejection of binaries of normal and abnormal and intersectional analysis of disability and extends these principles toward understandings of the bodymind. That is, neuroqueer theory allows for a multilayered analysis that identifies the intersecting and compounding effects of able-mindedness, able-bodiedness, and compulsory heterosexuality/cisgenderism (Egner, 2019). Egner also articulates neuroqueering as a "project of disidentification" (Egner, 2019, p. 133). Employing José Muñoz' concept of 'disidentification,' Egner refers to an alternative approach to the binary choice that marginalized groups often face between assimilation or counter-identification. Instead, disidentification is a "performative tactic" through which individuals "reject dominant notions of normativity" and "break free from the limitations of the social body" (Egner, 2019, p. 131). Neuroqueering then goes

beyond mere tolerance of neurodiversity, to fully reject the concept of a 'normal' body/mind. Instead, neuroqueer politics and practices invites individuals to "regard their own minds and embodiments as fluid and customizable, as canvases for ongoing creative experimentation" (Walker & Raymaker, 2020, p. 5).

Neuroqueer theory provides a groundbreaking framework to understand this intersection of identities and has been integral in the design of this research project. Neuroqueer theoretical scholarship provides a framework to not only resist binary and biomedical understandings of sex, gender, and sexuality, but to deconstruct binaries of neurotypicality and neurodivergence in favor of a more fluid and expansive understanding of bodyminds. This theoretical orientation will allow for data analysis that is rooted in a neuroqueer understandings and is resistant to neurotypical and hetero/cisnormative interpretation of the knowledge produced by participant insights.

Chapter 2: Literature Review

Introduction

Existent medico-psychiatric literature concerning the intersection of trans and neurodivergent identities has been found to rely primarily on discourses of "medical autism" and "cisgenderism," or a presumption that neurotypicality and cisgender identities are normative and desirable (Shapira & Granek, 2019, p. 502). As discussed in the background chapter, this literature often hypothesizes relationships of cause and effect between neurodivergence and trans identities (Shapira & Granek, 2019). For example, gender diversity among neurodivergent people has been hypothesized in clinical literature to be the result of "a high level of prenatal androgen" (van der Miesen et al., 2018, p. 1544) or an expression of the 'extreme male brain' theory of autism

(Baron-Cohen, 2002). That is, much of the clinical research on this phenomenon theorizes models of mutual pathology to describe both neurodivergence and transgender identities. The literature tends toward a bioessentialist understanding of gender as pre-determined by sex characteristics (rather than socially constructed) and a conceptualization of neurodivergence as abnormal and disordered (rather than a neutral or valuable facet of human diversity). Further, this body of literature has been minimally concerned with the perspectives and experiences of neurodivergent and transgender individuals.

Given the breadth of scholarship concerning rates of overlap and the limited nature of studies employing critical theory, the research considered for review here employs alternative frameworks to a medical model of pathology. This literature review is then concerned with research on the lived experiences of transgender and neurodivergent individuals and communities. As the neurodiversity movement and neuroqueer scholarship have grown and developed substantially in the last 20 years (Egner, 2019; Tumlin, 2019; Raymaker & Walker, 2020), scholars and activists have contributed invaluable context for understanding this phenomenon. However, it is important to note that despite the rapidly evolving nature of these fields, the literature concerning this intersection of identities is markedly scarce. Minimal scholarship has been devoted to exploring the ways in which transgender and neurodivergent people experience their gender identity or think about gender as a phenomenon. Further, the experiences of trans and neurodivergent people within broader LGBTQ+ communities have also been minimally considered. This review found only three articles concerned

with experiences related to gender identity construction and dynamics within neurodivergent and LGBTQ+ community spaces (Egner, 2019; Oswald et al., 2021; Strang et al., 2018). Of those three articles, only one (Egner, 2019) considered the experiences and insights of adult neurodivergent and transgender individuals. The present project is motivated by the need for further research on the experiential aspects of this phenomenon.

The articles included in this review were found through keyword searches in the University of Southern Maine Library OneSearch tool. Keywords searched include transgender, LGBTQ, autism, ADHD, neurodiversity, neurodivergence, neuroqueer and combinations therein. The literature for review can be typified in five main categories: clinical research, community-based policy briefs, first-person narratives, sociological inquiry, and neuroqueer theoretical analyses. After reviewing the existing research, three primary themes emerged. First, significant disparities in access to gender-affirming medical and mental health services exist for this population. Second, neurodivergent and transgender individuals may face behaviorist interventions that seek to suppress authentic gender expression. Finally, solidarity and mutual aid represent strengths of this community. However, limitations to inclusion and acceptance across difference have been found to exist within neurodivergent community spaces.

Access to Gender-Affirming Medical & Mental Healthcare

This review found that clinical research on this intersection of identities focuses primarily on the experiences of neurodivergent individuals seeking gender-affirming care. The literature suggests that for individuals who are transgender and neurodivergent,

additional barriers exist to accessing care compared to those faced by neurotypical transgender people (Jackson-Perry, 2020; National LGBT Health Center, 2020; Shapira & Granek, 2019; Strang et al., 2020). For transgender and neurodivergent young people seeking gender-affirming care, common clinical concerns include challenges with self-advocacy around gender dysphoria-related needs and experiences of providers and family members doubting the validity of their gender identities (Strang et al., 2020). Scholarship on both youth and adults has emphasized the existence of a pervasive belief among providers and family members that transgender identities are a 'symptom' of neurodivergence (National LGBT Health Center, 2020; Shapira & Granek, 2019; Strang et al., 2020). For transgender and autistic youth, gender diversity may be viewed by clinicians as a "special interest phase" (National LGBT Health Center, 2020, p. 1). The conflation of the autistic trait of developing acutely focused interests and the development of transgender identities appears to be relatively common among clinicians, as it has been hypothesized in clinical literature and reported experientially by autistic and transgender youth (National LGBT Health Center, 2020; Strang et al., 2018). As discussed in the background section, a diagnosis of gender dysphoria is often necessary to pursue gender-affirming care (Shapira & Granek, 2019). When providers characterize transgender identity development as a 'special interest' or symptom of neurodivergence, rather than a valid experience with resultant care needs, obtaining the necessary diagnosis to pursue gender-affirming medical interventions can become high-barrier and may require persistent self-advocacy.

Not only do transgender and neurodivergent people face significant challenges in accessing gender-affirming care, but best practice recommendations for providers also serving this population are few and far between (Shumer & Tishelman, 2015; Strang et al., 2016). This paucity of resources is particularly acute for young people seeking gender-affirming medical interventions. Few clinical guidelines exist to support young people who are both transgender and neurodivergent through the process of pursuing gender-affirming medical interventions (Strang et al., 2016; Strang et al., 2020). Further, lack of understanding and accommodations for differences in communication and information processing styles among neurodivergent individuals can exacerbate barriers to receiving gender-affirming care (Shumer & Tishelman, 2015; Strang et al., 2018). However, in one case study of a transfeminine and neurodivergent young person, researchers found that utilizing pictorial representations of concepts related to gender transition allowed the clinical team to communicate effectively with the client and develop novel approaches to informed assent (Shumer & Tishelman, 2015). In addition to developing appropriate accommodations for clinical communication, neurodivergent and transgender youth and their families have reported that opportunities for psychosocial support (including peer support) significantly benefited them through the process of pursuing medical transition (Strang et al., 2020).

This literature review found that clinical research on the experiences and needs of transgender and neurodivergent young people seeking gender-affirming medical care represents a growing body of scholarship. However, the focus of current clinical scholarship is primarily on medical interventions, with little research devoted to

supportive mental health care for this population. Of the literature reviewed, only one article (Strang et al., 2020) and one policy brief (National LGBT Health Center, 2020) emphasized the importance of psycho-social support for this population. In the case of Strang et al. (2020), psycho-social support recommendations focused solely on group therapeutic modalities. The remaining literature was focused on issues related to medical interventions, such as patient consent, psychoeducation, and relationship to intervention protocols (Shumer & Tishelman, 2015; Strang et al., 2016; Strang et al.; 2020). Only one case study was found that considered individual psychotherapy with an autistic trans woman around issues related to sexual orientation, gender, and autism (Violeta & Langer, 2017). It is also important to note that scholarship concerning the experiences of transgender and neurodivergent adults seeking gender-affirming medical interventions and mental healthcare was found to be less robust than literature on the clinical experiences of youth. In fact, all the literature reviewed concerning the development of clinical guidelines for neurodivergent-inclusive, gender-affirming care were focused on youth (National LGBT Health Center, 2020; Shumer & Tishelman, 2015; Strang et al., 2016; Strang et al., 2020). Only Shapira & Granek (2019) considered the experiences of adult transgender and autistic people in their meta-analysis of psychiatric case studies focused on this intersection of identities. These notable gaps in literature have informed the development of the present research questions, which seek to explore transgender and neurodivergent adults' experiences in medical and mental healthcare settings.

Behaviorist Interventions & 'Gender-Shaping Behaviorism'

Within sociological literature, policy briefs, and first-person narratives concerning the experiences of transgender and neurodivergent people, themes of medically sanctioned attempts at 'normalization' were common. This section will review a subset of the academic literature surrounding this intersection of identities that is focused on behavior compliance methodologies employed in educational and therapeutic work with neurodivergent youth and adults. As discussed in the background section, Applied Behavior Analysis (ABA) is a pedagogical and therapeutic practice that is commonly used with neurodivergent, and especially autistic, youth in behavioral health settings (Roscigno, 2019). ABA has long been the subject of critique among disability scholars and autistic self-advocates (Roscigno, 2019). However, in recent years, LGBTQ+ advocacy organizations have also raised ethical concerns about the field's emphasis on normalization and the ways in which this orientation may uniquely impact queer and transgender neurodivergent people (Autistic Self Advocacy Network, the National Center for Transgender Equality, National LGBTQ Task Force; 2016).

Scholarship on the history and contemporary usage of ABA offers insight into the ways in which compulsory-heterosexuality and compulsory-ablebodiedness coalesce as forces of institutional control in the lives of neurodivergent people. Research into ABA's origins has uncovered the intervention's fraught past, particularly in regard to its impact on children who were both gender non-conforming and neurodivergent. In their paper on the founder of ABA, Ole Ivar Lovaas, Gibson and Douglas (2018) trace Lovaas' work in the 1970s on 'The Feminine Boy Project.' At the same time that Lovaas was engaging in brutal experimentation on autistic children (such as using electric shock as an aversive),

he was also concerned with developing interventions to increase masculine behavior in young boys who had demonstrated feminine-typed characteristics (Gibson & Douglas, 2018). Lovaas justified his work in the Feminine Boy Project by predicting "serious disabling consequences for adults" including "interference with normal heterosexual relationship[s]" and the "prospect of adults choosing to alter their bodies using surgery or hormone treatment" in accordance with their gender identity or expression (Gibson & Douglas, 2018 p. 11). Lovaas' work in the 1970s with autistic and gender non-conforming children helped spark both an "autistic recovery industry" and an "LGBTQ conversion therapy industry" (Gibson and Douglas, 2018, p. 20).

In the nearly 50 years since Lovaas' work, so-called conversion therapy related to sexuality and gender identity has been nearly unanimously discredited within the psychological community (American Psychiatric Association, 2018). It has also been condemned as harmful and unethical by the National Association of Social Workers (National Association of Social Workers, 2015). Yet, ABA remains the preeminent model for work with autistic youth in the United States (Roscigno, 2019). Despite the wide-spread rejection of gender and sexual orientation change efforts among behavioral and mental health professionals, the continued use of ABA has allowed for neurodivergent LGBTQ youth and adults to be subjected to what Gibson and Douglas (2018) call "gender-shaping behaviorism" (p. 3). Gender-shaping behaviorism refers to interventions that seek to encourage hetero and cisnormative behaviors and discourage behaviors that are read as queer or gender non-conforming. Within some educational settings, this can include targeting the gender non-conforming behaviors of

neurodivergent children for ‘normalizing’ interventions (Shapira & Granek, 2019; ASAN, NCTE, LGBTQ Task Force, 2016). This may include “behavior plans” where “gender-affirming expressions or explorations risk harsh compliance-based punishment” (Brown, 2016, p.1).

These interventions not only seek to control behavior designated abnormal or deviant (i.e., non-neurotypical and non-cisgender), but effectively deny neurodivergent people their bodily and cognitive autonomy through curtailing their right to express their gender and/or sexuality. While these interventions primarily occur in educational settings and are intended to address social and behavioral skills, they may also impact individuals’ self-concept and identity construction. For neurodivergent and transgender youth, early experiences in “behavioral compliance or social skills training” may create additional barriers to feeling comfortable exploring gender non-conformity (Strang et al., 2020, p. 11). In 2016, the Autistic Self Advocacy Network, the National Center for Transgender Equality, and the National LGBTQ Task Force released a statement affirming the fundamental rights of autistic and transgender people. This statement also addressed the impact of gender-shaping behaviorism on transgender and autistic individuals’ ability to explore and express their gender identity:

> [Autistic] people may also be subjected to harmful “normalization” therapies that try to suppress autistic or socially nonconforming traits—which, in the case of trans or gender non-conforming autistic people, can include suppressing traits that seem inconsistent with their assigned gender. Some autistic people delay coming out or transitioning out of fear that unsupportive family members will place them

> under guardianships or force them into institutions in order to prevent them from living according to their gender. Denying transgender and gender non-conforming autistic people the respect, dignity, and equal access to services that they need can worsen the social marginalization that many of them face. (ASAN, NCTE, LGBTQ Task Force, 2016, p.1)

The ethical issues raised by transgender and autistic advocates resonate with several of the ethical principles expressed in the National Association of Social Workers' (NASW) code of ethics. Perhaps most notably among these values is 'dignity and worth of the person' and the responsibility of social workers to promote client self-determination (NASW, 2017). Gender-shaping behaviorism as well as other tactics of neuronormative normalization stand in contrast to these principles, as they seek to produce compliance through exerting control of neurodivergent and transgender bodyminds.

Characteristics of the Community

Self-Determination in Identity Construction

First-person narratives and sociological research demonstrate the complexity of identity construction, particularly in regard to language usage, for neurodivergent and transgender individuals and communities. The significant overlap between transgender and neurodivergent identities has sparked the development of intra-community terminology to describe the phenomenon (Brown, 2016). For example, the term 'gendervague' was created within the autistic community to describe the unique experience of holding a transgender and autistic identity. As Brown (2016) writes in their first-person narrative, "someone who is gendervague cannot separate their gender identity

from their neurodivergence – being autistic doesn't cause my gender identity, but it is inextricably related to how I understand and experience gender" (p. 1). While evolution in identity terminology has been meaningful for developing individual self-awareness, the role of language in describing this experience has also been found to be fraught and insufficient. Among LGBTQ+ neurodivergent youth who participated in research on identity, community, and activism, many demonstrated an "aversion to categorization" (Oswald et al., 2021, p. 8) that is inherent to the language of gender identity and diagnoses.

Community Solidarity

The importance of opportunities to be in community with people who share similar identities and experiences is common to many marginalized groups. However, for individuals holding multiple oppressed identities, finding community spaces that accept and value their intersectionality can be challenging. Queer and transgender neurodivergent youth have been found to experience exclusion in neurotypical LGBTQ+ spaces (Oswald et al., 2021; Strang et al., 2020). Conversely, in a survey of LGBTQ+ and neurodivergent youth, participants identified the importance of spaces for "queer autistic community" and opportunities to build friendships with peers who share identities and experiences (Oswald et al., 2021, p. 16). The value of community connections around these shared identities has been corroborated by additional clinical research, including a first of its kind, community-based participatory design study to develop a clinical model to support autistic and gender diverse youth. Strang et al. (2020) found that youth participants emphasized the importance of opportunities to gather and learn from one

another. Participants described the importance of building friendships with other neurodivergent and gender diverse youth and the ways in which these connections made them feel “less alone,” “supported,” “accepted,” and understood (Strang et al., 2020, pp. 9-10).

Research regarding LGBTQ+ neurodivergent community has also found that social media and other online platforms have been uniquely important in creating opportunities for individuals to connect and explore new ideas related to gender in a safe and accessible space (Brown, 2016; Oswald et al., 2021). Online communities have been found to be particularly impactful for neurodivergent and transgender young people, as they are more likely to be “isolated in homes, schools, and communities" (Oswald et al., 2021, p. 17). Such virtual spaces can afford young people the opportunity to express their gender and/or sexuality in a way that is not dictated by cissexist or neurotypical expectations and is free from surveillance by family and healthcare providers (Oswald et al., 2021). Similarly, Egner (2019) describes the ways in which these platforms provide adult community members “inclusion and value of their unique intersectional selves” (Egner, 2019, p. 142). Further, Egner characterizes the neuroqueer blog community as a space that rejects “exclusionary practices” and “assimilationist rhetoric and challenges dominant discourses that privilege some bodyminds over others” (Egner, 2019, p. 142).

Racism within the Neurodiversity Movement & Diagnostic Processes

It is important to note that within neurodivergent communities, exclusionary practices persist. As Morénike Giwa Onaiwu (2020) writes in her first-person narrative on being a Black, neurodivergent woman navigating neurodivergent community spaces:

"neurodiversity is very heavily 'White' in terms of how it is packaged, described, and perceived" (p. 60). As Onaiwu (2020) describes, racism is prevalent within neurodivergent communities both in terms of interpersonal dynamics and the ways in which whiteness is centered in discourse, community-building, and advocacy. Further, medical racism causes disparities in access to services and diagnosis among neurodivergent people of color (Onaiwu, 2020). White male children are significantly more likely to receive an autism diagnosis than children of color (Onaiwu, 2020). Instead, Black and Latinx boys are more likely to be diagnosed with "ADHD and/or Conduct Disorder and Oppositional Defiant Disorder" (Onaiwu, 2020, p. 62). Further, these disparities evoke racist aspects of early autism science, where "the creation of 'autistic' children occurred in relation to and distinction from the more commonly recognized category of largely poor, often immigrant, and highly racialized 'feebleminded' people" (Gibson & Douglas, 2018, p. 6).

Conclusion

This literature review has explored existent clinical and sociological research, first-person narratives, and policy briefs focused on the experiences of transgender and neurodivergent individuals. Clinical research on this intersection of identities focuses primarily on issues related to gender-affirming medical interventions and related mental health care, including disparities in access that exist for this population. These disparities range from identity invalidation from providers and family members to denial of gender-affirming care, to inadequate accommodations in healthcare settings. In behavioral health settings, gender-shaping behaviorism continues to impact the lives of neurodivergent

youth and adults. Despite the fact that sexual orientations and gender identity change efforts have been discredited by the American Psychiatric Association and the National Association of Social Workers (among other professional organizations), behavior plans that punish and suppress neurodivergent and gender non-conforming traits persist in educational environments. These practices can have long-term impacts on individuals' ability to explore and express gender and sexual identity. Further, they can be understood to conflict with the NASW code of ethics principle of dignity and worth of the person.

Sociological research and first-person narratives exploring transgender/LGBTQ+ neurodivergent communities demonstrate the ways in which community dynamics impact individual identity construction and access to mutual aid (Oswald et al., 2021; Strang et al., 2020; Egner, 2019). This body of literature illuminates how within transgender and neurodivergent communities, identity construction is a complex phenomenon that has engendered both the development of new terminology and understandings of the profound limitations of language and its resultant categories. Research on the impacts of community solidarity and resource sharing indicates that mutual aid is a significant strength of this community. In particular, online spaces may provide opportunities for youth to escape familial and medical surveillance and find resources for identity development and community building. Similarly, neurodivergent and transgender adults may find unique opportunities to be understood as their full intersectional selves among online neuroqueer communities. Despite the powerful nature of community solidarity, it is evident that racist social dynamics persist within neurodivergent communities. The lack of literature outside of first-person narrative on this topic reveals a need for further

research concerning the experiences of LGBTQ+ neurodivergent people who are Black, Indigenous and people of color.

The current body of scholarship provides important insights for social work practice with individuals and communities at the intersection of these identities. However, several significant gaps in the research exist. First, clinical research has focused primarily on transgender and neurodivergent individuals' experiences of medical and psychiatric systems. Moreover, this research has focused primarily on youth seeking gender-affirming medical interventions, and the experiences of adults are less well understood. Clinical research has also neglected neurodivergent and transgender individuals' experiences accessing mental healthcare more broadly and more information is needed about experiences in counseling and social work settings. These findings have contributed to the present research questions concerning individuals' experiences with mental health providers and access to quality mental healthcare.

Although the importance of community solidarity is becoming increasingly well-documented, less is known about neurodivergent individuals' experiences within the larger LGBTQ+ community. Given these outstanding questions, the present research explores neurodivergent and transgender individuals' perceptions and experiences of broader LGBTQ+ and transgender-specific community spaces. Finally, and perhaps most importantly to the scope of this project, little has been written about how transgender and neurodivergent individuals experience and understand their gender identities and the concept of gender more broadly. While neuroqueer research provides a critical theoretical framework for conceptualizing this phenomenon, the majority of scholarship remains

theoretical and few studies have incorporated neuroqueer praxis into research focused on individuals and communities. The present study attempts to explore these gaps in knowledge and contribute to the development of just and equitable social work practice with neurodivergent and transgender individuals and communities.

Chapter 3: Methodology

Research Method: Phenomenology & Queer Phenomenology

This study utilizes both hermeneutic and queer phenomenological approaches to address two research questions. First, how do neurodivergent and transgender individuals understand and experience their gender identity and neurodivergence? Second, do participants draw connections between their understandings and experiences of gender and their own neurodivergence? Phenomenology as a research method seeks to understand phenomena from the perspective of the individuals who experience it and attempts to "describe the meaning of this experience—both in terms of what was experienced and how it was experienced" (Neubauer et al., 2019, p. 91).

Phenomenology

Phenomenology encompasses a philosophical movement, a diverse range of research methodologies, and an overarching paradigm of qualitative research (Kafle, 2011). The philosophical traditions that espoused phenomenology developed over several centuries; but most contemporary historians credit Edmund Husserl for defining phenomenology in the early 20th century (Neubauer et al., 2019). Husserl's work radically rejected positivism's claim that external reality can be objectively observed, "and instead argued that phenomena as perceived by the individual's consciousness should be the object of scientific study" (Neubauer et al., 2019, p. 92). The truth of a

phenomenon then lies in the individual's experience of it, rather than in supposed empirical observations (Neubauer et al., 2019). The development of phenomenology facilitated a novel shift in scientific focus, one that required "the researcher to return to the self to discover the nature and meaning of things" (Neubauer et al., 2019, p. 92). Husserl's conceptualization of phenomenology later became termed 'transcendental phenomenology' (Kafle, 2011). As Kafle (2011) further explains, within contemporary transcendental phenomenology, there is a supposition that the researcher may fully "suspend personal opinion" to discover a phenomenon's "core or essence through a state of pure consciousness," in order to offer a "a single, essential and descriptive presentation of a phenomenon" (p. 186).

Hermeneutic phenomenology is another branch of the discipline that derives from the work of Martin Heidegger and represents a significant departure from Husserl's original paradigm (Kafle, 2011). Where transcendental phenomenology seeks to reach a singular understanding of a phenomenon, hermeneutic phenomenology is fundamentally concerned with the "subjective experiences of individuals and groups" (Kafle, 2011, p. 186). The discipline is also concerned with the *lifeworld* (Neubauer et al., 2019), or environmental context in which individuals and groups exist, and how the interactions between individuals and their lifeworld shape understanding of experiences. Further, hermeneutic phenomenology seeks to go beyond the individual experience and contribute to larger understandings of societal phenomena through "unveil[ing] the world as experienced by the subject" (Kafle, 2011, p. 186).

Hermeneutic phenomenology rejects the transcendental notion that personal bias can be removed from research (Kafle, 2011). Instead, hermeneutic phenomenology embraces interpretation over impartial description, and even characterizes transcendental description as itself interpretive (Kafle, 2011). Where transcendental phenomenology seeks to neutralize the researcher's personal ideologies, hermeneutic phenomenology articulates the researcher's subjectivity as a facet of the interpretative process (Neurbauer, 2019). Hermeneutics is then an interpretivist approach that "seeks culturally derived and historically driven interpretations of the social life world" (Alsaigh & Coyne, 2021, p. 2). Within Gadamer's hermeneutics, a researcher's own preconceptions are, in fact, what "makes understanding likely" between researcher and participant (Alsaigh & Coyne, 2021, p. 2). The research process is understood to connect "people who express themselves, and those that understand them" through "human consciousness – 'universality' and a 'fusion of horizons'" (Alsaigh & Coyne, 2021, p. 2). This concept of fusion of horizons will be considered further in the analysis description at the end of this chapter. Overall, a hermeneutical approach allows the researcher to recognize the infinite diversity of perspectives, while utilizing their own subjectivity and pre-understandings as a tool for deeper interpretation (Alsaigh & Coyne, 2021).

Queer Phenomenology

Queer phenomenology is one of the multitudes of sub-disciplines of phenomenology that have arisen during the twentieth and twenty-first centuries (Neurbauer, 2019). Queer phenomenology was developed by Sara Ahmed (2006) and emphasizes the role of orientation and spatiality in understanding queer experiences.

Ahmed's (2006) work asks questions of which objects - bodies, ideas, politics - are spatially accessible, familiar, and encouraged and which are "oblique" or "wonky" (p. 66). Further, queer phenomenology posits that directionality is never neutral (Ahmed, 2006). Rather, individuals and groups are othered through directional and spatial language and the embodied understanding of these terms. Queer phenomenology employs metaphors of lines and paths created through repetition across generations to describe how expectations of marriage and reproduction become the default orientation for individuals living in heteronormative cultures (Ahmed, 2006). Queer desires and expressions can be understood as an orientation toward something other than what is prescribed by the well-trodden paths; something unfamiliar and unrecognizable from normative angles of perception (Ahmed, 2006).

Queer phenomenology then is oriented toward such moments of instability, or that which "slips," and offers a way to "approach what is retreating" and to "inhabit the world at the point at which things fleet" (Ahmed, 2006, p. 566). This methodology finds what is "queer within phenomenology" to offer an unfamiliar perspective on phenomena, and in the process of doing so finds "joy and excitement" in the "horror" of being disoriented (Ahmed, 2006, p. 544). Queer phenomenology does not specifically employ a critical disability lens, yet there are nevertheless echoes of neuroqueer theory in Ahmed's work. These overlaps are particularly evident in the exploration of how normativity is achieved through repetition of orientations. One such connection may lie in the oft used clinical language of 'low' and 'high' functioning labels to describe autism (Tumlin, 2019). As Tumlin (2019) writes, the "problem" with the autism spectrum is that while it may be

intended to represent a diversity of experiences, “in practice, it has been a linear path that goes from less to more Autistic” (p. 13). The spectrum is further broken down into a binary of “convenience” through the categories of high and low functioning (Tumlin, 2019, p. 13). This binary separates human beings according to what they “can or cannot do rather than who they are” (Tumlin, 2019, p. 13). The language of functioning labels and the linear spectrum of autism create a directional hierarchy of neurotype. From the perspective of queer phenomenology, ‘higher level’ bodyminds can be understood to be valued over ‘lower level’ bodyminds, and the implicit educational and therapeutic goal for autistic people is to move *up* and *toward* neurotypicality.

The Present Study & Self-Reflection

Given the exploratory nature of this study and the minimal understanding of this confluence of identity/experience, phenomenological research methods provide a fitting framework for data collection and analysis. The goal of this study is to learn about neurodivergent understandings of gender directly from neurodivergent people, and a phenomenological approach allows their insights and experiences to inform interpretation. Specifically, this project employs a hermeneutic phenomenological approach that is informed by queer phenomenology.

Hermeneutic phenomenology was selected on the basis of the researcher’s understanding of her own subjectivity as not only inseparable from the research, but valuable to the interpretive process. The researcher’s decision to disclose her own queerness, cisness, and neurotypicality during the recruitment process supported relationship building between researcher and participants through creating transparency

around shared experiences and the limitations of understanding. Further, the researcher's queer identity and roots in queer community created both an ease of recruitment and complex dynamics in the process of interviewing several friends and acquaintances. These points of subjectivity represent a critical aspect of the interpretive process, through the "dialectical interaction between the pre-understandings of the interpreter and the meaning of the text" (Alsaigh & Coyne, 2021, p. 2). Given the intimacy between the researcher, the participants, and the subject matter, hermeneutical phenomenology provides a meaningful tool for continuous and non-linear reflection and re-interpretation on/of the texts and the research process.

Queer phenomenology was incorporated as a tool to generate analysis with an awareness of participants' unique orientations. That is, this study considers how participants' ideologies, desires, and embodiment are oriented in relation to normative performances of gender and neurotype. Attention to queer orientations provides a framework for developing understandings of gender and neurodivergence that are outside the parameters and expectations of cisgender and neurotypical perspectives. Queer phenomenology is a fitting framework to disrupt linear and hierarchical understandings of both gender and neurotype and will allow for participants' own unique orientations to reveal both neurodivergent understandings of gender and trans understandings of the phenomena of mind, brain, and embodiment.

Selection and Recruitment of Participants

Ethical Considerations

The study and all materials and procedures were reviewed and approved by the University of Southern Maine Institutional Review Board to assess adherence to ethical guidelines in research with human subjects. Consent, privacy, and confidentiality represented significant ethical issues in this study. All participants received a consent form describing the purpose of the research, their rights as a participant, and the risks and benefits of participation. The form included two opportunities to endorse or withhold consent. Participants first indicated their consent to participate and then were asked a separate question regarding their consent to record the interview. Consent to participate and consent to record were both indicated by participant signatures. All of the interviews were held over Zoom, an online-based video-call platform.

Ethical concerns around confidentiality and privacy existed primarily in regard to transcripts and audio files. Ethical issues surrounding transcripts included identifying information and participant informed consent. Raw transcripts included many points of identification, such as participant names, locations, and involvement with organizations or entities, among others. To ensure privacy and provide participants with control over the sharing of personal information, it was important for participants to have the opportunity to review their interview before quotes from transcripts were included in the study. To address both issues, participants were emailed a copy of their transcript and had two weeks to review and approve the content. After this approval, transcripts were thoroughly de-identified. Ethical issues surrounding audio files were related to internet security. Participants were able to request a copy of their interview audio file. Due to the large file size of the audio interviews, sharing them required the researcher to upload the

files to Google Drive. However, ethical concerns existed around the vulnerability of Google Drive and the possibility of files being leaked. To minimize risk, those that requested their audio files were provided with a link to the recording and given two weeks to download the file (with the option to re-request access.) After two weeks, the files were removed from the researcher's Google Drive to protect participant privacy through ensuring that interview audio could not be found on the internet. The audio files of the participants who did not request copies were removed from the researcher's computer after transcription. All audio files were uploaded to an external hard drive that was kept in a locked cabinet after being removed from the researcher's computer.

Sampling

This study utilized a combination of voluntary response and snowball sampling resulting in a sample of 13 participants. To qualify for the study, individuals were required to identify as both transgender and neurodivergent. Potential participants were informed that for the purpose of this study, transgender is inclusive of trans men, trans women, non-binary individuals, those questioning or exploring their gender identity, or any individual who does not otherwise identify as cisgender. Neurodivergent was defined for participants as inclusive of individuals who identify as neurodivergent/diverse and/or with the experiences of autism, ADHD, developmental differences, or learning differences. Participants were also required to be 18 years of age or older and be able to speak and understand English.

Recruitment Design

The initial study design proposed a diverse range of outreach strategies intended to recruit up to 10 participants. Proposed recruitment methods included outreach via University of Southern Maine email listservs, flyer-based outreach in LGBTQ+ community spaces in southern and central Maine, social media outreach, and direct email communication to individuals known to the researcher as members of this community. In the first week of recruitment, the researcher decided not to employ all outreach strategies concurrently. This decision was based in recognition that recruitment began during the December holiday season of 2021. The researcher was concerned that email and flyer-based communication may have had minimal notice during the holiday season and university recess. Instead, the researcher first conducted social media outreach with the intention to begin the email and flyer-based outreach after the new year. However, after two days, 18 individuals had completed the initial interest form. As this number already exceeded the intended number of participants, the researcher did not conduct the other intended methods of outreach. (The limitations of solely employing social media-based recruitment will be explored in the discussion section.) Given the opportunity to have a larger sample than initially imagined, the researcher expanded the study parameters and contacted the first 13 individuals to complete the interest form. The remaining five were contacted and asked if they would like to be on a waitlist, should any of the first 13 individuals choose not to participate. None of the participants who were contacted about the waitlist initially responded. However, after all the first 13 participants ultimately chose to participate in the study, the waitlist participants were contacted again. After a second contact, all but one waitlisted participant responded with understanding that they

would not be able to participate in the study. One participant on the waitlist never responded to either attempt at contact.

Instagram-Based Recruitment

Social media outreach included the researcher sharing information about the study on her personal Instagram page. Instagram is a free photo and video sharing app that is open to users 13 years of age or older (Meta, 2022). The app is currently one of the most widely used social media platforms and as of December of 2021, Instagram was reported to have over 2 billion users (Rodriguez, 2021). The decision to utilize a solely Instagram-based recruitment strategy was rooted in the researcher's assumption that the information would be easily and widely disseminated across the platform. This assumption was further substantiated by the researcher's own connection to internet-based LGBTQ+ communities. At the time of recruitment, the researcher changed the settings on her personal Instagram page to allow her profile to be publicly available. This meant that any Instagram user would be able to view and follow the page without the researcher's expressed consent (Meta, 2022). This change allowed the recruitment material to be viewed and shared by any person on the platform.

Recruitment information was shared in the form of an informational graphic. Instagram allows users to share up to 10 images in one post and the researcher created 8 images to be used in the recruitment post. The recruitment infographic is included in the appendix. These images described the purpose of the study, the role of the researcher as a Master of Social Work candidate and salient aspects of her own identity (including race, sexual orientation, gender identity, and neurotype), qualifications for participation, an

overview of the interview process, risks and benefits of participation, and instructions for registering to participate. The textual information of the infographic was re-typed in the 'caption' of the Instagram post, so that individuals who utilize screen reader technology could access the content of the post. This post was also shared in the researcher's Instagram 'story.' The Instagram story is a means to share images, videos, or text with followers for only 24 hours, after which the story is deleted from the profile (Meta, 2022). In both the post and story, the researcher invited other Instagram users to share the information on their own pages. This invitation to share created a means to conduct social media-based snowball sampling.

Participant Registration

The recruitment post directed interested participants to a Google form page via a link provided in the researcher's Instagram 'bio.' The Google form summarized the role of the researcher, the purpose of the study, requirements for participation, and the interview process. The form also indicated that completion did not represent a commitment to participate and provided the researcher's email address for further questions. The Google form collected information on potential participants' names and pronouns and confirmed that they are over the age of 18 and identify as both transgender and neurodivergent. The form also collected information about availability and preferred forms of communication. Finally, the form provided space for participants to ask any questions about the study and include additional information, such as accessibility needs. After completing the form, the researcher contacted participants via email or text message, depending on individual preferences. Initial outreach included further

information about the interview process, assessment of participant's needs and questions, and suggestions of potential dates and times for the interview.

Participant Overview

At the time of the study, seven participants used they/them pronouns, two used he/him pronouns, one used she/her pronouns, two used she/they pronouns, and one used he/they pronouns. One participant described her gender identity as 'female' and two participants described themselves as a 'trans man.' All other participants endorsed, at least in part, non-binary, genderqueer, or genderfluid identities. Participants described their neurodivergence in terms of ADHD, autism, borderline personality disorder (BPD), bipolar disorder, processing disorder, dyscalculia, obsessive compulsive disorder (OCD), synesthesia, anxiety, depression, experiences of suicidality, and "general neurodivergence." Many participants endorsed multiple of the aforementioned descriptors. The findings and discussion sections will offer in-depth consideration of participants' understandings of their gender identities and neurodivergence. Participants range in age from approximately 25-40 years old. Information about participants' locations was not collected. However, the researcher's conversations with participants revealed that individuals from across the United States participated in the study. Specific data on race, ethnicity, religion, class, education, or physical disabilities was not collected. Although it appears from participants' own narratives that the majority of participants identified as White and non-Latinx. The choice not to collect this data was made in order to narrow the scope of the study to focus primarily on experiences related to transgender and neurodivergent identities. However, this lack of demographic data

represents a limitation of the study that will be considered in the discussion chapter. Despite the fact that the researcher did not intentionally collect this data, for many participants, these facets of identity came up during the interview process. These intersectional experiences are considered in the findings and discussion chapters. It is also important to note that four participants were known personally to the researcher as either friends or acquaintances.

Data Collection & Analysis

Data Collection

Interviews were scheduled according to the participants' availability. Initially, participants were given the option to meet in-person or via Zoom. However, as interviews occurred during a surge in COVID-19 cases due to the Omicron variant (Stein, 2022), the researcher decided to hold all interviews remotely. Interviews were recorded through the Zoom recording function. Both the researcher and the participants turned off video functionality in order to increase participant privacy through creating an audio-only recording. The average interview lasted between 45 minutes and one hour. The researcher utilized a semi-structured interview process in which the central focus was participants' experiences and understandings of gender and neurodivergence (Creswell & Poth, 2018). For accessibility reasons, one participant opted to answer the interview questions in written form rather than participating in an interview.

During the study design process, the researcher created an interview guide with fifteen questions to be asked of all participants. Interview questions were divided into four thematic sections. The first section explored gender and neurodivergent identity.

These questions considered how participants conceptualize their identities, how those identities were developed, and the salience of gender identity and neurodivergence within overall self-concept. The second section focused on connections that may exist for participants between experiences and understandings of gender and neurodivergence. The third considered experiences within the broader LGBTQ+ community. The final section explored participant experiences accessing mental health care and gender-affirming care. Interview question development was guided by both the research questions and the literature review. Questions about identity and connections between gender and neurodivergence stemmed directly from the research questions. Those focused on experiences within the wider LGBTQ+ community and with mental health care and gender-affirming care were asked in response to the existent scholarship. Participants were provided with a copy of the interview questions prior to the interview, in order to increase accessibility among diverse cognitive styles (Dadas, 2018). The full interview guide is provided in the appendix.

Data Analysis

The hermeneutic circle offers five stages of phenomenological research and writing that guided this study's process of analysis. The five stages are presented first in broad terms, followed by a more specific exploration of the present methodology. The first stage in the hermeneutic circle represents the researcher coming to understand the "participants' horizon," or perspective, through being immersed in the data (Alsaigh & Coyne, 2021, p. 7). The second stage occurs when the researcher's own horizon is achieved through data analysis, including abstraction, synthesis, and theme development

(Alsaigh & Coyne, 2021, p. 7). During this stage, sub-themes are moved into larger themes and are related back to the larger meaning of the interview content (Alsaigh & Coyne, 2021). Next, stories are reconstructed through the "illumination and illustration of phenomena" (Alsaigh & Coyne, 2021, p. 7). Illumination and illustration occur through connections drawn between interview content and existent literature and is articulated in the findings chapter (Alsaigh & Coyne, 2021). The final stage is one of integration and critique. At this stage, themes are critiqued and final interpretations of the research are presented (Alsaigh & Coyne, 2021). The completion of the final stage facilitates a "fusion of horizons" between the researcher and the participants, as presented in the discussion section of the study (Alsaigh & Coyne, 2021, p. 6).

The first stage of analysis was focused on transcription. After each interview was completed, the audio files were uploaded into an online, artificial intelligence transcription service. In order to ensure that transcripts were verbatim representations of the interview content, the researcher listened to the audio recordings of the interviews while reading and editing the transcripts produced by the transcription service. This process also served as a first 'naive read' of each transcript. The term 'naive read' refers to the initial readings of the text, in which the researcher shifts into a "phenomenological attitude" and strives to be "open" to meanings of the text (Lindseth & Norberg, 2004, p. 149). At this point in the phenomenological process, the text is not yet interpreted. Rather, the "first conjecture" of meaning is made and this reading will go on to inform the development of structural analysis (Lindseth & Norberg, 2004, p. 149). After the transcripts were edited for accuracy, they were returned to participants who indicated that

they wished to receive a copy. Participants had two weeks to request that any information be removed or added to their transcripts. Following the initial naive reading, the researcher conducted a second naive read while simultaneously de-identifying the texts.

After the naive reads, the transcripts were read again for "significant statements" (Creswell & Poth, 2018, p. 79). Examples of significant statements are included in the appendix. Significant statements included those that reflect participants' experiences and understandings of their gender identities and neurodivergence, connections that they may or may not draw between gender identity and neurodivergence, experiences within the broader LGBTQ+ community, and experiences with mental healthcare and gender-affirming medical care. All the significant statements in each transcript were then interpreted in order to produce a meaning unit. The significant statements and the meaning units across all transcripts were then read together to discover "clusters of meaning" (Creswell & Poth, 2018, p. 79). These clusters of meaning supported the development of 15 initial themes (Alsaigh & Coyne, 2021). From the initial themes, five essential themes emerged and will be detailed in the findings and discussion sections (Alsaigh & Coyne, 2021).

Chapter 4: Findings

After engaging in the phenomenological process, five essential themes emerged from the data: fluid and expansive identities (1), relationality and identity development (2), connections between gender and neurodivergence (3), diverse experiences within LGBTQ+ community (4), and experiences within the healthcare system (5). In the first theme, the fluid and expansive nature of gender identity and neurodivergent identity are considered as two separate sub-themes. The second theme includes two sub-themes,

community as a catalyst for gender and neurodivergent identity recognition and the impact of social perception on participants' gender and neurodivergent identity development and expression. In the third theme, three sub-themes are discussed, including commonalities in experiences of marginalization between trans and neurodivergent identities, neurodivergence as a factor in developing a more expansive understanding of gender, and gender and neurodivergence as intersecting processes of embodiment. Sub-themes in the fourth theme include experiences within the LGBTQ+ community and overlap between LGBTQ+ and neurodivergent communities. Finally, the fifth theme includes three sub-themes: minimal experiences of ableist discrimination and denial of gender-affirming care, rampant transphobia across healthcare settings, and recommendations for providers based on participant responses. Themes and sub-themes are diagrammed below.

Table 1: Graphic representation of themes

Theme 1	Fluid and Expansive Identities		
Sub-themes	Gender Identity	Neurodivergent identity	
Theme 2	Relationality and Identity Development		
Sub-themes	Community as catalyst	Impact of social perception	
Theme 3	Connections between Gender & Neurodivergence		
Sub-themes	Experiences of marginalization	Neurodivergence expanding gender identity	Intersecting processes of embodiment
Theme 4	Diverse Experiences within LGBTQ+ Community		

Sub-themes	LGBTQ+ community	Overlap between communities	
Theme 5	Experiences within the Healthcare System		
Sub-themes	Minimalist experiences of ableist care	Transphobia across settings	Recommendations for providers

Theme One: Fluid & Expansive Identities

Participants articulated fluid and expansive understandings of both their gender and neurodivergent identities. Two sub-themes will consider how participants construct and articulate first gender identity and then neurodivergent identity. The gender identity sub-theme addresses participants' expansive relationships with concepts of womanhood and manhood, gender evolution, and the fluid and multidimensional nature of gender identity. The neurodivergence sub-theme addresses participants' relationships with the language of diagnosis, understandings of neurodivergence as a 'perspective,' and the experience of appreciating neurodivergence within a neuronormative culture.

Gender Identity

Participant gender identities were reported to be highly nuanced, with many articulating expansive, evolving, or fluid experiences of gender. The majority (n=10) of participants described their gender identity, at least in part, as non-binary. Across all participants, only two described their gender in exclusively binary terms, such as "female" or "trans man." This section first considers the experiences of participants who held gender identities that were somewhat aligned with concepts of womanhood or

manhood. Next, participant experiences with gender evolution are discussed. Finally, participants' fluid and multifaceted descriptions of gender are presented.

Among participants who held gender identities that were somewhat aligned with concepts of womanhood or manhood, many articulated nonbinary visions of these concepts. For one participant, this meant identifying with trans masculinity rather than binary manhood. As they shared, "I identify as transgender, in kind of thinking of it as an umbrella term, where I feel very transmasc [trans masculine], but not necessarily transgender man in a binary sense." Another participant who does identify as a trans man, described how the category of man is still an approximation that cannot fully capture his gendered experience: "Though I do fully identify as a man 100%...there's an in-between that I feel like I am…Man is comfy for me. That's who I feel that I am. But I also don't really vibe with the concept of man." As he went on to share, his gender identity does not determine his gender expression: "My secret desire is to wear a dress again. But only after I have a full beard…I want to be gendered so correctly, that I can wear a beard and people will be like: That's a man in a dress."

Several participants articulated an experience of (trans)gender evolution. Among these participants, this process often involved first identifying with binary trans identities and later coming to identify with non-binary or genderfluid identities. One participant described how her understanding of gender identity has evolved to encompass something beyond binary womanhood:

> I find myself going back and forth on that [gender identity] all the time. When I came out, I was very much trans femme, trans woman… Have to be femme[2] all the time…Got to be passing[3] - I hate that word…And in the last couple years, honestly - I use she/they pronouns and I'm really a lot more comfortable with non-binary. I definitely kind of think of myself as femme and describe my sexuality as lesbian…And femininity and femme is still a part of my life. But I think probably…non-binary femme is where I'd put myself. But I think about it a lot…And I think that's something that I think I'm always going to be thinking about.

This unfolding understanding of gender was echoed by other participants. As one participant who identifies as a non-binary trans man shared, "I tried to force myself…into the opposite side of a binary that also didn't really fit me… I am definitely leaning more into the feminine side of things now. And letting that queer aspect of my gender come out more." Another participant who identifies as genderqueer, genderfluid, or non-binary described how their gender identity development involved the relinquishing of a "costume of masculinity." After a process of "soul-searching," they "started using they/them pronouns [and] went off testosterone" in order to reach a place of "embracing the fluidity of my gendered experience."

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[2] Femme is a queer and trans gender identity/expression term that refers to an experience of femininity that does not necessitate a cis/female identity (Blair & Hoskin, 2015).

[3] Within trans community, passing refers to the extent to which an individual is read in public spaces as cisgender; e.g. if a trans woman would be assumed to be a cis woman by a (cis) stranger (Anderson et al., 2019).

This articulation of gender fluidity was common across many participants. One way this was evident was through the use of multiple, sometimes contextual, identity terms. For some participants, several identity terms were employed to further enrich descriptions of their gender. This was especially true among participants who identified, at least in part, as non-binary. For one participant, three descriptors were necessary to capture the complexity of their gendered experience, including "non-binary," "woman," and "genderqueer." Another utilized "transgender," "non-binary," and "genderfluid." For others, gender identity required even further contextualization. Among these participants, gender could not be contained in a singular articulation of identity and required multiple identity terms and explanatory language. One participant employed three identity terms and a definition to capture the complexity of their gendered experience. As they describe, "I typically say genderqueer, genderfluid. I think non-binary is the one that I use when I don't want to have to explain anything…Genderfluid is a little bit more accurate, or genderqueer." The meaning of these multiple identities was summarized by the explanation that they "don't engage with gender in a fixed way." Another participant echoed the sentiment that the use of identity terms varies situationally. As he described, he uses different terms depending on the audience, stating "Normally when a person asks me that question, I just say: I'm a man, I'm a trans man. But if I'm speaking with someone within my community, it's a lot more complicated than that, I think." For these participants, descriptions of gender are fluid across social settings, where some identity terms are employed for ease of communication and others for more accurate and holistic expression.

Neurodivergence

The ways in which participants described their neurodivergence were similarly multidimensional. Neurodivergent identity was articulated through complex interchanges between pathology paradigm and neurodiversity paradigm language. Participants moved fluidly between characterizing neurodivergence in terms of diagnosis and symptomology and as a perspective or neurotype. One participant shared: “With the pandemic, I think my symptoms of ADHD have worsened. And I don't love to say it that way. Because ADHD to me is a neurotype. It's not a disorder. But that's the language that I have to use.” This ambivalence did not go unnoticed by participants. As several participants articulated, their self-descriptions are constrained by the limitations of language. One participant's statement was particularly resonant with what many expressed when they said:

> Some of the labels I've found helpful, so far, are having ADHD, and being on the autism spectrum. And I think those terms can be useful. But I don't feel like they are inclusive. I prefer to use just neurodivergence, as an overall term. Because I feel like I don't identify as … one or the other or both.

Another described an internal struggle with the implications of the language used to describe their diagnosis, saying, “I'm always feeling like I'm combating, kind of, opposing language.”

Although all participants employed at least one diagnosis to describe their neurodivergence, each participant also expressed an understanding of neurodivergence as an intrinsic aspect of their perspective and positionality. One participant articulated

neurodivergence as the way that they "experience the world" and as a means to "describe consciousness." Perhaps most commonly, neurodivergence was described as a different, alternative, or expansive way of thinking. As one participant shared, "I definitely think differently than a lot of people, in that I'm usually 10 steps ahead." Another participant characterized their unique perspective as a dialectic element of ADHD thinking: "I know that ADHD people sometimes have a difficult time with black and white thinking. But I also think, in a lot of ways, we're willing to be more expansive." One participant positioned their thinking as not only different from others, but as "different from the way that [they're] expected to think." The contrast between neurodivergence and normative thinking patterns was echoed in another participant's conceptualization of neurodivergence as a "word [that] means being wired to think outside-the-box. In a way that society maybe hasn't deemed socially acceptable or profitable." In one interview, a participant criticized the larger validity and usefulness of the dichotomy of neurodivergent and neurotypical:

> I'm waiting for the day where neurodiverse and neurotypical aren't even words that we need to have. Because that's another binary! Why are we creating another 'this or that'? We know that autism is a spectrum. Neurodiversity in general is probably a spectrum. That's the thing with the: Do I have autism? Do I not? Am I just ADHD? I don't think that that is even really a question that we should be asking.

Participants also expressed a dynamic tension between the challenges of living in a neuronormative culture and their appreciation for the unique abilities that

neurodivergence affords them. Many participants described a multifaceted vision of neurodivergent identity. One participant articulated a particularly stark contrast between the ways in which they have been marginalized as a neurodivergent person and their own appreciation for their neurodivergence. As they explained, neurodivergence contributed to their "delayed social development" and made them vulnerable to being "taken advantage of…as well as emotionally, physically, and sexually abused." Yet, as they went on to share: "on the other hand, more than anything, I love the way I think. I am very smart and intelligent and creative and clever, and I have a lot of things that I am passionate and interested in and I am a deeply loving and caring person."

Others, particularly those who were assigned a diagnosis as children, articulated an evolving conceptualization of their neurodivergence. As one participant described, their perspective on bipolar disorder shifted from viewing it as something "negative or a problem" to identifying the ways in which they "can work with neurodivergence" and understand it as "a gift." Another reflected a similar journey, stating that:

> When I was young, I didn't totally understand it. I resented it a lot. It felt like a burden. As I've gotten older, I've learned to…accept who I am and what my limitations are. But also understand my strengths from it and…those things that it naturally makes me a little better at.

As one participant identified, the challenges of being neurodivergent stem from the fact that "our world is not set up for neurodiverse folks." Despite these difficulties, they shared that they have come to "love the fact that [they're] neurodiverse," in part because

of how neurodivergence "makes [them] a better advocate, and a better activist and a better thinker."

Theme Two: Relationality & Identity Development

This theme explores relationality and identity development in two dimensions. First, the sub-theme of community as a catalyst for identity recognition is explored in terms of gender and neurodivergence. This sub-theme considers how relationships with other transgender and neurodivergent people contributed to participants' identity development. The second sub-theme speaks to the impact of social perception on participants' sense of the overall importance of gender and neurodivergent identities, as well as on neurodivergent and gender identity development and expression. In this sub-theme, relationality in the social environment is explored through considerations of how being perceived shapes self-concept and self-expression of gender and neurodivergence.

Community as a Catalyst for Gender Identity Recognition

While several participants described inklings of transness during childhood, all 13 participants situated the development of conscious awareness of their gender identity as occurring between adolescence and adulthood (approximately 15-32). For those that had experienced an evolution of transgender identity, these realizations typically occurred in young adulthood (early 20s). The majority of participants (n=11) described relationships with other queer and trans people as an important experience in developing their gender identity. These pivotal connections typically occurred during young adulthood and included intimate partners, friends, roommates, and connections made in online community spaces. As some participants described, relationships supported gender

identity recognition through creating opportunities to learn about trans experiences. For others, self-recognition occurred as an experiential process. One participant shared how an exploration of the meaning of a sexual relationship led to self-discovery, stating:

> For whatever reason, I found myself really, really attracted to this cis lesbian woman. And she was attracted to me. And we had really, really good chemistry. And I said: I'm so confused. You describe yourself as a lesbian…You've only ever been with cis women…How are we being physically intimate? And she goes: I don't see you as that. I see you as a woman. And that knocked me out. And now we're married…She really helped me figure that out.

Many participants shared that learning from other trans people about their experiences created an opportunity for self-recognition and self-acceptance. Specifically, several participants detailed accepting their own identities through interactions with friends or other community members with similar identities. One participant described messaging a friend after seeing their post on a blog about being non-binary. They stated: "And so they were telling me about their identity…and how you can exist in the middle, and I was like: Holy shit. I had no idea...So that's when I came out." Others described the importance of receiving support, validation, and affirmation from other trans people. As one participant shared, discussing their gender exploration with a trans friend gave them the "internal permission" to accept their trans identity. Another described how ongoing dialogue about gender with a roommate who was non-binary was "really helpful" for her in coming to understand her own gender identity.

Community as a Catalyst for Neurodivergent Identity Recognition

Participants were nearly equally split between those who had formal diagnoses and those who had self-diagnosed and/or identified with neurodivergence outside of the paradigm of diagnosis. Some self-diagnosed participants shared that they were seeking formal diagnosis and others expressed that they were not interested in receiving a diagnosis. Several participants had both formal diagnoses and diagnoses that were self-determined. Other participants did not have formal diagnoses but had other medicalized indicators of neurodivergence, such as a participant who took medication for ADHD symptoms without an ADHD diagnosis.

Participants who engaged in self-diagnosis and those who were diagnosed as adults described a process of self-recognition that was markedly similar to participant experiences with gender identity development. That is, many participants described a relational process of neurodivergent identity recognition. Relationships that facilitated recognition of neurodivergence included friendships, family, intimate partners, and online communities. For example, one participant's observations about a friend's autistic traits sparked a process of self-recognition. As they described, recognizing autistic aspects of their friend's behaviors allowed them to recognize these traits in themself. This realization inspired them to "research tons of information on autism." After finding an educational resource about autism with "over 200 traits listed," they described seeing themself in this document, stating: "this is all me."

Participants also described a sense that within the "last year or two" there has been an increase in representation of neurodivergent experiences in online spaces. This expansion of neurodivergent voices on social media platforms, particularly "Tik Tok and

Instagram" was found to be important for several participants' recognition of their own neurodivergence. For one participant "scrolling on Tik Tok" and seeing "relatable" posts from "people with ADHD" sparked their own journey to recognizing their neurodivergence. Another participant shared how increased representation has supported them in finding the language to describe their neurodivergence through "better understand[ing] exactly what these different terms mean." As they went on to share: "people just being really open and honest about their own experiences of neurodivergence…helped me to better understand where I'm at."

Several participants described a process of mutual self-recognition of neurodivergence and gender identity. For these participants, gender and neurodivergent identity development happened concurrently, informed by relationships with other queer/trans and neurodivergent people. As they described, it was a parallel process of internal realizations and external reflections that contributed to identity recognition. For example, one participant shared how their group of queer, trans, and autistic friends discovered their neurodivergent and trans identities "together." Further, they expressed a sense that without this group of friends, they wouldn't "have come to these conclusions as quickly." Another shared about their process of deconstructing the role that they "had unintentionally built up that was… [a] mask of a cis, female, neurotypical person." As this participant shared, when their "friend circle became more trans and autistic" it became easier for them to stop "being what [they] thought [they were] supposed to be…and start being what was naturally [them]."

Impacts of Social Perceptions on Gender Identity Importance & Expression

Gender identity was found to be of mixed significance to participants' overall sense of identity. Five participants described gender identity as intrinsically important to self-concept. Among these respondents, one participant expressed how her gender identity was a source of "pride." As she went on to share, "this part of my identity is everything to me. It's really present in everything I do." One participant described his gender identity as a "huge part" of his larger sense of self. For him, this importance was connected to experiences of social marginalization. As he described about being trans:

> People think that it's all that I am because I talk about it a lot. But I talk about it a lot because it's important. And if I could just walk in a place and get treated the same as everybody else, I wouldn't be talking about it so much.

A similar sentiment was expressed by a participant who connected the importance of gender identity to "acknowledging" how not being able to "express" her gender identity as a young person "affected" her ability to fully understand and embody an authentic self-hood. Finally, gender identity was also articulated as an important means to understand oneself, to be understood by others, and to be connected to "people who have had similar experiences."

Eight participants expressed ambivalence or neutrality about the importance of gender identity. Some participants expressed this through answers of uncertainty, such as one participant who responded: "I think it's both yes and no." Others gave qualifying answers, such as "It's important. But not overly important." This participant went on to explain that he does "want to be a visible and good role model for younger queers" but in his "day to day operations, it's not super high up there." This sense that gender identity

fluctuates in importance was evident in another interview. As this participant offered, “I feel like it's important in some ways, and kind of not in others. It's important because it affects the way that I move through the world. And I take a lot of joy in expressing my gender. But also, it's not my entire being.”

However, across both groups there was a shared sense that the importance of gender identity and expression was conditional. For many, this was communicated through descriptions of how gender identity was most important within social contexts. One participant described this balance, saying, “it's important to me in the sense that assumptions aren't made about my gender…when I'm alone, I don't think about it. But when I interact with someone else, or an organization, or entity, … it starts to matter to me.” A similar sense that identity is most important in relational settings was shared by a participant who expressed ambivalence about gender identity terminology. As they shared:

> Those identities that people are trying to understand, in my case, they feel like they're less for me, and more of a way for me to communicate to other people…I don't feel that [being] transgender is a super important part to my personal identity... It's just easier language for me to communicate with other people what my experience in the world is.

Another participant identified gender identity as important only because of societal “expectations” and the experience of holding a “marginalized identity.”

Several participants considered the role of social perception in gender expression and medicalized transition. These participants raised questions of how their own gender

expressions and motivations for seeking gender-affirming medical interventions may be informed by social dynamics. For one participant, "the perception that people have" informs his choices about gender expression and gender-affirming medical interventions. As he describes, if not for other peoples' perceptions, he "wouldn't feel the need to change anything about [himself]" and "probably wouldn't have ever started T[4]." He went on to pose the rhetorical question of whether his "gender identity depend[s] on other people perceiving" him. This response illuminates the tension experienced by a number of participants between their internal sense of gender and the ways in which expression and presentation are shaped by the experience of being perceived and interpreted by others. Other respondents articulated a sense of the importance of being aware of these dynamics and resisting externally imposed expectations of trans "authenticity." Two participants offered remarkably similar comments on the impact of perception on decisions about medical transition:

> There have been a lot of folks that I have really admired—younger folks than I, even—who are saying 'no' to medically transitioning…And saying: I don't care if I don't look like a typical woman or man. Or don't present androgynously as a non-binary person. Because I'm not doing it for you, I'm doing this for me. There's still so [many] preconceived notions of what quote unquote authentic trans experience is. And I think a lot of those feelings can be internalized for trans people. It's really interesting to consider: What are my motivations as far as this whole concept of transitioning? And are you doing it for yourself because you'll

[4] Here, 'T' refers to the use of testosterone hormones.

feel more comfortable? Are you doing it for other people so that you'll maybe be perceived in a…way that you want to be perceived?

Impacts of Social Perceptions on Neurodivergent Identity Recognition & Expression

Participants also explored how social narratives surrounding neurodivergence and neurotypicality impact diagnosis, self-recognition, and self-expression. Several participants discussed how pervasive stereotypes about gender, race, and class impact access to diagnosis. One particularly salient issue among participants who were assigned-female-at-birth [AFAB] was provider misrecognition of autism and ADHD. As one participant described, in his experiences with clinical diagnosis, "autism wasn't even on the table." After engaging in his own research process, he has come to believe that "autistic AFAB people get misdiagnosed with BPD [borderline personality disorder] all the time." For him, lack of access to diagnosis caused "a lot of years of confusion" and he felt that he would have been "able to understand [him]self a lot better if…[he] had been tested for it [sooner]." In a similar story, a participant described being "diagnosed with anxiety, depression, borderline personality disorder, bipolar type two" before providers recognized their ADHD. This participant also described a process of self-education. They described their sense that "female socialized people, or girls and women, end up not getting diagnosed or getting misdiagnosed because of a difference in the internalizing of the symptoms of ADHD." Another participant who identifies as autistic and having ADHD, described their childhood experience of receiving a conduct disorder diagnosis. They attributed their socioeconomic class and experiences growing up in an urban environment as factors in their early diagnosis of a conduct disorder rather than autism

and ADHD: “I also went to school in the [city] school district. So, I think a lot of the therapists in that area just kind of were like: Oh, this is a problem kid. Let's write that down.”

For some participants, stereotypes surrounding diagnoses also impacted their own ability to recognize their neurodivergence. Gender, age, and social behavior were found to be particularly relevant factors that inhibited self-recognition. As one participant described, “I didn't know that I could be autistic [because] I had seen the stereotypes of white dudes with autism.” For one participant, gendered ideas about ADHD coalesced with associations with school age children: “I feel like I’ve always had this idea that ADHD is something that little kids have…I always had this idea of this specific, super hyper-active little boy who can't sit still.” Another participant described how stereotypes of autistic people as asocial challenged their ability to believe their autism diagnosis. He described experiencing “a lot of denial at first” and a sense that he was “not autistic” because he was “too much of a social butterfly” and is able to “make eye contact.”

Participants also considered how social stereotypes about neurodivergence and the resultant barriers to diagnosis contribute to their ability to claim a neurodivergent identity. For one participant, the challenges of accessing “official diagnosis” as someone who does not “fit the archetype” of an autistic person creates a sense of “imposter syndrome.” Despite personally identifying as autistic, the fact that they do not hold a medically sanctioned diagnosis has caused them “hesitation to claim it publicly.” Another participant framed this discussion in terms of “authenticity.” As they explain, within discourse surrounding neurodivergent identity, authenticity is sometimes determined by

whether individuals "choose to seek out a medical diagnosis" or "use prescriptions." Noting that while "some people do not have a choice in those things," tension exists around who is able to be "seen as a valid neurodivergent person" and who is able to "claim those identities."

Several participants explored the phenomenon of 'masking'[5]. In discussions of masking, participants revealed how able-mindedness in the social environment shapes the extent to which they are able to express their neurodivergence. Several participants emphasized the experience of not understanding or relating to the unspoken social "expectations and cultural norms," yet needing to "pretend to know what's going on" in order to fit into the dominant neurotypical culture. One participant described the tension between the desire to appear as if they understand normative social dynamics with the need to engage in "constant advocacy" in order to be fully included in social spaces. Another participant described how "stigma" informs the pressure for her to be "seen as okay." For one autistic participant, the expectation of masking in professional settings was particularly emotionally taxing and impacted his ability to engage in self-care. As he explained:

> Sometimes talking is too much…Talking sounds like knives in my mouth...And when I'm working, I can't really do that. I can't decide not to talk to a customer... So, in those situations, I'm already overwhelmed…But, yet, I still have to keep going… I still got six more hours in the day. And then I got to go home and talk

[5] Masking or camouflaging refers to when autistic (or otherwise neurodivergent) individuals attempt to obscure expression of neurodivergent traits in order to pass as neurotypical, for reasons of safety or social acceptance (Cage & Whitman, 2019).

> to my boyfriend about my day or whatever. And I don't want to blow him off... And then what do I got to do? Laundry? I can't do it. Taxes? No. I can't check my banking. No, none of this can happen. For days. For weeks even. Because I'm so spent. I'm spending all my time being masked, trying to pretend that I'm neurotypical in front of these people that I can't do the things in my life that I need to do. It's exhausting.

Theme Three: Connections Between Gender and Neurodivergence

A primary finding of the study is the prevalence of connections drawn between gender and neurodivergence. All 13 participants articulated some relationship between their experiences of neurodivergence and gender. However, the nature and significance of these connections varied across interviews. Participant connections are summarized in three sub-themes. First, several participants identified commonalities in experiences of marginalization between trans and neurodivergent identities. Second, the majority of participants theorized their neurodivergence as affording them a more expansive understanding of gender. Third, some participants described gender and neurodivergence as mutually informed aspects of their personhood. Additionally, many participants endorsed connections that fit into multiple themes, as conceptualizations of gender and neurodivergence were nuanced and most could not be singularly categorized. Finally, it is important to note that, for some participants, connections were difficult to describe and intuitively felt, thus these responses could not be organized into one of the following categories. This category of responses will be further discussed in the limitations section.

Commonalities of Marginalization and Otherness

Several participants drew connections between their gender and neurodivergence as marginalized identities. As one participant described, their experience of social othering as a child was connected to both their gender expression and neurodivergence. This experience of mutual marginalization created a lasting internal connection between gender and neurodivergence for many participants. They summarized it this way:

> In relationships, this is where I think maybe gender identity and neurodivergence crossed over a lot. When I was younger, especially, I really struggled socially. I didn't look the same, I didn't talk the same, I didn't behave the same as a lot of my peers. And so when I was young, I never really felt like I fit in or had a good, comfortable space. I often felt tolerated, but not well understood.

Another participant who was recently diagnosed with autism, articulated how experiences with marginalization as a trans person inform his understanding of neurodivergence: "My neurodivergence is kind of an othering thing…So, in that way, I understand that from being trans. I understand that being autistic is going to other me." One participant drew connections between the phenomena of 'masking' and being 'in the closet.' For him, neurodivergent and trans identities are experienced as connected sites of stigma. As he describes, rejection of the internalized stigma of both identities was necessary in order to become his full self:

> I am familiar with the parallels and the connections between gender identity and neurodivergence... I do kind of see it connected in my own sense. Because I was in the closet for so long and I was masking for so long… So I think that is where I

saw some crossovers. Where it was a really long time, where I was just not myself.

Other participants connected neurodivergence and transness through a shared orientation away from normativity. These participants articulated how prior experiences of "living outside the norm" allowed them to embrace additional non-normative identities. From this perspective, neurodivergence as a non-normative identity/experience facilitates the internal capacity to liberate oneself from rigid and binary gender expectations. As one person shared:

> You have to kind of do away with society's expectations, because you realize, like: I'm never going to be this thing. And so it kind of gives you a freedom to be whatever you want. And if you're thinking about the world in that sort of view, it makes sense to me that you could feel more free in your gender to express it as you wish and lean into the fact that you think a little differently and that's perfectly okay.

Two participants described connections between transgender identity and neurodivergence through experiences of mutual pathologization. For these participants, the relationship between identities is forged, in part, through social invalidation. This double jeopardy created a fear of living publicly as both a trans and neurodivergent person. As one participant articulated:

> Where I would describe myself as a trans man, I wouldn't necessarily say to someone: I'm an autistic trans man. I wouldn't really present myself with that because I'm afraid. People already see me as a certain type of way when I say that

> I'm trans. And I don't want them to see me as like: 'You're only trans because you're autistic. You just don't know what you're talking about.' I don't want to invalidate my gender...I don't need any more invalidation in my life.

Expansive Perspective Contributes to Expansive Genders

Twelve of the thirteen participants articulated a relationship between the unique perspective afforded to them by neurodivergence and their understanding and/or experience of gender. Many participants theorized that because of their ability to think in expansive and non-normative ways, they were better able to reject cis- and heteronormativity. As one participant succinctly shared, "I think if our brains are expansive, of course, our gender will be too." This sentiment was echoed across several interviews. One participant described neurodivergence in terms of "creativity" and "ability to make…out-there, wild connections." For them, this expansive perspective "affected [their] gender" through the ability "to make a lot of loose connections come together." Another participant drew a connection between neurodivergent thinking and their relationships to gender as a concept, in addition to their personal experience of gender. As they theorized, "because neurodivergent people's brains just kind of work in a different way… it makes a lot of sense that we would also have a very different way of viewing and interacting and understanding gender."

For others, the connection was based specifically in the ways in which neurodivergent perspectives may be at odds with normative social concepts. As one participant offered, "there's a weird thing with socially constructed norms, social constructs in general, that often neurodiverse people don't understand. And gender being

one of those." For this participant, "transness, gender vagueness, gender queerness" are "linked to that questioning or disconnect from the social constructs." In this sense, a connection between transness and neurodivergence is forged through a mutual rejection of normativity. Another participant echoed this sentiment through characterizing neurodivergent people as better able to "recognize the queerness within us" and resist "compulsive heteronormativity."

Gender and Neurodivergence as Intersecting Processes of Embodiment

Participants also elucidated understandings of gender and neurodivergence as interconnected parts of their larger sense of self. These participants theorized gender and neurodivergence as co-created and mutually informing aspects of identity. Some of the same participants who connected the expansive perspective afforded to them by their neurodivergence to their gender identity and understanding of gender, also described this type of intersecting process. Yet for some participants, it was impossible to situate either neurodivergence or gender identity as happening 'first' in the development of self. As one participant shared, "A lot of the realizations I formed [about gender and neurodivergence] happened at about the same time. It's sort of like the chicken and the egg conversation." This sense of simultaneous development was common across several interviews. Some participants drew connections between their "coming out process" and their "unmasking process." Further, for one participant, the word 'unmask' was applicable to not only their neurodivergence, but to their gender identity as well. As they stated, "as I unmasked my gender, I realized that I was neurodiverse or autistic…As one gender layer has unraveled, I feel like neurodiverse layers unravel as well." Another

participant described a sense that neurodivergence and transness were inseparable and indistinguishable parts of their selfhood. “I think for me gender identity and being neurodivergent are kind of intertwined in the way that I’ve always experienced them as kind of the same thing…Both…are big parts of myself and make up who I am…as a person.” In one participant’s exploration of this intersecting process, they addressed the oft asked question of what ‘causes’ neurodivergence and trans experiences. As they explain, these identities are interdependent aspects of the whole of their bodymind:

> I think my ability to live in those gray areas, and my joy of being in them is kind of what leads me to be genderqueer. Or something along those lines, where there is no cause, there is no effect. And I'm not a cause and effect…I have heard the question a lot of what makes someone transgender? Or what makes someone neurodivergent? Are you born with it? Do you become this? Is it genetic? And for one, there is no one cause and I don't think there needs to be a cause. My being neurodivergent doesn't come before me being transgender and being genderfluid. It doesn't cause that... It's more just, they happen concurrently. Because within the ecosystem of my body, they have to. One can't survive without the other…They grew up together.

Theme Four: Diverse Experiences within LGBTQ+ Community

Experiences as neurodivergent people within the larger LGBTQ+ community were highly varied among participants. Overall, participants expressed both affirming and exclusionary experiences within the community. This section presents experiences within the broader community through two sub-themes. First, experiences within the LGBTQ+

community are presented including both experiences of acceptance and exclusion. Then, participants' sense of the overlap between LGBTQ+ and neurodivergent communities is shared.

Experiences within LGBTQ Community

At least some experiences of inclusion within the broader LGBTQ+ community were common across nearly all interviews (n=12). Those that described experiencing acceptance often emphasized the ways in which LGBTQ+ community contributed to feeling safe, affirmed, and understood in regard to their gender identity and sexual orientation. As one participant explained, "anytime I found queer community, I felt so much more at home…I definitely feel like I need to be in queer community in order to thrive. Because nobody else is going to understand my being better than another queer person." This sentiment was mirrored across several other interviews. Other participants highlighted the importance of being able to access mutual aid through LGBTQ+ community. For some, this was particularly salient in regard to accessing gender-affirming care. One participant described how "building community" with other trans people "who have been navigating the healthcare system" has allowed them to find "recommendations for PCPs and different health services that have been extremely helpful." As they went on to note, "I feel like so much of receiving affirming and quality care is just by word of mouth." One participant described how an LGBTQ+ affinity space at his university supported him in escaping an abusive and transphobic family situation:

> So, the LGBT Club president, she concocted this whole thing. She and her friend. As soon as I got dropped off at the front entrance, he pulled up at the back

> entrance. We all got in his car. He drove to my dad's place where I had a key. I got in and loaded up all my shit, left a note, left his key, and dipped.

Participants also described the ways in which LGBTQ+ community may be exclusionary to neurodivergent and otherwise marginalized populations. Most participants described experiences of both acceptance and exclusion within the broader community, with only one participant sharing only experiences of exclusion. Social dynamics explored by participants included intra-community identity policing and social rejection. As one participant articulated, despite holding non-normative sexual and gender identities, "queer community itself [is] very White, cis-centered." They went on to explain how "folks with disabilities, neurodivergent and otherwise" are "marginalized by a lot of the community." Other participants also described a sense of intra-community marginalization of trans and/or disabled identities. Among these, some described how the compounding effects of able-mindedness and transphobia result in identity policing. As one participant shared: "I think there are a lot of neurotypical queer and trans folks that end up kind of gatekeeping the way that people exist in their queerness. Especially for folks that are more outside of the binary…in their presentation." One participant described in particularly vivid detail how their experiences within queer community as a neurodivergent person have been harmful and invalidating:

> I have not felt welcome as a neurodivergent person in queer-specific spaces…A lot of queer people I've talked to in those spaces have been very grateful for those spaces and feel like they've "found their people," where I have been left feeling more alone, and in one disastrous incident, felt so othered that I left feeling like I

> wasn't actually trans at all… I think that those spaces serve a purpose…and there's nothing wrong with their existence...But they aren't my spaces. I think inclusivity is important, but I almost wish that there was a clear separation between neurotypical and neurodivergent gatherings, only because the hope of going to these events and spaces and finding out you're the weird one, is totally heartbreaking and painful for me.

Overlap between LGBTQ Community & Neurodivergent Community

Several participants who described feeling accepted within the broader LGBTQ+ community also articulated a sense that neurodivergence is well-represented and understood within their communities. These participants typically described a sense that their queer and trans communities were highly neurodivergent. As one participant described his university LGBT affinity group, "I don't think there was a neurotypical soul in that club." Among those who had at least some experiences of exclusion within the broader community, most articulated a sense that being in community with other trans and neurodivergent people represented the greatest opportunity for acceptance and inclusion. As one participant shared "I don't think I have any close friends that are just queer or just neurodivergent. All the people that I get along with and who are 'my people' are queer and neurodivergent, specifically trans and neurodivergent." This sense of belonging among trans and neurodivergent communities was echoed in other interviews. As one participant shared about their experience working with other trans and neurodivergent people, "that has made me feel so welcomed. They are so forgiving. And they realize that we think differently. And they're also much more honest, and much more

upfront and transparent." Some participants who had experienced an overlap between LGBTQ+ and neurodivergent communities also noted the ways in which personal experiences of marginalization can contribute to greater "acceptance" of others.

Theme Five: Experiences Within the Healthcare System

Participants were asked about their experiences accessing medical and mental healthcare including gender-affirming care. Within this theme, three sub-themes emerged. First, participants described minimal experiences of discrimination or denial of gender affirming care that was based on assumptions about neurodivergence. Second, transphobia was found to be pervasive across healthcare settings. Third, participants' recommendations for providers are considered.

Minimal Experiences of Ableist Discrimination or Denial of Gender-Affirming Care

Across all 13 interviews, none of the participants reported experiencing invalidation or lack of acceptance of their gender identity based on assumptions about their neurodivergence by mental health or medical providers. Further, none of the participants indicated that they had experienced denial of gender-affirming care based on assumptions about their neurodivergence.

However, it is important to note that several participants expressed caveats to their experiences. Some participants attributed the fact they had not experienced discrimination or denial of care to the fact that they had not pursued gender-affirming care. As one participant explained, "I haven't sought out any sort of thing like that. So that was not an issue I faced." Yet, these participants were aware of this phenomenon and had considered the personal and community-wide implications of able-mindedness within

the healthcare system. As one participant shared, “Being neurodivergent and having mental illness as well, I have considered whether I would experience denial of gender affirming care.” Another participant, who had not personally experienced this phenomenon, nevertheless expressed a meaningful critique of medical and mental health practitioner assumptions about neurodivergence and trans identities:

> I've definitely read similar stuff. Not seeing neurodivergent people as capable of knowing that about themselves. Which I find interesting, because it's like: Well, what about neurodivergent people who are just saying that they're cis? Can we trust them to know that they’re cis? How do we know? What if they’re wrong?

Some participants felt that the reason they had not experienced able-mindedness in gender-affirming medical or mental healthcare was because their neurodivergence was not known to providers. As one participant shared, “I haven't really [sought] out professional medical care connected to my neurodivergence. So, I think that is an easy way to avoid that.” A similar sentiment was echoed by another participant who had not faced “discrimination based off perceived or known diagnosis.” However, he placed a greater emphasis on provider perceptions of neurotypicality rather than diagnosis-based assumptions. He attributed the fact that he had not experienced discrimination or denial of care to the fact that he does not “come off to most people as someone who is neurodivergent.” As he went on to explain, this assumption is based on stereotypes, as “there is a perception of what ADHD looks like [and] I don't fit the bill in a very typical way that people are used to seeing.” Despite not reporting experiences of discrimination or denial of gender-affirming care, one participant did recount an experience of a mental

health professional assuming that their trans identity was a "symptom" of their neurodivergence. Their story, a piece of which is shared here, represented one of the most profound incidents of transphobia and able-mindedness shared across all interviews:

> At [the] inpatient [program], there was this one guy...He always approached me in groups and would only call me by my dead name[6], and then say 'the transexual.' And I would correct him and he would just go: 'Mhm, mhm, yup.' And ask really upsetting questions like: 'Are you pre-op or post-op and what makes you think you're a transexual?' And he just made me feel like a case study and not a human at all. I feel like he assumed because of my many mental health diagnoses, that me being trans was just a symptom of them.

Rampant Transphobia Across Healthcare Settings

Experiences of transphobia in a diversity of healthcare settings as well as in interactions with health insurance systems were prevalent across many interviews. Every participant shared at least one experience of how transphobia impacted their experiences with medical, mental health, or gender-affirming care. Several participants expressed that they did not feel comfortable or safe disclosing their gender identity to medical providers. For many of these participants, the risk of a harmful response from the provider was not worth the emotional energy required to explain their identity. As one participant described, "I personally don't advocate for myself, where I tell my healthcare providers my gender unless they ask me. I personally do it because I don't feel like teaching." This sentiment was echoed by other participants, including one who noted that her fear was

[6] Dead name refers to a name given at birth that a trans person no longer uses (Chiu, 2018).

based on the fact that providers "hold the power…[to] withhold care." Several participants articulated experiences of explicit disregard, discrimination, and traumatization in medical settings. For one participant, the "little things," such as her doctor's "insit[ance] on writing 'genetic male' in after-visit notes," added up to a larger feeling of being disrespected. Another participant described an experience of being outright "refused care" by a "primary care doctor." As they explained, the provider denied them care on the grounds that he did not "know how to treat a transgender person" and was not "willing to learn."

Participants also described transphobic interactions in inpatient and outpatient therapeutic settings as well as with psychiatrists. For many, experiences of transphobia persisted despite their best efforts at self-advocacy. As one participant described about seeing a therapist, "despite being very clear at the beginning of the session that I used she/her pronouns…I was met with consistent misgendering." Another participant shared their experiences of disclosing their gender identity in an in-patient psychiatric setting. For them, their disclosure "was mostly ignored, except for official procedures." Despite sharing their identity with staff members, "no one asked [their] pronouns or recognized that [they were] trans." Instead, they were "always called she/her by the nurses and the staff, and everyone was under the assumption that [they] were a girl." Notably, among the participants who had experienced affirming mental healthcare, half of all positive experiences were attributed to working with a queer or trans therapist or one affiliated with a gender care clinic.

Finally, participants described encounters with transphobia while navigating health insurance systems. For one participant, this included an expectation from his insurance company that his medical transition process would follow a prescribed course of interventions. While seeking top surgery[7], he found that his insurance would not cover the procedure because he was "not on testosterone at the time." As he described, insurance requirements for coverage of gender-affirming care are based on predetermined "little square boxes," instead of respecting the diversity of transition experiences. He therefore had to "jump through a few hoops" to prove the validity of his identity and his choices about medical transition. Another participant who had experienced barriers to insurance coverage of gender-affirming care identified the ways in which navigating health insurance systems can be particularly arduous for trans and neurodivergent people. As they shared, after being denied coverage by a "blanket exclusion on transgender health care" in their workplace policy, it took them nearly a year of legal battles in order to "even come close to whole and making it right." They further explained how while this process would be challenging for anyone, for neurodivergent and trans people, it is particularly inaccessible:

> When you are seeking gender-affirming care, there's a lot of hoops to jump through. And it takes a person who can really be organized and speak well and present legal language, in a kind of emotionless way. And that's hard for most people, period. And as a neurodivergent person, it can be even harder because it

[7] Top surgery refers to a gender-affirming surgical procedure designed to remove breast tissue and flatten the shape and appearance of the chest (University of California San Francisco Gender Affirming Health Program, 2019).

> takes a lot of skills to do that...For somebody to present that case to either a doctor or a lawyer and all the people and resources that you have to touch in order to get certain gender-affirming care…And if you're neurodivergent and have trouble expressing yourself clearly, either in writing or in words, it seems insurmountable.

Participant Recommendations for Practice

All participants were asked what they would like medical and mental healthcare professionals to understand about their experiences as transgender and neurodivergent people. This question, in addition to questions about experiences accessing care, elicited frustration from many participants at the injustices they had experienced in healthcare settings. When asked about whether she had experienced competent and affirming care, one participant responded with a comment about the implications of the question and the fact that it needed to be asked of participants. As she explained, the "competence" of a provider for cisgender and neurotypical people would be assumed. Yet, trans and neurodivergent people are expected to be met with a lack of understanding. As she asked: "Why is the bar so low?" Another participant described frustration at coming across therapists who falsely "advertise that [they] are LGBTQ-friendly or neurodiverse-friendly," when they have not received adequate training for serving these populations. One participant expressed the magnitude of impact that these injustices have on trans people, stating that when people are denied "access to appropriate care, it is disabling, debilitating, and life-threatening."

In addition to themes of disappointment with inequities in care, participant responses reflected two primary ideas. First, several participants emphasized the importance of providers recognizing the validity of identity and listening to patients/clients. One participant expressed the importance of practitioners recognizing them as the expert on their own neurodivergence. As they shared, “at the end of the day, I know more about my brain than they do after a 30-minute meeting.” Another participant emphasized a similar sentiment, stating that a critical aspect of affirming care is for providers to “take people's lived experiences as valid ways of identifying.” For one participant, providers' ability to understand them as a “whole person” included “affirming [their] gender identity and neurodivergence.” They went on to draw a connection between affirming care and accurate diagnosis, stating:

> I find when a practitioner gets to know me before the diagnosis, they are easily able to correctly diagnose me, because their willingness to want to know about me as a person and the time they take with me allows me to trust them more and reveal more of myself to them.

Aspects of this sentiment was echoed in another interview, in which a participant shared their belief that “the diagnosis process for adults is in need of updating. And it needs to reflect lived experience.” Several participants also addressed the need for providers to listen and learn about gender from transgender and neurodivergent people. As one participant explained, if providers could “try to understand it on those terms…then maybe they'd be able to better help us.” Another shared that “a lot of it comes down to just listening and understanding.”

The second primary idea that participants emphasized was the importance of providers seeking further information about transgender and neurodivergent experiences without asking patient/clients to act as the educator. This was one of the most common categories of responses across all participants. One participant's comments eloquently bridged these two themes, when they stated that providers need to "listen and do the additional research." One participant noted that he does not need providers to "fully understand" his identities. Rather, he would prefer that they "take the time to…get educated," perhaps by doing "research and read[ing] some good books written by trans people or…neurodiverse people." Two participants emphasized the importance of providers having accurate language to describe transgender and neurodivergent identities. One described the importance of language in terms of "knowing what to ask, or how to ask it, or what they're looking for." Another gave an example of how outdated diagnosis terminology or ableist language impacts their relationships to providers:

> I get really nervous when I see on people's Psychology Today bio that they work with people who have Asperger's, but they don't list anything about ASD [autism spectrum disorder]...I know some people don't even know yet that it is an outdated term... But, it's always kind of a red flag to me when that is said...Or using functioning labels…It makes me want to not share so much about myself. It doesn't feel like a safe place to be.

Finally, several participants shared the importance of not having to explain their identities and experiences to providers. As previously discussed, the burden of serving as educator in healthcare settings was found to decrease the likelihood that participants felt

comfortable sharing their gender identities and neurodivergence. One participant succinctly emphasized the implicit injustice in this phenomenon, stating:

> I'm not saying, cis people and…neurotypical people can't serve neurodivergent and queer people. But they really have to understand that we have specific needs. And we are not here to teach you, we're coming to you because we need support... Being [the] educator…that's not what we're here for.

Chapter 5: Discussion

Introduction

This chapter addresses the study's two primary research questions by interpreting the findings presented in the previous chapter. The discussion portion of this paper represents the fifth stage in the hermeneutic circle when the themes are further explored and final interpretations of the data are presented (Alsaigh & Coyne, 2021). In the language of hermeneutic phenomenology, this chapter represents the "fusion of horizons" between the participants and researcher (Alsaigh & Coyne, 2021, p. 6). That is, this discussion encompasses both the perspectives of the participants and the positionality and prior knowledge of the researcher and integrates these two horizons into one interpretation. This section will first address each of the five themes considered in the findings section, including nine of the sub-themes. The tenth sub-theme of participant recommendations for providers will be considered in the implications for practice section. Throughout this chapter, findings are interpreted and contextualized within the body of prior scholarship on this intersection of identities. Implications for social work practice are then presented in three themes. Finally, the limitations of study are presented and directions for future research are offered.

Fluid and Expansive Identities

Participants articulated gender and neurodivergent identities that were highly nuanced and thoroughly explored. In regard to both identities, participants offered expansive visions of historically narrow concepts, shared experiences of identity evolution, and described fluid relationships to identity through the use of multiple terms and explanatory schemas.

Gender Identity

Prior research on this intersection of identities has found that LGBTQ+ neurodivergent youth may have an "aversion to categorization" around identity and that normative conceptualizations of gender may not be able to capture the richness of queer/trans and neurodivergent experiences (Oswald et al., 2021, p. 8). Additionally, trans and neurodivergent youth have been found to hold expansive, non-binary, and shifting gender identities (Strang et al., 2018). In a study of neuroqueer blog communities, Egner (2019) found that adult LGBTQ+ and neurodivergent adults also expressed a rejection of "identity-based categorization" (p. 135). These insights are reflected and further substantiated in the present study's findings about participants' gender identity and relationship to gender as a concept. Participant gender identities and broader understandings of gender were found to be non-binary, fluid, and not easily contained by existent language. As in prior studies, some participants questioned or rejected normative gender identity language, such as the participant who remarked that "all these labels probably fit [non-binary, gender fluid genderqueer] but…also none of them at the same time." Participant gender expression was also found to be expansive.

Participants articulated experiences of gender that were spacious enough to include trans men who "dress like women all the time…wear[ing] skirts and dresses, makeup and lashes, and nails and wigs" and trans femmes who reject the prescriptions of passing in favor of a non-binary gender identity and "androgynous" gender expression.

Similarities to Oswald et al. (2021) and Egner's (2019) findings were also reflected in participants' understandings of gender as a concept. As one participant described, their gender is "non-binary or queer, as in…leaving that male to female spectrum. And… going off on a…Y axis." This conceptualization of gender on an entirely different plane than that of diametrically opposed categories of masculinity and femininity was resonant with other participants. Others critiqued the entire existence of gender as a concept, questioning its usefulness as a descriptor of human beings.

Participants' descriptions of gender evolution across the life course represents a novel finding of this study. As discussed in the literature review, few studies have considered trans and neurodivergent individuals' experiences and understandings of gender and gender identity. However, the existent few have focused more on current relationships to gender identity and less on identity development and evolution (Egner, 2019; Oswald et al., 2021) or about youth short-term gender identity trajectories (Strang et al., 2018). While it remains unknown to what extent this finding is generalizable to larger trans or trans and neurodivergent populations, it nevertheless contributes a new facet of understanding to previous literature on the fluidity of gender among trans and neurodivergent people.

This study found that several participants described experiences of gender evolution toward (gender)queerness. For many this process involved initially connecting to binary trans identities and later recognizing non-binary or genderfluid identities. These transformations were not always linear. Rather, they often involved "unraveling layers" of gender and queerness and circling back to earlier parts of their identity that were initially cast off in favor of binary trans identities. For example, one participant who identifies as a non-binary trans man recalled an experience as a teen in which they Google searched "gay man trapped in a woman's body." While the results of this search were disappointing, he has since found creative ways to come home to this early inkling through "leaning into the feminine…and queer aspects of [his] gender." Movingly, participants often expressed joy in experiencing gender transformation, such as the participant who articulated the "beautiful alchemy you get to experience as a transgender person."

Neurodivergent Identity

Few prior studies have considered neurodivergent identity construction, in general or among LGBTQ+ people. This literature review found only one article that conducted original research on LGBTQ+ individuals' conceptualizations of neurodivergent identity. Egner's (2019) study of neuroqueer blog communities found that members rejected understandings of neurodivergence that are rooted in "medicalized conceptions of pathology" (p. 141). The present study offers some contradictory data to Egner's (2019) findings. Participant conceptualizations of neurodivergence ranged from those situated within what one participant called the "Western medical lens," to an understanding of

neurodivergence as something that another theorized as describing "consciousness." While some participants were more oriented in one direction or the other, all employed both pathology paradigm language and neurodiversity paradigm language. Further, participants often moved fluidly between the two paradigms, according to the demands of their responses. Participant descriptions of neurodivergence also varied depending on diagnosis. For example, participants who had experienced depression were more likely to characterize their neurodivergence in terms of "sickness" and use person-first (rather than identity-first) language, compared to other participants. Some of the participants with diagnoses of bipolar disorder and obsessive-compulsive disorder described these experiences as "mental illness," while referring to their respective autism and ADHD as "neurodivergence." However, these participants still self-identified broadly as neurodivergent and often did use "neurodivergence" to encapsulate all their experiences.

While participant motivations for language use cannot be understood definitively, two potential explanatory theories are offered. First, these participants' use of pathology paradigm language may be related to the fact that intra-community discourse has only just begun to include experiences historically categorized as 'mental illnesses' under the umbrella of neurodivergence (Wise, 2021). That is, they may have less familiarity with neurodiversity paradigm language because they have not been represented in that category. Another potential explanation relates specifically to participants who had experienced depression or OCD. It is possible that these participants' use of pathology paradigm language reflects a belief that the social and emotional challenges of depression or OCD outweigh the potential benefits of this experience to contribute to their individual

perspective. This explanatory theory is informed by Tumlin's (2019) concept of traits that are "not core to personhood" (p. 11). That is, perhaps participants who experience depression or OCD do not view these experiences as intrinsic to who they are. Whereas autistic participants or those with ADHD primarily understood their neurodivergence as intrinsic to their larger selfhood. In fact, none of the autistic participants or those with ADHD reported a desire to change or eliminate their neurodivergence. This study's findings about neurodivergent identity construction among autistic participants and those with ADHD are more reflective of Egner's (2019) scholarship. As Egner (2019) found among neuroqueer bloggers, "medical model discourses of cure" represented a "central point of marginalization" (p. 141). These findings suggest that neurodivergent identity construction may be related to both differences in internal experiences (depression or OCD vs. autism) and external perceptions (inclusion within neurodivergent community). As the neurodivergent umbrella grows to encompass a greater diversity of bodyminds, it remains to be seen if evolution in cultural discourse may inform identity construction among those whose experiences are outside of those traditionally understood as neurodivergent.

Participants' use of paradigmatic fluidity can also be understood as indicative of a creativity in neurodivergent identity construction that is similar to that of gender identity. This creativity occurred despite profound limitations in language. While this was not unlike what participants expressed about the constraints of gender identity terminology, it seems that available language for neurodivergence is even less descriptive and imposes more barriers to expression. Pathology paradigm language remains pervasive (Walker &

Raymaker, 2020) and for most participants they had only recently become familiar with the language of the neurodiversity paradigm. Where participants were able to access a multitude of identity terms related to gender identity, they were limited to either diagnostic language or to the singular word "neurodivergent," or as some participants preferred, "neurodiverse." To illustrate the contrast, the reader is invited to imagine the richness of identity construction that would be lost if participants could only describe their gender identity as cisgender, transgender, or having gender dysphoria[8]. Identity language around neurodivergence is gradually evolving, such as a proposed change to the category of ADHD that would eliminate the words 'deficit and disorder' and replace it with "Kinetic Cognitive Style" (Walker & Raymaker, 2020). In the meantime, participants engaged in creative forms of resistance to neuronormativity through weaving together the language of both paradigms to suit their needs in the process of identity construction.

In addition to a multifaceted use of language, participants also articulated neurodivergent identities that were expansive enough to hold multiple truths. Despite describing both individual challenges and challenges related to living in a neuronormative culture, many participants expressed an appreciation for their neurodivergence. This appreciation can be understood as a site of resistance to the systemic able-mindedness faced by participants and exposure to social narratives and, as one participant described, "conditioning [that] neurodivergence is wrong." Participants

[8] Gender dysphoria is the DSM-5 diagnosis describing "clinically significant distress or impairment related to a strong desire to be of another gender, which may include desire to change primary and/or secondary sex characteristics" (American Psychiatric Association, 2022).

also offered understandings of neurodivergence that were dialectic and non-dualistic. Several participants pointed to the fact that neurodivergent people may both demonstrate "black and white thinking," *and* engage in "creative," "expansive," or "outside-the-box" cognitive processes. Other respondents called into question the validity of neurodivergent and neurotypical as categories. This deconstruction of the binary between neurodivergence and neurotypicality aligns with prior neuroqueer scholarship. Imagining a neuroqueer future, Walker & Raymaker (2020) write, "in such a society there would be no such thing as neurotypicality, no such thing as a 'normal mind'" (p. 5). Further, several participants constructed a bridge between their understandings of gender, sexual orientation, and neurodivergence. These participants theorized that in some ways queer and trans people are inherently neurodivergent. This concept of the queerness of neurodivergence directly reflects the neuroqueer supposition of a link between heteronormativity and neuronormativity, where "to queer one is inevitably to queer the other to some degree" (Walker & Raymaker, 2020, p. 5). This finding is notable as existing neuroqueer scholarship is primarily theoretical in nature. These responses suggest that neuroqueer orientations do resonate with some trans and neurodivergent individuals' experience and offer a helpful framework for scholars and practitioners seeking to understand this intersection of identities.

Relationality & Identity Development

Participants' identity development, expression, and sense of overall importance was found to be shaped in relation to others. Relationality was found to be important in two primary ways. First, for many participants, gender and neurodivergent identity

recognition occurred within the context of relationships. Second, social perceptions, including individual social interactions and social narratives, were found to inform participants' sense of identity importance, development, and expression.

Community as a Catalyst for Identity Recognition

Relationships with other queer, trans, and neurodivergent people were found to support participants' identity recognition and development. Relationships were inclusive of friendships, intimate partners, family members, and online communities. Among participants who had not been diagnosed as children, a similar process of relational self-recognition of neurodivergence was found across interviews. While online communities were brought up in discussion of gender identity development, they were most salient in participant narratives about recognizing their neurodivergence. The importance of online communities in creating space for neurodivergent identity development that is outside of the constraints of neuronormativity reflects existing literature on LGBTQ+ and neurodivergent experiences (Brown, 2016; Egner, 2019; Oswald et al., 2021). However, the full magnitude and implications of this phenomenon are currently unknown and represent an important direction for future research. For several participants, recognition of neurodivergence and gender identity occurred concurrently. This parallel process of recognition was not unique to neurodivergence, participants also connected their gender identity development to journeys with sobriety and with coming to identify as fat, among others. These findings suggest that the embodied nature of all these phenomena (gender, neurodivergence, substance use, and body size) may create a need for simultaneous recognition in order for any to be understood.

The importance of relationships in recognizing transness, queerness, and neurodivergence can be contextualized through the lens of queer phenomenology. As Ahmed (2006) writes, "objects that are near enough can be described as heterosexual objects" (p. 86). That is, cisness, heterosexuality, and neurotypicality are what is readily available in our culture. This reality is inscribed through centuries of repetition of hetero/cis/neuronormative culture. In this way, heterosexuality (and cisgenderness and neurotypicality) is then "produced as an effect of the repetition of a certain direction, which takes shape as the 'background'" (Ahmed, 2006, p. 88). In creating community with other trans, queer, and neurodivergent people, participants reorient themselves away from objects and spaces that have become so predetermined as not to be noticed, toward something else entirely. Connecting with other trans and neurodivergent people allowed participants to become oriented toward queer/divergent understandings of their bodyminds. Through these relationships, participants developed expansive understandings of self, other, and the larger social environment. And the a priori meaning of objects such as mind, body, and gender are reconfigured as something unfamiliar but intuitively understood and welcomed as home.

Impact of Social Perceptions on Identity & Expression

Social contexts and dynamics were also found to impact the importance of participants' gender identities within their overall self-concept. While the reported importance of gender varied across participants, the majority articulated a sense that gender identity and expression was most important in social settings. For some participants, this meant that gender identity *became* important in relation to the

possibility of being misgendered. That is, the experience of being perceived necessitated a more vigilant expression of gender, whether through embodied expression or communicating with others about gender identity and pronouns. For these participants, identity language and gender expression functions as a utilitarian means of communication, offering only an approximation of their full gendered experience. While transphobia and able-mindedness has been found to impact neurodivergent and trans individuals' ability to express their gender identity (Oswald et al., 2014; Strang et al., 2018), little has been written about how social dynamics that do not necessarily involve overt discrimination may impact gender expression. This finding and the lack of previous scholarship suggests the need for additional research about the impact of social interactions/perceptions on the importance of gender identity and choices related to gender expression for trans and neurodivergent populations.

Social perception was less relevant to the reported importance of neurodivergence, or the language used to describe neurodivergence. Rather, social narratives about neurodivergence shaped participants' abilities to recognize and claim neurodivergent identities. Many participants pointed to disparities in diagnosis of autism and ADHD for women, people of color, and queer and trans people. Participant claims are substantiated by a wealth of scholarship (Green et al., 2019; Mandell et al., 2006; Onaiwu 2020). It is important to note that like social narratives, psychiatric diagnoses can also be understood to be socially constructed (Gagné-Julien, 2021). That is, categories of 'mental illnesses' are defined "by referring to social and cultural values" rather than "denoting true natural facts" (Gagné-Juien, 2021, p. 9405). While not expressly stated,

participants' discussions of the role of sexism, racism, and transphobia in diagnosis, speak to an understanding of diagnosis that is informed by constructivism. Additionally, stereotypes about neurodivergence in both cultural narratives and medical settings have shaped the way participants relate to their own neurodivergence. Several participants described their process of unlearning "oppressive" narratives about neurodivergence. The process of overcoming internalized beliefs necessitated that participants create a novel, (trans)gender-informed perspective on their own neurodivergence.

Participants also considered the role of social perception on gender and neurodivergent identity expression. In regard to gender identity, social perception was particularly relevant to medical transition. As several participants shared, decisions related to gender-affirming medical interventions may be shaped in part by a desire to be "perceived in a…way that [they] want to be perceived." Participants' articulation of the difference between gender expression that is informed by the anticipated interpretations of others and those that reflect what was intrinsically "comfortable" were not always easy to parse. Moreover, participants did not necessarily have answers to these questions themself, but rather posed them as "interesting to think about."

Expression of neurodivergence was often framed in terms of 'masking.' Masking refers to the act of obscuring neurodivergent traits in order to appear neurotypical for reasons of social acceptance (Cage & Whitman, 2019). Participants conceptualized masking as "pretending to know what's going on," not understanding or relating to unspoken "expectations and cultural norms," and minimizing neurodivergence in order to avoid "stigma." As one participant shared, masking in the professional environment

significantly negatively impacts his overall health and well-being. This finding reflects earlier research that has indicated that masking can be detrimental to autistic individuals' mental health and even contribute to what has been termed, 'autistic burnout' (Higgins et al., 2021). Autistic burnout is conceptualized as inclusive of "significant mental and physical exhaustion" and "interpersonal withdrawal," among other symptoms (Higgins et al., 2021, p. 2365). Among autistic adults, internalized stigma has been found to be a factor that contributes to the decision to engage in masking (Cage & Whitman, 2019). This finding is consistent with the present research, as several participants described engaging in resistance to internalized pressures to mask. These findings point to the need for further research, as scholarship concerning the processes through which neurodivergent people resist and reject internal or external pressures to mask is scant. Several participants also drew connections between the experience of coming out and unmasking. For some, these processes were parallel and for others they were interconnected. Yet, all participants who spoke to unmasking described experiencing a sense of increased self-awareness and greater understanding from others through the process. However, more research is needed to explore the potential relationship between unmasking and coming out.

One potential interpretation of questions raised by participants about gender and neurodivergence expression is through theories of symbolic interactionism, particularly Cooley's concept of 'the looking-glass self' (Scheff, 2005). The idea of the looking glass self includes two primary concepts. First, individuals engage in constant "monitoring [of the] self from the point of view of others" (Scheff, 2005, p. 147). Second, "living in the

minds of others, imaginatively, gives rise to real and intensely powerful emotions, either pride or shame" (Scheff, 2005, p. 147). For participants, this might occur as hesitance to reveal their neurodivergence for fear of "invalidating" their trans identity or waiting to "wear a dress" until after having a "full beard," or opting for a succinct, "simple" iteration of gender identity in order to avoid being misgendered. Whether liberatory or oppressive, the perceptions of others fundamentally shape the expression and even understanding of participants' gender identity and neurodivergence. Another useful theoretical lens for interpreting these findings is found in neuroqueer theory's emphasis on the function of performativity in expressing neurotype and gender (Walker & Raymaker, 2020). Within this framework, the forces of cis and neuronormativity create pressure for participants to perform socially acceptable versions of themselves, whether through masking or through a gender expression that aligns with what a (trans) man or woman is 'supposed' to be. When considered through the lens of performance, the tension between internal experiences and external expression can be understood to be shaped by the power of the 'audience', or social environment. That is, the dominant cisgender and neurotypical culture may marginalize or socially ostracize those who perform deviant iterations of gender, body, and mind.

Connections Between Neurodivergence & Gender

This study sought to determine whether participants drew connections between their neurodivergence and their experiences and understandings of gender identity and gender as a concept. Few prior studies have considered trans and neurodivergent perspectives on a potential relationship between the phenomena of gender and

neurodivergence. However, earlier scholarship does suggest that LGBTQ+ and neurodivergent individuals may experience gender and neurodivergence in a way that is somewhat interconnected (Egner, 2019; Oswald et al., 2021). Therefore, this study's finding that all 13 participants articulated some relationship between their neurodivergence and gender identity offers further understanding of a phenomenon that has been minimally explored from the perspective of those who experience it.

Commonalities of Marginalization and Otherness

Several participants articulated a connection between their neurodivergence and trans identities that was rooted in a shared experience of marginalization. For some, particularly those who received a diagnosis as children, an internal connection was forged early between their neurodivergence and gender non-conforming traits. For these participants, the expression of their gender and neurotype was identified by others—family, peers, or professionals—as deviant or problematic from a young age. For other participants whose recognition of their neurodivergence came after they had begun to develop a trans identity, there was a sense of an existing schema into which neurodivergence could be incorporated. Some framed the connection in terms of a shared site of stigma, such as the commonly articulated connections between "masking" and being "in the closet." These types of connections echo elements of the sub-theme considering social perceptions and identity and expression. That is, marginalization, stigma, and othering are socially bound phenomena that can shape individuals' understandings and experiences of their non-normative identities. Participant connections between neurodivergence and gender that were rooted in shared otherness also speak to

the power of experiences of marginalization of one aspect of identity to permeate the larger self-concept. For participants who spoke about incorporating their neurodivergence into a schema of otherness, selfhood cannot be compartmentalized. Rather, neurodivergence and gender identity (and presumably other facets of identity) are experienced simultaneously in interactions in the social environment.

This type of connection reflects the need for intersectional analysis of trans and neurodivergent experiences. The theory of intersectionality derives from Black feminist scholarship and describes the ways in which "race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities" (Collins, 2015, p. 2). Participant experiences of transness and neurodivergence may then involve mutually constituted experiences of otherness and social marginalization. That is, the ways in which they experience and are perceived in their gender identity are informed by able-mindedness and the ways in which they experience and are perceived as neurodivergent are informed by transphobia. These findings also resonate with ideas from minority stress theory, particularly in regard to the expectation of discrimination and resultant hypervigilance (Meyer, 2003). For example, one participant described how his experiences as a trans person in the social environment informed his understanding of autism as something that will 'other' him. This participant had recognized his gender identity before his neurodivergence and had only recently been diagnosed as autistic. For this participant, the expectation of transphobia has not only been internalized, but permeated another, newer facet of his identity. This is not to say the expectation of able-

minded discrimination is unfounded. Rather, that for individuals who hold multiple marginalized identities, anticipation of discrimination may not be limited to one facet of identity but may instead become globalized internally.

This type of connection is somewhat different from the other subtypes, as it is created in relation to the social environment rather than internally. Nevertheless, participants articulated a strong connection between these two identities that was based on a shared experience of existing outside of dominant models of cisgendered bodyminds. These findings speak to the need for further research about how trans and neurodivergent individuals may conceptualize connections between these identities and the role of marginalization in that relationship. While experiences of marginalization were often described as painful, some participants also commented on the value that perspectives forged in otherness offered them. These participants typically also articulated the types of connections explored in the following sub-themes, particularly the idea that neurodivergent perspectives contribute to expansive gender identities. These participants described a sense of how this interrelated otherness, though challenging, afforded them novel and meaningful ways of knowing their genders, bodies, and minds.

Expansive Perspective Contributes to Expansive Genders

The majority of participants (n=12) theorized a relationship between the unique perspective afforded to them by neurodivergence and their understanding and/or experience of gender. This connection was based on an understanding of neurodivergent minds as "creative," "expansive," and able to engage in "outside-the-box thinking." These findings resonate with previous neuroqueer scholarship that has posited a link

between neurodivergent perspectives and understandings of gender. For example, Jackson-Perry (2020) employs Bayesian decision theory to consider how neurodivergent individuals may have unique relationships to gender as a social construct. Bayesian decision theory posits that individuals' past experiences, or 'priors,' generate an immediate understanding of the meaning of a given stimulus (Jackson-Perry, 2020). This understanding informs individuals' perceptions of what is possible in the present based on what has happened in the past (Jackson-Perry, 2020). Neurotypical people are more likely than neurodivergent people to have "steep priors" and neurodivergent people are often better able to engage in "outside the box" thinking and may rely less on priors in the meaning making process (Jackson-Perry, 2020, p. 225). This difference in perception may allow neurodivergent people to be "better positioned to overcome the social conditioning that incites us to regard gender as fixed, binary, and directly related to genital anatomy" (Jackson-Perry, 2020, p. 225).

While Jackson-Perry's (2020) scholarship was theoretical in nature, the present study contributes data suggesting the validity of this hypothesis. While participants did not directly describe 'priors,' those who articulated this type of connection did position neurodivergence as the primary embodiment that opens the door to the possibility of an expansive understanding of gender. Respondents who described this kind of connection included both those who had received a diagnosis in childhood and those who had become aware of their neurodivergence as adults. These participants theorized that their ability to think in non-normative ways positioned them to be better able to reject cis- and heteronormativity. Some participants who drew these types of connections spoke

specifically about their relationships to normative social concepts. For these respondents, their disconnection to socially constructed gender norms and "compulsive heterosexuality" allowed them a more expansive lens on gender. These findings reflect earlier scholarship that suggests that trans and neurodivergent young people may experience "less pressure to conform to gender stereotypes" (Strang et al., 2018, p. 15). While these findings represent intriguing exploratory results, further research is needed to better understand the prevalence and mechanism of this connection between gender and neurodivergence as well as the potential role of priors.

Gender and Neurodivergence as Intersecting Processes of Embodiment

Participants were also found to describe their neurodivergence and gender as interconnected parts of their larger selfhood. For these participants, gender and neurodivergence were understood as either mutually occurring, mutually-informing, or entirely inseparable elements of selfhood. Some of the respondents who articulated a theory of how expansive minds can contribute to expansive genders also described experiencing this type of intersecting process of embodiment. However, some participants fully rejected the idea that neurodivergence can be understood to come "first." For these participants, trying to determine the order of development is an irrelevant endeavor, like the question of the "chicken and the egg." One participant specifically eschewed the question of cause and effect. This reference to the question of cause and effect responds to and resists the body of medico-psychiatric scholarship that has pathologized both neurodivergence and trans identities. This experience may be best understood through the lens of queer phenomenology. As any attempt at creating an

etiology of transness or neurodivergence fundamentally fails to capture either element and the intimacy of their interdependence. Understood through a medical model, transness and neurodivergence represent deviations from the expected/intended course of the development of a 'normal' bodymind. Queer phenomenology instead allows this participant's articulation of their bodymind to be understood as one that is queer in its orientation toward something that has been made "unreachable by the lines of conventional genealogy" yet has come into view by "seeing the world 'slantwise'" (Ahmed, 2006, p. 107). That is, through rejecting the narrative of "cause and effect" this participant is able to experience and articulate a fully integrated queer, trans, and neurodivergent selfhood that cannot be contained by the lines of normative gender or neurotype development, no matter how deeply etched these lines may be.

Tenuous Connections

For some participants, the connection between gender and neurodivergence was more nebulous. While this did not represent most respondents, it is nevertheless important to qualify and contextualize the finding that all participants drew connections between these phenomena. For example, one participant first stated that they couldn't "speak to this" when asked if they drew any connections between their gender and neurodivergence. Yet, when asked if their neurodivergence shaped their understanding of gender as a concept, they responded: "Yes, in some ways. Even though I said no before. Because I also think if our brains are expansive, of course, our gender will be too". For others, the connection was intuitive but not easily explained. As one participant shared:

> I had no idea that there's a correlation between being trans and being neurodivergent…I do feel like there is a lot of overlap between the two for myself…It totally makes a lot of sense to my brain that like those two things would be very related to each other. And it's so hard to describe or pinpoint the exact ways that I think they have overlaps. What the things in common are. But I don't know, there's something. It just really makes sense to me.

This statement came in response to a question that first describes existent findings that some trans and neurodivergent people draw connections between their gender and neurodivergence. Participants were then asked if this aligns at all with their experiences. (See appendix for full interview guide.) This participants' response suggests that it is worth considering whether the question itself was leading. However, though the spark of connection was new and difficult for them to describe, it is also important to trust participant responses at face value and recognize participants as experts in their own understandings and experiences.

Diverse Experiences in LGBTQ+ Community

Experiences in LGBTQ+ Community

Participant experiences in the broader LGBTQ+ community were varied, and many described both acceptance and exclusion. Participants shared fewer experiences of marginalization related to their neurodivergence in LGBTQ+ community spaces than those of acceptance. However, the stories of exclusion that were shared align with previous findings that neurodivergent, queer and trans individuals may experience exclusion within neurotypical LGBTQ+ community spaces (Oswald et al., 2021; Strang

et al., 2020). Dynamics of exclusion included social rejection and identity-gatekeeping. Identity-based "gatekeeping" and/or invalidation was found to be the most common form of marginalization described among those who had experienced social exclusion. These experiences were typically articulated in relation to non-binary or genderfluid identities. For these participants, able-mindedness interacted with what may be a particular shade of transphobia that centers 'binary' trans experiences to create invalidating and exclusionary social dynamics. While the phenomenon of 'gatekeeping' has traditionally been understood in the context of structures of power, intra-community gatekeeping in relation to sexual and gender identity and belonging has found to exist within the LGBTQ+ community (Parmenter et al., 2021).

Despite these experiences of exclusion, the majority (n=12) of participants shared at least some experiences of acceptance within the broader community. The contrast between this finding and prior literature represents an important direction for future research about the experiences of neurodivergent people in LGBTQ+ community. For these participants, acceptance was articulated in terms of safety, understanding, and affirmation. Experiences that illustrated these feelings included feeling welcomed within trans spaces and accessing mutual aid through community. Several participants theorized that experiences of acceptance arose from the fact that queer and trans people are members of a marginalized group. As such, the LGBTQ+ community may be capable of greater empathy and understanding of trans and neurodivergent individuals' "whole, authentic, entire selves". However, the prevalence of inclusive experiences may also be related to this study's sample, particularly in regard to age. The previously cited studies

conducted by Strang et al. (2020) and Oswald et al. (2021) indicating the prevalence of social exclusion considered the experiences of LGBTQ+ neurodivergent youth. It is therefore possible that as adults, participants may have greater access to queer and trans communities that are welcoming of neurodivergence. Further, some of this access may also be related to these participants' ability to make choices about where they live, work, and socialize, which is an opportunity that is not afforded to all neurodivergent people.

Overlap Between LGBTQ+ & Neurodivergent Communities

Several participants also shared a sense that neurodivergence was well-represented and welcomed within their queer and trans communities. When asked what they would like neurotypical LGBTQ+ people to understand about their experiences, one participant jokingly responded, "those people exist?". This sense of LGBTQ+ community as highly neurodivergent resonates with the substantial body of scholarship indicating that neurodivergent people are more likely to be transgender (Janssen et al., 2016; Strang et al., 2014; Warrier et al., 2020). Further, many participants shared that they felt most at home among other trans and neurodivergent people and that these relationships fostered opportunities for mutual support in identity development, access to mutual aid, and experiences of social acceptance. This finding is aligned with existing scholarship on the social experiences of LGBTQ+ neurodivergent people (Egner, 2019; Oswald et al., 2021; Strang et al., 2020). Both Strang et al. (2020) and Oswald et al. (2021) found that among LGBTQ+ and neurodivergent youth, opportunities to be among other young people at the intersection of these identities supported identity development and the creation of supportive relationships. Egner (2019) found that neuroqueer blog communities created

opportunity for LGBTQ+ and neurodivergent adults to explore neurodivergent, queer, and trans identities (and dis-identification) and politics outside of cis/hetero/neuro-normative discourses. The present study provides further support to prior scholarship about the importance of intra-community solidarity for individuals at the intersection of these identities.

Participants' emphasis on the importance of community spaces that are both trans and neurodivergent and the harm that some experienced in neurotypical LGBTQ+ spaces speak to the role of minority stress in the social lives of neurodivergent and trans people. For example, the participant who described doubting the validity of their trans identity after attending a predominantly neurotypical LGBTQ+ gathering, offers an example of the ways in which discrimination may be internalized and impact self-concept. Further, the emerging theory of 'intraminority stress' (Pachankis et al, 2020) may also be relevant to participants experiences within neurotypical LGBTQ+ community. Intraminority stress theory was originally developed to describe the ways in which gay and bisexual cisgender men may face unique stressors and mental health challenges due to the presence of competition and hierarchy within the gay male community (Pachankis et al, 2020). The theory has since been expanded to consider the experiences of lesbian and bisexual cisgender women (Mahon et al., 2021). Intraminority stress has also been specifically linked to increased social anxiety among lesbian, gay, and bisexual men and women (Mahon et al, 2021). That is, intraminority stress may negatively impact LGB individuals' overall mental health and social experiences in both heterosexual and LGBTQ+ communities (Mahon et al, 2021).

Intraminority stress among transgender and neurodivergent populations has not, to date, been considered. However, the present findings and prior scholarship on intraminority stress suggest that discrimination, hierarchy, or exclusion (or the expectation of these experiences) within LGBTQ communities may impact transgender and neurodivergent individuals' experiences within LGBTQ+ community spaces. That is, the confluence of minority stress and intraminority stress may increase feelings of social anxiety and impact trans and neurodivergent individuals' ability to feel safe and included within the larger LGBTQ+ community. Conversely, trans and neurodivergent social spaces that may be less likely to perpetrate dynamics of marginalization may offer respite from experiences of intraminority and minority stress. Experiences of intraminority stress within the LGBTQ+ community and the resultant expectation of discrimination may necessitate the creation of separate social spaces for trans and neurodivergent people. However, further research is necessary to better understand the ways in which minority stress and intraminority stress may impact LGBTQ community dynamics among individuals who hold multiple marginalized identities.

Experiences in the Healthcare System

Minimal Experiences of Ableist Discrimination or Denial of Gender-Affirming Care

None of the 13 participants reported experiencing discrimination or denial of gender-affirming care that they attributed to provider able-mindedness. This is a significant finding of this study, both because of the uniformity of responses and because it represents a stark contrast to the existing body of clinical literature. Prior research concerning the experiences of this population within mental and medical healthcare

settings has suggested that trans and neurodivergent people face significant barriers to gender-affirming care (Jackson-Perry, 2020; National LGBT Health Center, 2020; Shapira & Granek, 2019; Strang et al., 2020). Participants did offer several potential explanations for the lack of discrimination. These included not seeking gender-affirming care, not disclosing their neurodivergence to providers, or not presenting in a way that is "typical" of neurodivergent people. Several participants were also aware of this phenomenon and expressed that it was something they were concerned about experiencing.

In addition to these well-founded explanations, it is also important to note that the existent literature on this phenomenon primarily focuses on youth (National LGBT Health Center, 2020 Shumer & Tishelman, 2015; Strang et al., 2016; Strang et al., 2018; Strang et al., 2020). While experiences of denial of gender-affirming care and invalidation of trans identities has been found to occur for neurodivergent adults (Shapira & Granek, 2019), the prevalence is not as well understood. It is possible that it may be somewhat easier for adult neurodivergent people to access gender-affirming care than youth, due in part to adultism in gender-affirming care settings. Further, as several participants indicated, they were able to receive care through models of informed consent and therefore were not required to receive any mental health evaluations or counseling. Another potential explanation may lie in the fact that this study's sample included only participants with speaking abilities. And as many participants described, they may be both able and choose to engage in masking as a tool for engaging with systems of power. If this sample had included neurodivergent people who did not communicate within the

dominant linguistic paradigm, these results may have been different. An exploration of the representation in the sample will be discussed further in the Limitations section. As previous scholarship has indicated, there exist few clinical models to support non-verbal neurodivergent people in accessing gender-affirming care (Shumer & Tishelman, 2015).

Rampant Transphobia Across Healthcare Settings

The prevalence of transphobia in healthcare settings also represents an important finding of this study. Every participant reported experiencing at least one instance of transphobia in experiences with either medical, mental health, and gender-affirming care or combinations therein. Experiences ranged from microaggressions, to straightforward disrespect, to denial of care. In medical settings, participants reported hesitance to disclose their gender identity for fear of being met with misunderstanding or denial of care. They also described experiences ranging from providers over-emphasizing their sexual anatomy when it was not relevant, to denial of care on the basis of being transgender. These findings align with earlier scholarship concerning trans experiences with medical providers. In 2015, the US Transgender Survey found that 33 percent of trans people who had sought medical care had at least one negative experience related to their gender identity, including verbal harassment and refusal of care (James et al., 2016).

In regard to mental healthcare, participants described experiencing transphobia in inpatient and outpatient settings as well as in psychiatry. In therapeutic spaces, misgendering and deadnaming was the most common type of transphobia reported. These findings align with prior indications that trans people experience stigma and discrimination from mental healthcare providers (Johnson & Rogers, 2019). One

participant described a particularly egregious experience with transphobia from a staff member at an inpatient psychiatric setting. As they shared, they were not only misgendered and deadnamed, but asked invasive questions about their body and experiences of sexual assault. This participant further shared their belief that this provider assumed that their gender identity was a "symptom" of their "mental health diagnoses." This experience reflects earlier findings that providers may regard trans identities as a 'symptom' of neurodivergence (National LGBT Health Center, 2020; Shapira & Granek, 2019; Strang et al., 2020). However, the extent of the transphobia and ableism described by this participant goes far beyond previously reported findings.

Finally, two participants also described experiencing denial of insurance coverage for gender-affirming care. One participant described having his health insurance attempt to deny coverage of his top-surgery because he had not previously chosen to pursue hormone replacement therapy. This is similar to El-Hadi et al.'s (2018) findings that rigid medical and insurance protocols for transition create barriers to accessing gender-affirming care. Moreover, these policies may reify normative understandings of transgender experience within the medical community. As this participant shared, this requirement attempted to force him to fit his experience of transition into a "little square box" that was not appropriate to his care needs. Another reported being denied coverage through a blanket exclusion on transgender healthcare in his workplace healthcare policy. In order to have the procedure covered, this participant engaged in a year-long legal battle over the claim. As he shared, this process was even more arduous due to the requirement to appear "organized and speak well and present legal language, in…an

emotionless way". He explained that as a neurodivergent person who has a non-normative communication style, it was particularly challenging for him to engage in this kind of self-advocacy.

Both of these stories reflect earlier findings that insurance and healthcare systems create significant barriers to gender-affirming care (van der Miesen et al., 2020). Further, although direct experiences of discrimination or denial of gender-affirming care based in provider assumptions about neurodivergence were not reported, the story about the challenges of navigating health insurance and legal systems as a neurodivergent person points to a de facto form of able-mindedness. That is, if trans people seeking gender-affirming care are often required to engage in self-advocacy that requires masking and conforming to the requirements of structures of power, neurodivergent people may still face greater barriers to care, even if those barriers are not coming from providers.

Implications for Social Work Practice

The findings from this study offer several important implications for social work practice with trans and neurodivergent populations. Many of the following suggestions come directly from participants' recommendations for providers, and participant voices will be woven throughout this discussion. Recommendations for practice are organized in three sections. First, implications for social work education are considered. Next, implications and suggestions are shared in regard to both direct service and advocacy.

Social Work Education

The current findings underscore the need for social workers to understand both trans and neurodivergent identities outside of a framework of pathology. Currently, social

work education policy and accreditation standards include gender identity as an aspect of human diversity that must be addressed within schools of social work (McCarty-Caplan, 2022). However, while "disability" is also included as a facet of diversity that must be considered, neurodiversity and the experiences of neurodivergent people are not accounted for in accreditation standards (Council of Social Work Education, 2015). In order to prepare social work students for practice with neurodivergent populations, schools of social work should incorporate the neurodiversity paradigm into educational models, including in coursework on human diversity, practice with individuals, families, and groups, and diagnosis and treatment modalities. This may seem a radical proposal, as it would necessitate rejecting much of the existent scholarship that conceptualizes neurodivergence as pathology. However, as neurodiversity scholars have pointed out, there is historical precedent for this kind of evolution in thinking:

> In 1960, it would've been unthinkable to most psychologists to throw out every bit of scholarship and practice that stigmatized homosexuality and treated it as a pathology. And yet, over the past few decades, the academic and professional mainstream has done exactly that—and the results have been entirely beneficial (Walker & Raymaker, 2020, p. 3).

In addition to embracing the neurodiversity paradigm in social work curricula, schools of social work would benefit from considering neurodiversity in their diversity, equity, and inclusion goals. That is, both the student body and the faculty should reflect the neurodiversity of the larger community. In regard to faculty, social work students benefit

from the opportunity to learn from faculty with lived experiences that inform their social work practice.

Social work education does not end after graduation and continuing education is both a licensing requirement and an integral part of reflective praxis. As many participants indicated, it is critical for mental health practitioners to engage in self-education about trans and neurodivergent experiences. For participants, this included education around updated and inclusive trans and neurodivergent identity language and the lived experiences of this population. Several participants recommended that practitioners should learn directly from materials created by trans and neurodivergent people. Given the rise in representation in neurodivergent voices in online spaces, social workers may consider seeking education from trans and neurodivergent first-person narratives via social media.

Direct Service & Advocacy

Several participants spoke directly to the disappointment they experienced when therapists listed specialties in serving LGBTQ+ or neurodivergent populations yet were not competent and affirming in practice. Both the act of seeking further education about trans and neurodivergent experiences and recognizing the limitations of one's current knowledge represent important aspects of practicing cultural humility. Cultural humility describes the practice of engaging in "self-evaluation and critique… redressing the power imbalances in the [worker]–patient dynamic, and… developing mutually beneficial and non-paternalistic partnerships" (Tervalon & Murray-Garcia, 1998, p. 123). Understood through this lens, it is critical for social workers to be transparent about their knowledge

and practice skills in work with diverse populations. Such an approach to practice involves, as one participant shared, a willingness to acknowledge the need "to do more research…And even to say…I feel like I'm out of my depth in terms of this. Or I feel like I'm not going to be able to understand you…And I found someone who can". In addition to practicing cultural humility, incorporating an understanding of minority stress theory into social work practice is critical for serving this population. Recognition of how structural, interpersonal, and internalized ableism and transphobia may impact mental and physical health provides a more comprehensive perspective on the lived experiences of trans and neurodivergent clients. Further, if clients have developed an expectation of discrimination due to minority stress, this may represent a barrier to social workers seeking to form a trusting relationship. Workers should be knowledgeable about this dynamic and work to build trust through validation, affirmation, and patience.

Participants emphasized the need for practitioners to listen to clients' lived experiences and recognize the validity of their identities. Across interviews, participants expressed a desire to feel heard and to be recognized as the expert on their own experiences of gender identity and neurodivergence. Several respondents even shared that they did not have to be fully "understood" by providers. Rather, it was most important that the fundamental truths of their experiences were accepted. These responses in concert with the findings about the prevalence of non-binary gender identities, point to the importance of social workers developing familiarity with the phenomenon of gender fluidity. As participants shared, gender fluidity represented a meaningful and joyful part of their trans experiences. As such, social workers should recognize shifting or evolving

gender identification and expression as a valid experience that is indicative of self-awareness, rather than an underdeveloped self-concept. Additionally, the prevalence of self-diagnosis among respondents speaks to the need for a collaborative assessment process. Participants who were self-diagnosed described experiences of struggling to access formal diagnosis. When they were able to see providers, the credibility of their self-diagnosis was doubted in ways that caused "hurt" during a "vulnerable moment" of seeking care. While clinical social workers hold expertise about assessment and diagnosis, these responses speak to the value of incorporating client lived experience and expertise into the process.

Finally, this study's findings speak to the importance of social worker advocacy and activism in issues related to trans and neurodivergent lives. First, social workers can advocate for the inclusion of the neurodiversity paradigm into social work practice and social work education, as well as for representation of trans and neurodivergent people in the field. Further, social workers can advocate for incorporation of the neurodiversity paradigm in practice with colleagues in the broader mental health field. Second, where diagnosis still determines access to resources such as medication and disability accommodations, social workers can advocate for the inclusion of lived experience into diagnostic criteria. As participant responses illuminate, their experiences often did not reflect normative expressions of neurodivergence. Inclusion of lived experience can contribute to redressing disparities in diagnosis across lines of race, class, sexual orientation, and gender identity and expression. For practitioners in healthcare organizations or those that provide gender-affirming care, workers can advocate for

informed-consent models of care that are inclusive of neurodivergent thinking, processing, and communication styles. Further, advocacy for greater equity in access to gender-affirming care for all trans people will also benefit neurodivergent people, as this study's findings suggest that neurodivergent people may face greater barriers to care.

Limitations & Directions for Future Research

This study has several important limitations to consider, most in relation to the sample. First, the small sample size, while appropriate to the exploratory and qualitative nature of the study, indicates that the findings cannot be generalized to the larger population of trans and neurodivergent people. This study also did not collect data about race, ethnicity, age, class, or location. However, based on the information that was shared anecdotally by participants, it appears that the study was majority White and between the ages of approximately 25 to 40. Given the lack of data and the apparent racial and age homogeneity of the sample, findings cannot necessarily be understood to be representative of young adults, people in middle age, elders, or people of color who are trans and neurodivergent. Trans women and trans feminine people were also underrepresented in this study, comprising only 2 of 13 participants. Finally, this study did not include participants who are non-speaking or those whose communication styles are not primarily verbal.

Limitations in regard to the diversity of the sample may be related in part to the study's methodology. As discussed in the Methods chapter, participant recruitment occurred entirely on Instagram. While participation was limited due to the researcher's capacity, this meant that only a specific audience was reached. Had recruitment included

the other intended communication platforms (university email list-servs and local flyer-based outreach), a greater diversity of participants may have been achieved. Further, conducting outreach via the researcher's own social media page may have also contributed to the racial and age homogeneity of participants, as participant demographics reflect the researcher's personal community. These issues in representation necessitate that this study is not taken to represent the full diversity of trans and neurodivergent experience.

Both the findings and limitations of this study point to important directions for future research on experiences at the intersection of these identities. First, in relation to the limitations, it is critical to integrate a more intersectional understanding of the experiences of trans and neurodivergent people. The present study did not address the role of race and ethnicity in participant experiences and understandings, and future research would benefit from foregrounding the lived experiences of trans and neurodivergent people of color. Further, the experiences of elders and those in mid-life have been minimally explored and would contribute to an understanding of these phenomena that addresses generational differences. Several participants also spoke to experiences as people who are multiply disabled. Due to limitations in writing capacity, these perspectives were minimally incorporated into thematic development and analysis. However, these experiences offer important insights into the larger phenomenon of disability and how neurodivergence may interact with other aspects of disabled embodiment. Additionally, all participants appeared to live outside of institutions or guardianship arrangements. These limitations were likely due to limitations in

recruitment, as well as the researcher's learning more fully accessible approaches to interviewing. However, developing ethical and accessible approaches to research methodology in order to include trans and neurodivergent people who experience the greatest social marginalization/isolation is critical to building a vigorous and varied body of literature on this understudied intersection.

This study's findings also provide several potential directions for future study. First, this study found that trans and neurodivergent people may experience several gender evolution(s) across the life course. This finding suggests that more scholarship about the social and temporal fluidity of gender identity among this population may contribute to greater understanding of both this intersection and to the phenomenon of gender more broadly. Neurodivergent identity construction, particularly among LGBTQ+ neurodivergent people, has also been minimally studied. The paucity of research on this topic, the contrasts between this study and Egner's (2019) scholarship, and the small sample size of this study points to the need for further research on this phenomenon. Further, this study's findings about fluidity in identity language and differences across diagnoses, suggests that this is a generative direction for future research. Topics might include how diagnosis (whether clinically-determined or self-determined) and neurodivergent intra-community discourses shape identity development and use of identity language. The connections drawn by participants between their gender and neurodivergence also speak to the need for further scholarship. Future research could explore the prevalence of these connections across the larger trans and neurodivergent population. Additionally, further exploration into the mechanisms through which these

connections are created could shed more light on neuroqueer theories positing a link between trans and neurodivergent embodiment. In regard to participant experiences within LGBTQ+ community, additional research is needed to determine how experiences may differ among youth and adults. Finally, the sharp contrast between this study's findings on experiences with gender-affirming care and prior literature indicates that more information is needed to understand what factors, such as age, location, or verbal abilities, may contribute to accessible care.

Conclusion

This study was guided by two overarching research questions. First, how do neurodivergent and transgender individuals understand and experience their gender identity and neurodivergence? Second, do participants draw connections between their understandings and experiences of gender and their own neurodivergence? In regard to the first research question, participants articulated fluid, expansive, and evolving visions of gender and neurodivergent identities. Further, the ways participants developed and expressed these identities were found to be relationally informed. Identity was not found to be inherent or consistent but shaped through experiences in trans and neurodivergent community and by forces of cis- and neuronormativity. Participant understandings of gender and neurodivergence also spoke to the ways in which normative conceptualizations of these phenomena could not fully hold their trans and neurodivergent embodiment. That is, participants offered understandings of their gender and neurotype that deconstructed binaries of typicality/divergence and questioned the validity of either system's ability to describe their experiences. For many participants,

this ability to be oriented away from normativity and toward something more expansive and welcoming was, in fact, attributed to their very transness and neurodivergence.

In response to the second research questions, all participants articulated a connection between their experience of gender and neurodivergence. Whether connections were loose and intuitive, rooted in shared marginalization, moving from neurodivergence toward transness, or intimately interconnected; a relationship between these phenomena resonated across interviews. Many participants noted how difficult it was to explain these connections. Yet they did not run from the slippery nature of these experiences and understandings. Rather, they reached toward these uncertainties in a way that echoes the idea of queer phenomenology as a "disorientation device" that allows for the "oblique to open up another angle on the world" (Ahmed, 2006, p. 172). Participants' trans understandings of neurodivergence and neurodivergent understandings of gender make use of what is oblique and unable to be contained by language, category, or spectrum, to offer profound insight into and appreciation of the infinite diversity of human bodyminds. Despite experiences of social and systemic marginalization, participants articulated understandings and experiences of gender and neurodivergence that were rooted in joy, creativity, and resistance - attributes that can be understood to be unlikely, but brilliant "moments of disorientation" that can offer us "hope of new directions" and that may, in themselves be "reason enough for hope" (Ahmed, 2006, p. 158).

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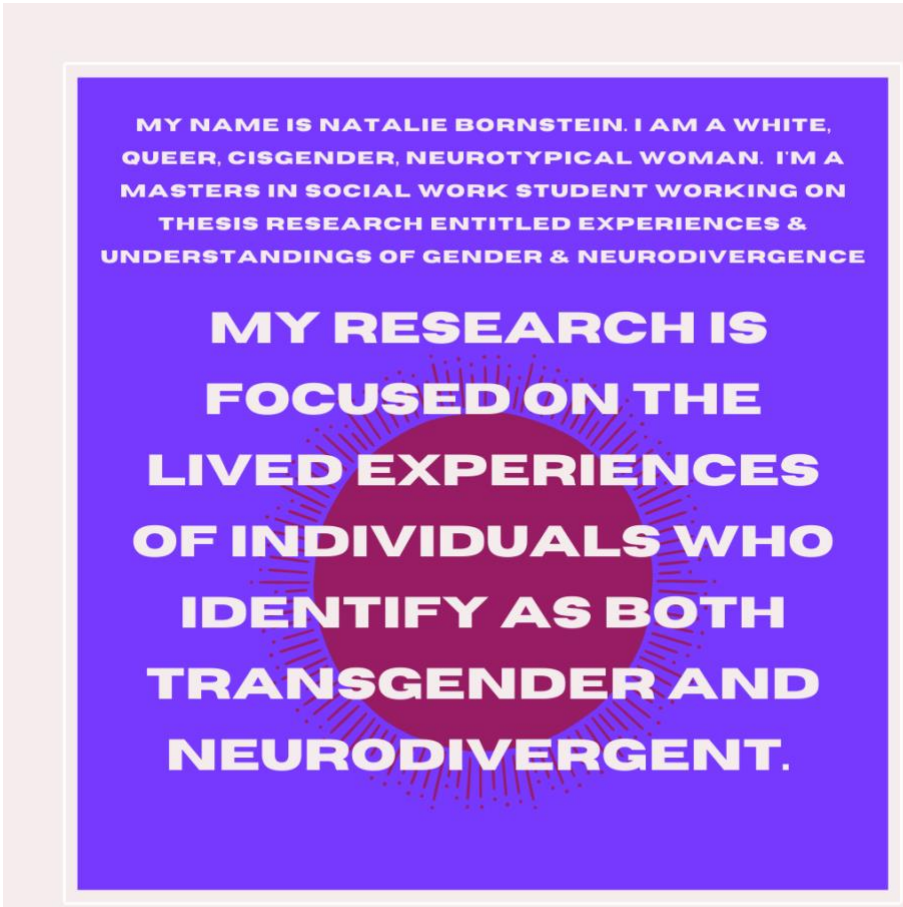
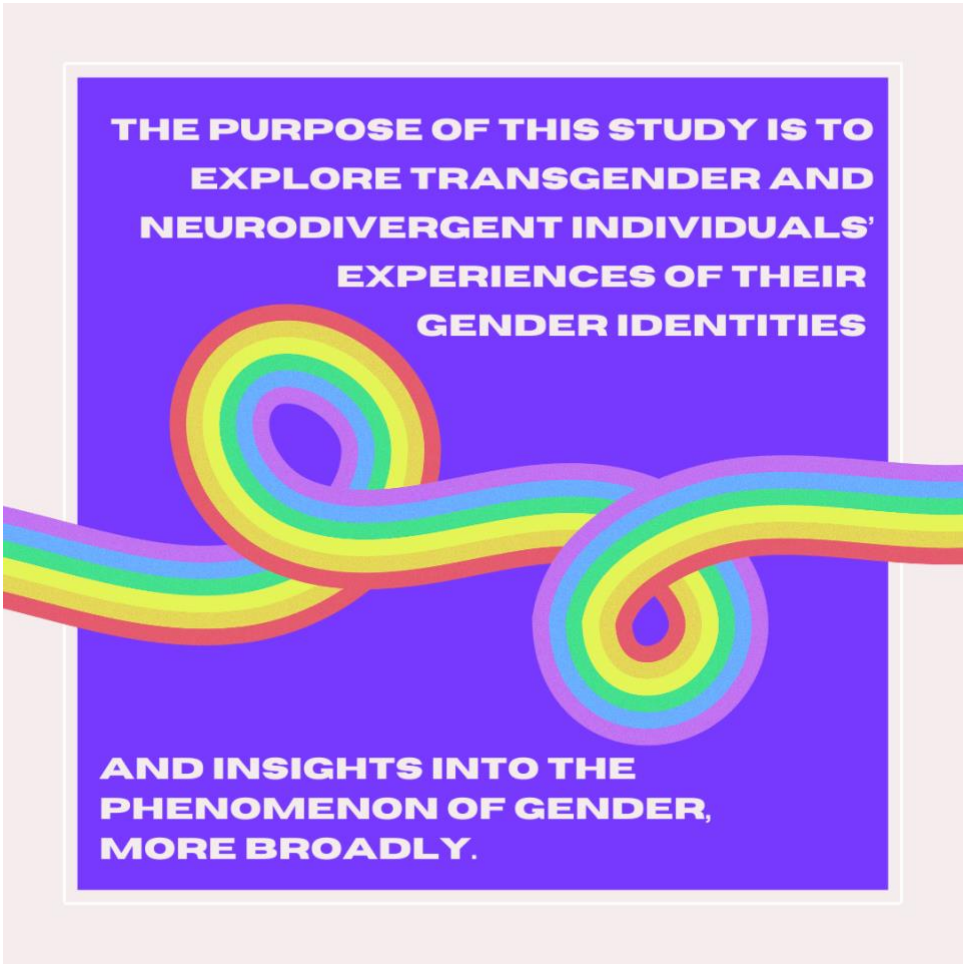
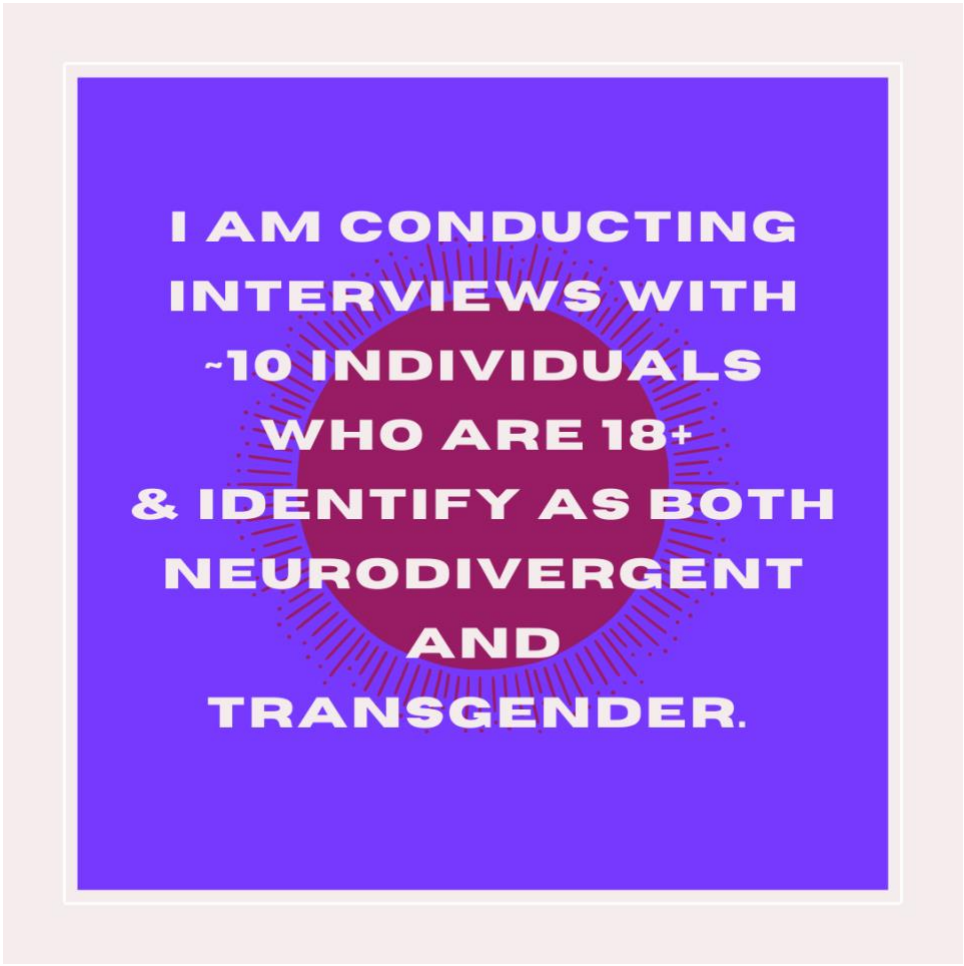
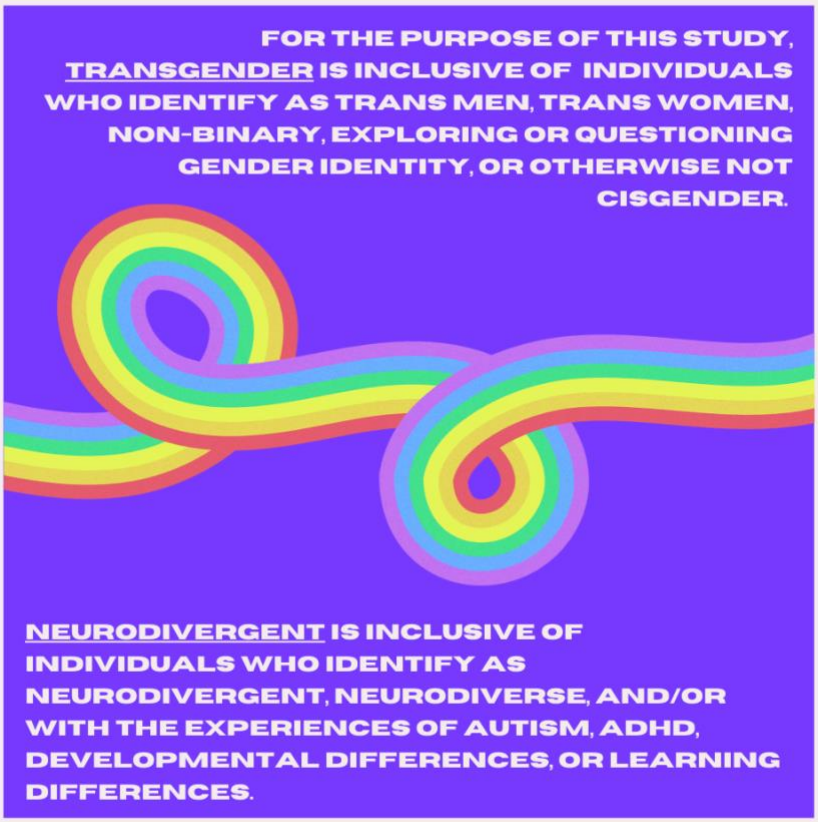
Appendix A: Instagram Recruitment Infographics


MY NAME IS NATALIE BORNSTEIN. I AM A WHITE, QUEER, CISGENDER, NEUROTYPICAL WOMAN. I'M A MASTERS IN SOCIAL WORK STUDENT WORKING ON THESIS RESEARCH ENTITLED EXPERIENCES & UNDERSTANDINGS OF GENDER & NEURODIVERGENCE
MY RESEARCH IS FOCUSED ON THE LIVED EXPERIENCES OF INDIVIDUALS WHO IDENTIFY AS BOTH TRANSGENDER AND NEURODIVERGENT.

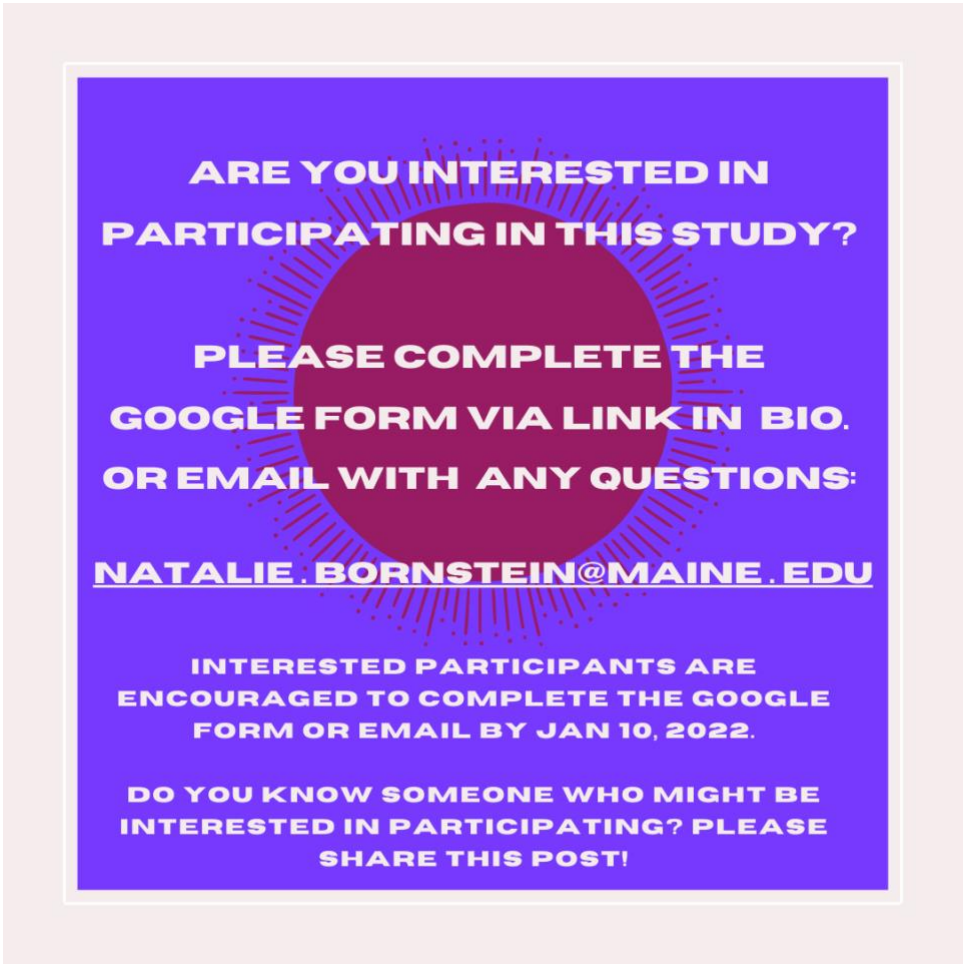

THE PURPOSE OF THIS STUDY IS TO EXPLORE TRANSGENDER AND NEURODIVERGENT INDIVIDUALS' EXPERIENCES OF THEIR GENDER IDENTITIES
AND INSIGHTS INTO THE PHENOMENON OF GENDER, MORE BROADLY.


I AM CONDUCTING
INTERVIEWS WITH
~10 INDIVIDUALS
WHO ARE 18+
& IDENTIFY AS BOTH
NEURODIVERGENT
AND
TRANSGENDER.


FOR THE PURPOSE OF THIS STUDY, TRANSGENDER IS INCLUSIVE OF INDIVIDUALS WHO IDENTIFY AS TRANS MEN, TRANS WOMEN, NON-BINARY, EXPLORING OR QUESTIONING GENDER IDENTITY, OR OTHERWISE NOT CISGENDER.
NEURODIVERGENT IS INCLUSIVE OF INDIVIDUALS WHO IDENTIFY AS NEURODIVERGENT, NEURODIVERSE, AND/OR WITH THE EXPERIENCES OF AUTISM, ADHD, DEVELOPMENTAL DIFFERENCES, OR LEARNING DIFFERENCES.


INTERVIEWS WILL BE ABOUT 1 HOUR LONG AND CAN BE CONDUCTED IN-PERSON OR OVER ZOOM.
QUESTIONS ARE OPEN-ENDED & FOCUS ON:
GENDER IDENTITY & GENDER AS PHENOMENON
NEURODIVERGENCE
EXPERIENCES IN LGBTQ+ COMMUNITY SPACES
EXPERIENCES ACCESSING MENTAL HEALTH RESOURCES


THERE ARE NO DIRECT BENEFITS TO PARTICIPATING IN THIS STUDY. PARTICIPANT INSIGHTS CAN CONTRIBUTE TO SOCIAL WORK PRACTICE WITH THIS POPULATION.
INTERVIEW QUESTIONS DEAL WITH SENSITIVE SUBJECT MATTER RELATED TO HISTORICALLY MARGINALIZED IDENTITIES & MAY ELICIT DIFFICULT THOUGHTS & FEELINGS. PARTICIPANTS WILL RECEIVE INFO ABOUT LOCAL & NATIONAL MENTAL HEALTH RESOURCES.
PARTICIPATION IS VOLUNTARY& PARTICIPANTS CAN WITHDRAW AT ANY TIME.


ARE YOU INTERESTED IN PARTICIPATING IN THIS STUDY?
PLEASE COMPLETE THE GOOGLE FORM VIA LINK IN BIO. OR EMAIL WITH ANY QUESTIONS:
NATALIE.BORNSTEIN@MAINE.EDU
INTERESTED PARTICIPANTS ARE ENCOURAGED TO COMPLETE THE GOOGLE FORM OR EMAIL BY JAN 10, 2022.
DO YOU KNOW SOMEONE WHO MIGHT BE INTERESTED IN PARTICIPATING? PLEASE SHARE THIS POST!

Appendix B: Interview Guide

1. How would you describe your gender identity?

2. Can you tell me about your journey of exploring or coming to understand your gender identity?

3. Do you feel that your gender identity is an important part of your identity and/or how you think about yourself? If so, in what way?

4. How would you describe your neurodivergence? How do you think your experience of neurodivergence shapes your thoughts, emotions, or relationships?

5. Can you tell me about your journey of coming to understand and relate to your neurodivergence?

    - Potential Follow-Up Question: How has your understanding of or relationship to your neurodivergence evolved over the course of your life?

6. Do you feel that your neurodivergence is an important part of your identity and/or how you think about yourself? If so, in what way?

7. Through the research I have done, I have learned that neurodivergent individuals are more likely to be transgender, gender expansive, and/or gender nonconforming than neurotypical individuals. I have also learned that some neurodivergent and transgender people draw connections between their neurodivergence and their gender identity and experience of gender. For example, within the autistic community, I understand that the term ‘gendervague’ is an identity term that refers to the unique experience of being both trans and autistic. What do you think about that? Does this align with any of your experiences? In what ways?

8. I’m interested to know how or if gender identity or experiences as a trans person may have shaped how you understand your neurodivergence?

9. Do you think that your neurodivergence has impacted how you think about gender as a concept? If so, how?

10. Have you sought out LGBTQ+ or transgender-specific community spaces? Can you tell me a little about your experiences as a neurodivergent person in those spaces?

- Potential Follow-Up Question: If you have felt welcomed and included in LGBTQ+ spaces in regard to neurodivergence, what has that looked and felt like?

- Potential Follow-Up Question: If you have not felt welcomed and included in LGBTQ+ spaces in regard to neurodivergence, what has that looked and felt like?

11. What would you like neurotypical LGBTQ+ or transgender individuals and communities to understand about your experience as a neurodivergent transgender person?

12. Have you ever received mental health services, such as seeing a therapist, psychologist, or psychiatrist? If so, have these providers been competent and affirming in regard to your gender identity? Your neurodivergence?

    - Potential Follow-Up Question: If you have seen providers who you found to be competent and affirming, what were some of the main factors that made their approach effective?

    - Potential Follow-Up Question: If you have seen providers who you found not to be competent or affirming, what were some of the main factors that made their approach ineffective or harmful?

13. Have you ever experienced invalidation or lack of acceptance of your gender identity based on assumptions about your neurodivergence from medical or mental health providers? What did this invalidation or lack of acceptance look like?

14. In my reading and research I have found that neurodivergent people may face discrimination and denial of gender-affirming medical interventions. Have you ever experienced denial of gender-affirming medical interventions based on your neurodivergence? If so, could you share a bit about these experiences?

15. What would you like mental health and medical professionals to understand about your experiences as a transgender and neurodivergent person?

16. Is there anything else you would like to share about your experiences with gender identity and neurodivergence?

Appendix C : Example of Significant Statements

Significant Statement	Meaning Unit	Interviewee	Page
I'm non-binary and also transgender.	I describe my gender identity as non-binary and transgender.	5	1
Yeah, it took me a long time. Or so I feel. To get to understanding that I was transgender. I came from a really religious upbringing. And so there was a lot of shoving down and repressing not only my gender identity, but my sexuality. So, I kind of came out first as a lesbian. And then made more trans friends and realized that I was non-binary. And I didn't necessarily identify as transgender at that point. But now I do. And as I kind of started digging deeper into that gut feeling of, you know, who am I? Sort of thing. I realized I was trans and wanted to take hormones and kind of shifted how I see myself in the world. And then also people see me differently now, too.	I feel that it took me a long time to understand my gender identity and sexuality, in part because of my religious upbringing. I first came out as a lesbian. Making friends with trans people helped me to realize that I am non-binary. As I explored my gender further, I realized that I also identify as transgender and I begin to shift how I see myself and how others see me.	5	1
Yes, my gender identity is important to me. But it's also something that, as I've learned more about what is gender, what is sex. That things like pronouns mean less to me. And it's more about people understanding that there's not just male and female. And that you can't just see somebody on the street and assume you know that that person is she/her, ma'am. So it's important to me in the sense that assumptions aren't made about my gender.	My gender identity is important to me in the sense that it is important that others don't make assumptions about my gender. Part of the importance is about the larger societal understanding of gender as something that is bigger than binary sex categories.	5	1
Yeah, it's like when I'm alone, I don't think about it. But when I interact with someone else, or you know, an organization or entity, I think is when it starts to matter to me.	My gender identity feels most important to me when I am interacting with others.	5	1
My neurodivergence has been also a journey. Similar to my trans journey. It's been difficult to realize that I was neurodiverse. And actually, it's been part of my coming out process and my unmasking process. And so, as I kind of unmasked my gender, I realized that I	Coming to understand my neurodivergence has been similar to coming to understand my gender identity. The processes of coming to understand my gender identity and unmaking and realizing that I am neurodiverse/autistic have been parallel	5	2

was neurodiverse or autistic. And so it's been difficult to have that like - To get a diagnosis, for instance.	and related. It has been difficult to come to realize that I am neurodiverse/autistic.		
Yes, definitely. I feel like it shapes my thoughts and the way that I make connections with things. And what I need in terms of an environment or people that I hang out with on a regular sort of - like in my inner circle type thing. It definitely shapes my - kind of everything about my life.	My neurodivergence shapes everything about my life. It shapes how I make connections, what I need in my environment, and my close relationships.	5	2
I feel like both are related in the general sense that they're how you interact and see the world.	I draw a connection between neurodivergence and transness in that both relate to your perspective and how you move through the world.	5	2
But for me, I was really good at sort of playing this role over time that I had unintentionally built up that was like this mask of a, you know, cis, female, non-neurodivergent, neurotypical person. And so as I stopped being what I thought I was supposed to be. And just started being what naturally was me. Is when - that both kind of happened simultaneously as I was coming out as trans. And following people on Instagram that were also trans and then they were autistic. And my friend circle became more trans and autistic. And then my autistic friend and coworker just started, like referring to me, like, I knew that I was autistic.	Understanding myself as trans and autistic happened simultaneously through the deconstruction of the role that I thought I had to play. When I started being what was natural to me, I was able to recognize myself as trans and autistic. Being around other trans and autistic people in my life and on social media helped me recognize these things in myself.	5	2