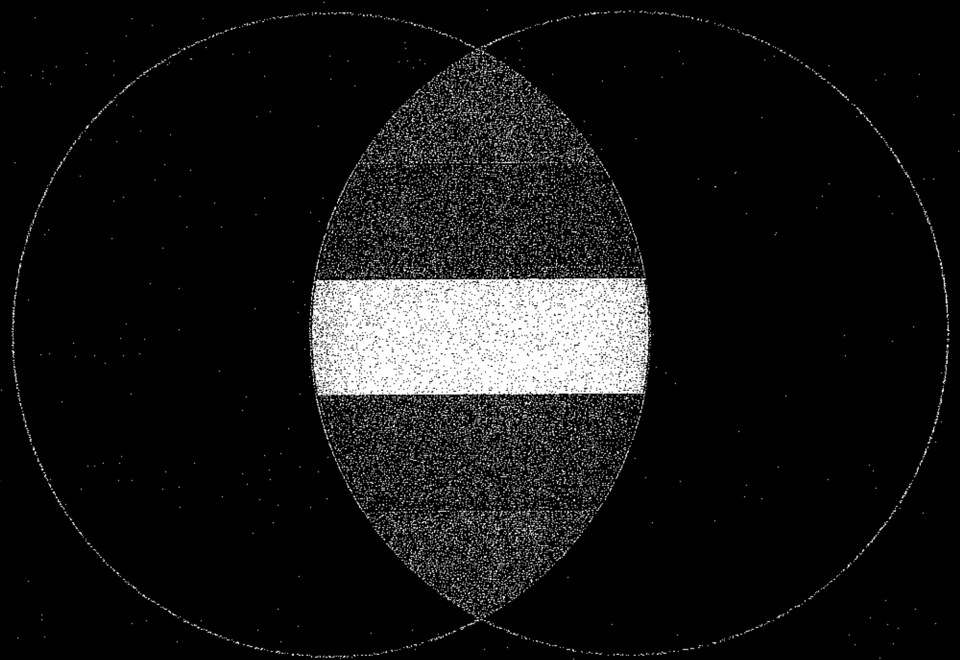
SUPPORTING TRANSGENDER AUTISTIC YOUTH AND ADULTS

A Guide for Professionals and Families



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This also can be done as collage, and may use animal imagery and other non-representational drawing.

b. *Slam poetry:* The spoken word community is full of trans and neurodivergent people. Search for transgender and slam poetry on the Internet and you will find many performances. Check out your local area for slam poetry gatherings and talk with organizers regarding their support for transgender autistic poets. Share poetry videos with clients and support them in their self-expression.

c. *Creative writing:* Transgender autistic writers abound. Check out Autonomous Press and fan fiction sites, and talk with your local bookseller. There is a growth in teen and young adult books that have well-developed neurodivergent protagonists. Encourage clients to do short writing prompts in sessions if they enjoy writing.

d. *Music:* This is another great venue for expression. Playing an instrument, singing, creating electronic music, or developing a great playlist provides a way to express self and connect with others.

e. *Dance:* While some dance may be awful for trans autistic people because of the overwhelming environment, difficulty with learning dance steps, or discomfort with touch, there may be types of dance that work well for an individual.

RESOURCES

Sensory diets

Musings of an Aspie: https://musingsofanaspie.com/2014/02/18/sensory-diet

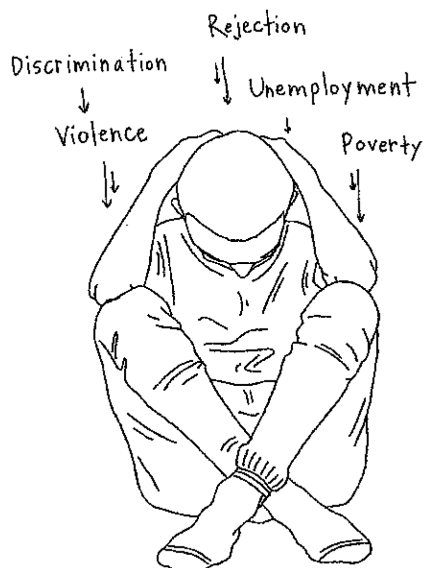
Writing letters for hormone treatment and surgeries

WPATH (World Professional Association for Transgender Health) *Standards of Care for the Treatment of Transsexual, Transgender and Gender Nonconforming People.* Available at www.wpath.org/publications/soc

Informed Consent for Access to Transgender Health (ICATH). Available at www.icath.org

Chapter 4

Working with Trauma and Minority Stress



Working with trans autistic youth and adults involves working with trauma and pervasive minority stress. Both transgender and autistic people experience high rates of acute traumas—the psychological results of violence, homicide, rape, suicide attempts, and having friends and community members die or be attacked. As most of this trauma is not internally but externally generated, the most effective way to reduce it is to change society. However, society doesn't walk into a therapy office. Those who experience societal violence and discrimination carry the burden of this oppression in their minds and bodies. Often these

clients believe they are damaged or weak or lacking resilience. Some transgender and autistic people know that family, close relationships, and society have created and maintained conditions that drive these traumas, and they are understandably angry. They will call into question strategies that reflect providers' unexamined privilege or ignorance of trans autistic realities, or they may simply quit participating. When clinicians recognize the price paid by trans autistic people for societal prejudice and aggressions, therapeutic trust grows. This trust, along with skillful trauma response strategies, can help minority members move from shame and helplessness to personal authority, community action, and healthy boundaries.

HOW VIOLENCE AND STRESS DRIVE TRAUMA, ANXIETY, AND DEPRESSION

Often people think of trauma as resulting from a single incident—a rape or a horrible car accident. However, for many people, individual traumas lie within a matrix of chronic stress. The steady diet of discrimination, the heart rate rising with every trip to the bathroom, the taunts and sneers in the school hallway or on the street, and the physical or sexual assault by a schoolmate or a date are all part and parcel of life for trans autistic people. Acute traumas rise as spikes above an already elevated baseline of activation and dissociation. Each time a threat becomes reality for oneself or one's friends, hypervigilance grows. This daily reality of discrimination and violence fuels feelings of rage, hopelessness, and danger that contribute to the anxiety, depression, and suicidality of transgender and autistic people (Clements-Nolle, Marx and Katz 2006; Wilson *et al.* 2016).

Violence and stress are what happen to people; trauma is how the body and mind respond to this violence and stress. Trauma may present through a variety of physical and psychological symptoms including acute injury, chronic stress-related health conditions, depression, anxiety, and post-traumatic stress disorder (PTSD). The World Health Organization (WHO) classified violence into three categories: self-directed, interpersonal (between two or more people), and collective (inflicted by large groups of people or institutions) (Krug *et al.* 2002). All three types of violence are experienced at high rates by transgender and autistic people.

These types of trauma are interrelated: The collective trauma of systemic oppression contributes to interpersonal trauma of violence and discrimination, which feeds into personal trauma of suicide and self-harm. Systemic oppression is discrimination against people of a minority group that is embedded into the structure of society. Those who are not subject to this oppression may not even be aware of its presence or effect. For example, discrimination against transgender people results both in the laws that prevent transgender people from using the bathrooms that are appropriate for their affirmed gender, and in the designation of all-gender bathrooms in schools and other public and private places. Backed by this sanctioned discrimination, perpetrators of hate crimes feel emboldened to attack transgender people who use the bathrooms that are most appropriate, and to commit other violence and bullying against transgender people. The combination of this systemic violence and the experience and threat of interpersonal violence can lead to increased suicide and self-harm by transgender people.

Suicide and self-harm

Suicide, suicide attempts, and self-harm behaviors are unfortunately common among trans autistic people. Suicide is traumatic for those left behind and deeply affects the entire community. Of course suicide attempts and suicidal ideation also are traumatic for the individual making the attempt. David Conroy, a survivor of suicide attempts, explains:

> Many of us are haunted by memories of acute crises, acts of self-injury, or extended periods of severe depression. Like citizens of a besieged city, we lived through periods of time in which we had a realistic and unrelenting fear that we would soon be dead. We suffer PTSD simply from having been suicidal, independently of whatever particular traumas may have contributed to our becoming suicidal, such as abuse during childhood or exposure to the violent death of someone else. (Conroy 2017)

Rates of suicide for autistic adults were found to be 7½ times higher than the rates for neurotypical people in a Swedish countrywide study (Hirvikoski *et al.* 2016). An English study of autistic adults confirmed these high rates, finding a "66% lifetime experience of suicidal ideation and a 35% lifetime experience of planned or attempted suicide" (Cassidy *et al.* 2014). Transgender adults in the USA attempt suicide at nine times the US national rate, with 41% having made at least one suicide attempt (Haas, Rodgers and Herman 2014). High suicidality begins in

childhood for transgender people, with 30% of transgender adolescents and emerging adults in a US clinical study reporting at least one suicide attempt, and 42% reporting self-injurious behaviors (Peterson *et al.* 2017). A study of Scottish transgender youth found the self-harm rate to be a startling 96% (Bridger *et al.* 2017). These findings are more than statistics for anyone who serves or cares for trans autistic people or who is a member of the trans autistic community. They represent clients, friends, and family members.

Fortunately, we know what will help the transgender community. Research into factors that reduce suicidality for transgender people does not point to anything about *being* transgender that increases suicidality; rather, it is how transgender people are *treated* that impels them toward suicidal thoughts and actions (Tannehill 2015). While awareness is beginning to grow regarding the high autistic suicide rate, there is no research available to identify contributors to autistic suicide or that identify resiliency factors. We do know that autistic suicide rates are four times higher for "high-functioning" than for "low functioning" autistic people, and two times higher for autistic women than for autistic men (Hirvikoski *et al.* 2016). Given that both transgender and autistic people are subject to ongoing interpersonal and collective discrimination and trauma, it is likely that some of the same factors that impact suicidality in transgender people and other discriminated groups also affect autistic people, although research is needed to identify autistic-specific risk and resilience factors.

Depression and anxiety co-occur at high rates for both transgender and autistic people (Croen *et al.* 2015; James *et al.* 2016). Psychiatric medication may be helpful for decreasing depression, anxiety, and suicidality. Unfortunately, autistic clients have noted the difficulty in finding medications that have the desired effect and to which they are not overly sensitive. These challenges, along with difficulty in accessing and working with psychiatrists who will understand and accommodate their autistic sensitivities, communication, and executive functioning differences have made clients reluctant to continue with psychopharmaceutic trials. Some clients have a positive response to certain forms of neurofeedback, which has less impact on sensitive digestion and metabolism, while others find medication that works well enough, after multiple trials.

Suicide crisis lines are an important component of suicide reduction. There are several hotlines currently available to transgender or LGBTQ people, yet responders may have little or no training in communicating with autistic people. No such autistic or neurodivergent-specific services are available. Hotlines and emergency services could be made accessible to autistic people if more were equipped for text messaging or chat, as many autistic people can't make phone calls, especially when in crisis, and a significant percentage of autistic people are also deaf (crisis service lines are listed in Chapter 9 Resources).

Efforts to reduce depression and suicidality must consider transgender and autistic experiences. Support groups and other activities that require large amounts of social engagement and sensory stimulation are generally uncomfortable for autistic people. Exercise and good sleep habits are often prescribed to depressed people but can be a setup for failure for autistic people, who frequently have difficulty with these suggestions due to complicated sleep problems and chronic health conditions that make exercise difficult. For transgender people, additional obstacles to exercise include chest binders (for AFAB people), locker rooms, and the inability to swim and still present as their identified genders. When trans autistic people are unable to follow exercise or sleep recommendations due to trans or autistic issues, they may be blamed for not getting better.

The most important and effective strategy for reducing suicidality among transgender youth is for primary caregivers to move toward a position of strong support for the child's asserted gender identity and expression (Travers *et al.* 2010; Veale *et al.* 2015). Given the greater dependence on parental support of autistic youth and adults, this recommendation becomes even more important for trans autistic youth. Guidelines for growing family support for trans autistic people will be presented in Chapter 6, and information on responding to crises, including suicidality, are provided in Chapter 9.

Interpersonal violence

Interpersonal violence is a common experience for many trans autistic people. Some forms of interpersonal violence are recognized as hate crimes and some, such as exclusion, are not criminal offenses but result in trauma nevertheless. These acts of violence and discrimination, along with the collective violence of systemic oppression, create minority stress. A hate crime is defined as "a criminal offense against a person or property motivated in whole or in part, by an offender's bias against a race, religion, disability, sexual orientation, ethnicity, gender, or

gender identity" (Federal Bureau of Investigation 2010). Even in places where these crimes might be prosecuted, trans autistic people are reluctant to talk with police as they fear exposure and retribution, don't have the energy to deal with court proceedings, or do not trust that the police will treat them well.

Between 2008 and 2016, more than 2,300 transgender people were murdered around the world. Most victims were under the age of 30. In the USA, most of those murdered were trans women of color. The 2,300 figure is in all probability a low estimate, as many hate crimes go unreported and most countries do not identify or track homicides of transgender people as such (Trans Murder Monitoring Project 2017). Because transgender people have become more visible in the media and some antidiscrimination laws have gone into effect, it is easy to get lulled into the idea that violence is decreasing. This may be true in some locales, but is certainly not universally true.

Physical and sexual violence toward transgender people begins in elementary school and continues into adulthood. More than 13% of the 27,000+ participants in the 2015 *US Transgender Survey* reported being sexually assaulted in K-12 grades, and 47% reported being sexually assaulted sometime in their lifetimes. US jails, prisons, and juvenile detention facilities are especially dangerous for transgender people, who are five times as likely to be sexually assaulted by staff and nine times as likely to be assaulted by fellow inmates than cisgender inmates (James *et al.* 2016). Throughout all reports on murder and sexual and physical assault, the rates of violence increase for those who are disabled, people of color, identifiably transgender, poor, homeless, or sex workers.

Trans and autistic and other people who experience hate crimes against their identity communities know that this violence is not an act from one individual to another but from an individual to a class of people that includes themselves. Janet Mock writes: "This pervasive idea that trans women deserve violence needs to be abolished. It's a socially sanctioned practice of blaming the victim. We must begin blaming our culture, which stigmatizes, demeans, and strips trans women of their humanity" (Mock 2014, p.161).

Research into violence against autistic people is very limited. Domestic violence and sexual assault of autistic people is largely unaddressed in research and in social service programs, and is just beginning to be noticed in research. In a 2013 study of "high-functioning" autistic adults, both men and women had two to three times the rates of sexual-contact and sexual-coercion victimization as did neurotypical adult controls (Brown-Lavoie, Viecili and Weiss 2014). Autistic youth experience twice as much bullying as their neurotypical peers. Those with greater communication differences, higher sensitivity and reactivity, and fewer friends are bullied multiple times a week for many years (Cappadocia, Weiss and Pepler 2012). Autistic adults are more likely than age, sex, and IQ-matched peers to report experiences of physical, emotional, and psychological abuse from an adult and victimization, bullying, robbery, and sexual assault by a peer (Weiss and Fardella 2018). This victimization continues into adulthood; people "with social or behavioral disabilities" are twice as likely to be victims of crimes as non-disabled people (Coleman and Sykes 2016).

Systemic oppression of trans autistic people

Chronic stressors for trans autistic people include: discrimination in employment, medical settings, housing, and education; general social discrimination; prejudiced media portrayal; and systemic discrimination, such as the absence of ways to indicate non-binary gender on most documents. Information on responding to the housing, employment, education, and general societal discrimination of trans autistic people can be found in Chapter 8.

The poverty experienced by transgender and autistic people severely impacts their ability to access the medical and social services they need. Funds for electrolysis, transportation to support groups, clothing, legal name-change paperwork, travel and housing costs during and after gender-affirming surgery, and trained gender therapists are limited or nonexistent. This inability to take action on medical and social transition is a common source of distress for trans autistic people without a source of income, or who are living on meager social support.

While social supports may provide some medical or therapy care, there is little choice of care provider. One of the most frustrating experiences for me as a provider (and vastly more frustrating for my clients) is sending someone for psychiatric evaluation, psychological assessment, or medical care, and having them refuse to complete the assessment or follow-up treatment because of misgendering and discriminatory treatment by staff, or being labeled as resistant or noncompliant because they couldn't tolerate the treatment environment or recommendations. There is a tremendous amount of minority stress that trans autistic

people experience within the medical and mental health system. This was the area most commented upon in the Neuroqueer Survey. When asked "What steps can mental health providers take to better meet/serve trans autistic patients/clients?", respondents replied:

> My experiences with mental health providers were so bad, these questions [on the survey] were on the edge of triggering. Providers need substantial education around how to adjust their allistic-focused methodologies to work for autistic people; the therapeutic strategies are not the same! (47-year-old white genderqueer)

> Listening and believing/accepting without challenging, making assumptions, and/or antagonizing; explicitly acknowledging when they are insufficiently educated in either/both issues and taking steps to seek out relevant information/training. (22-year-old white non-binary xenogender)

> Do not always automatically question one identity due to the other. Yes, a person can be trans AND autistic. Be more supportive, inform themselves better about the issues. Don't use stereotypes. Try to be sensitive about the issues, especially if the person doesn't seem to fit in the cliché image of a stereotype trans person or a stereotype autistic person. And yes, an autistic person can feel and have emotions too. It's a stupid stereotype that an autistic person can't perceive or understand emotions. And most importantly: be open and aware of diversity! If you know one autistic person, you know exactly one. The same applies to trans people. (28-year-old white trans man)

REDUCING TRAUMA AND BUILDING RESILIENCE

As providers, the most important steps we can take to support resilience is to know well the collective and interpersonal violence experienced by trans and autistic people, and particularly those who share other oppressed identities, including people of color, women, poor and homeless people, and sex workers. By affirming clients' experience of systemic oppression, and by discussing experiences as examples of minority stress, violence, and discrimination rather than identifying fears as simply anxiety or depression, clients can begin to recognize how much societal dysfunction they've been carrying and begin to hold others more accountable—at least in their minds—as it may not be safe to call out others as accountable at work or on the streets.

You may also begin to advocate with the client to support reframing their experiences and behaviors within the context of an inhospitable society rather than solely as a personal problem. Your involvement in advocacy for trans and autistic people, whether in correcting others' misgendering of your client or in changing the intake forms and waiting room areas to be autistic- and transgender-supportive, will send a strong signal of support. Regardless of being a provider, a family member, or an ally, the steps you take to understand and to act will make a great difference, both in your relationships with trans autistic people and in their hopefulness for themselves and their communities.

STEPS FOR SUPPORTING TRANS AUTISTIC PEOPLE EXPERIENCING TRAUMA AND MINORITY STRESS

1. Take workshops in unlearning racism, classism, and ableism. These can be found by contacting local and regional human rights organizations or local colleges.
2. Sign up for local and national/international updates on autistic and trans advocacy issues and become active as a professional, making calls and supporting trans autistic people in presenting their experiences. Consider what you can do in the local community to reduce minority stress for trans autistic people of all races, classes, and abilities. Contact local LGBTQ and disability rights organizations, and national or regional transgender support and disability rights organizations. Make sure transgender and autistic people hold key positions in the organizations you join or follow.
3. Discuss and share articles or videos about minority stress with your clients. Discuss experiences that clients have perceived as their own weaknesses and explore with them how systemic oppression and lack of accommodation for disabilities have contributed to these negative experiences and self-talk. Have honest discussions about any ways they may have experienced this minority stress in your office or practice and discuss actions to change these experiences (see Resources).
4. Look at minority stress in your own life. How have you responded internally? What has supported you? Will these kinds of supports be

appropriate for trans autistic people, or are they out of reach? Look for ways that you can make others in your workplace and consulting groups more aware of minority stress, privilege, and oppression.

5. Work with local transgender support groups to develop competency in supporting autistic transgender people. Possible ideas: access online meetings and community to gain understanding; incorporate information about autism and neurodiversity in trainings; consciously model recognition of neurodiversity and respect for differences in group meetings; and support neurotypical/neurodivergent dialogue in interactions with friends and colleagues.

6. Survey transgender care providers to identify communities which may not be served because they are not showing up in offices or clinics. Look for differences by zip/post code, race, ethnicity, housing status, and source of fee payment. Appeal to representatives from the unserved communities to meet with you and other care providers to discuss their needs for service. If possible, do the same with autism care providers.

7. Take trainings to develop skills in working with acute trauma. In these trainings, ask questions specific to working with transgender and autistic people, to bring these concerns to the forefront for providers specializing in trauma care. Form relationships with trauma specialists in your area and discuss trans, autistic, and minority-specific trauma issues and treatment.

RESOURCES

Minority stress

Video (3 minutes): *Stress and Resilience in the LGBT Community*, by I. Meyer, Williams Institute, UCLA, 2015. Available at www.youtube.com/watch?v=RqD0iLcTeAo

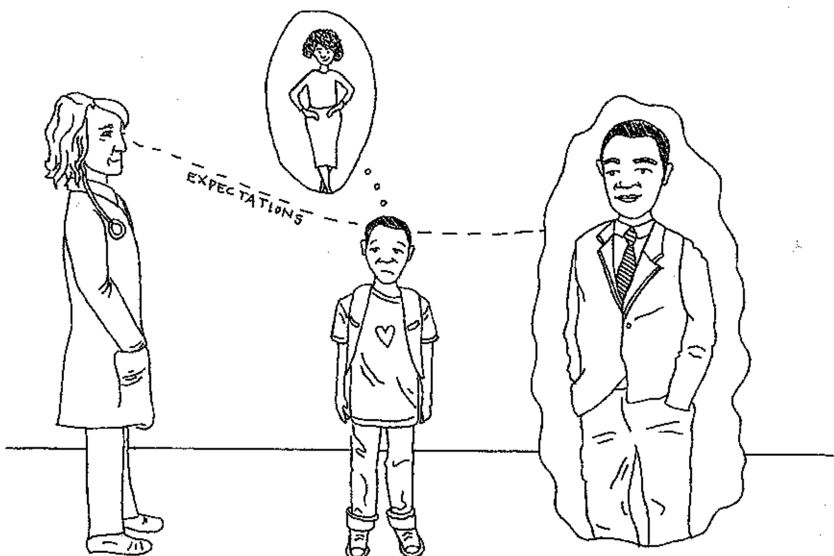
Video: *How Racism Makes Us Sick*, by D.R. Williams, TEDMED, 2016. Available at www.ted.com/talks/david_r_williams_how_racism_makes_us_sick/discussion

'Expecting Rejection: Understanding the Minority Stress Experiences of Transgender and Gender-Nonconforming Individuals,' by B.A. Rood, S.L. Reisner, F.I. Surace, J.E. Puckett, M.R. Maroney and D.W. Pantalone, *Transgender Health 1*, 1, pp.151–164, 2016. Available at www.ncbi.nlm.nih.gov/pmc/articles/PMC5685272

'Measuring Multiple Minority Stress: The LGBT People of Color Microaggressions Scale,' by K.F. Balsam, Y. Molina, B. Beadnell, J. Simoni and K. Walters, *Cultural Diversity and Ethnic Minority Psychology 17*, 2, 163–174, 2011. Available at www.ncbi.nlm.nih.gov/pmc/articles/PMC4059824

Chapter 5

Working with Connection, Attachment, and Relationships



THE IMPORTANCE OF BEING MET

We know ourselves through the reflection of others. Yet what happens when others perceive us as someone we are not? Or when others expect us to perform in ways that do not make sense to us, or of which we are incapable? It would be more accurate to say that we know ourselves from both the reflection of others and by the failure of reflection. From infancy, transgender and autistic people are assumed to be, and expected to perform as, someone they are not. This can result in a profound sense

of disorientation and disconnection. The poet Adrienne Rich expressed this experience when she wrote:

> When those who have power to name and to socially construct reality choose not to see you or hear you, whether you are dark-skinned, old, disabled, female, or speak with a different accent or dialect than theirs, when someone with the authority of a teacher, say, describes the world and you are not in it, there is a moment of psychic disequilibrium, as if you looked in to a mirror and saw nothing. Yet you know you exist and others like you, that this is a game with mirrors. It takes some strength of soul—and not just individual strength, but collective understanding—to resist this void, this nonbeing, into which you are thrust, and to stand up, demanding to be seen and heard. (Rich 1986, p.199)

For many transgender and autistic people to be acceptable, they have to *not* be themselves, which runs perilously close to not being. Simply by being their authentic selves, many transgender people risk losing the love and respect of family and community that is conferred when they mask their internal experience, or they risk losing themselves through a life of masquerade with all the attendant mental health consequences, as described in Chapter 6.

Autistic people share this experience in an even deeper and more inchoate way. In myriad ways, from infancy on, so many find themselves not met or mirrored by neurotypical family members or by peers, teachers, society, and media. For those who are able to mask or restrain their autistic expression, pretending to be "normal" begins before they even know what *pretend* means. This failure of mirroring, complicated by protective pretending, has profound effects on attachment and on the formation of secure and satisfying relationships with the self, with others, and with the world in general.

HOW THE TRANS AUTISTIC EXPERIENCE AFFECTS ATTACHMENT AND DEVELOPMENT

Attachment and development theory

A great deal of work has been done on the need for secure attachment with primary caregivers, and the impact of this primary bond on the development of the self and of the ability to be in relationships (Ainsworth 1973; Bowlby 1969, 1973). A brief review of attachment and development will serve as a foundation for understanding how the failure of mirroring, along with camouflaging of the self, can affect an individual's ability to self-regulate and to feel safety in relationships.

All humans manage their internal, environmental, and relational experiences. Much of what is involved in being human, even in being a mammal, lies in this management of inner and outer experiences. You may call this management skillfulness, avoidance, defensiveness, manipulation, adaptation, or all of the above. All are efforts to regulate the internal experience and have some agency or control over the external experience. This management is multilayered and interconnected.

When we are born, we have few resources available to regulate our bodies and to control our environments. What we have are the abilities to become activated, to cry and move about, and to shut down when crying and moving our bodies doesn't work. We also have the basic building blocks of social connection: touch, taste, smell, hearing, vocalization, and eye contact (although some of these may be missing or slow to develop). We rely on caregivers to help maintain the right temperature, provide nourishment, identify causes of pain and discomfort, and correct conditions so that we can come to rest. Our caregivers do this by paying attention to our nonverbal signals, by learning the difference between a cry for more engagement and a cry of overstimulation, as well as by co-establishing a rhythm to food, sleep, and activity that supports physical and emotional needs.

The more that a child finds their nonverbal communication well reflected and met, the more secure their attachment, hence the easier time the child will have in navigating relationship dynamics throughout their lives; from early friendships to later long-term intimacy (Schore 1994). If, however, a child feels they cannot be met by others, that their efforts to be seen are ignored or misunderstood, they will tend toward an anxious-avoidant attachment style. Anxious-avoidant styles are characterized by a constriction of emotional expression and avoidance of interaction. If their family and peer relationships are characterized by a constant need to perform to get needs met, or if caregivers are themselves highly activated by their own trauma, then anxious-resistant attachment ensues. Anxious-resistant styles are expressed as clingy and difficult to comfort, with an experience of helplessness. If children experience significant trauma early in life, disorganized attachment styles may develop. This attachment style is characterized by disoriented and highly dysregulated behavior and interactions.

What happens in the first three years, and especially in the period just prior to birth through the first three months, has profound lifetime effects on relationship patterns and internal regulation (Kain and Terrell 2018). These patterns of internal regulation and relationship are linked to an individual's primary attachment style: secure, anxious-avoidant, anxious-resistant, or disorganized. Many adoptive parents learn this as they care for their young children: even when their parenting is present and consistent, their child has experienced a major rupture in the consistency of smell, sound, and rhythm that served as the original set to their nervous system; and the child's ability to develop a secure attachment is strongly challenged by this early major rupture.

Autistic–allistic attachment challenges

Autistic children and their caregivers face considerable challenges with the early nonverbal and later verbal communication needed to develop co-regulation and caregiver–child secure attachment. The neuro-physical actions involved in social communication don't work as well, or work differently, for autistic children, for reasons that remain unclear. We know there are differences in ventral vagal nervous-system functioning (the neurological underpinnings of social communication) and that there are a variety of genetic and developmental reasons why this may occur. We do know that what is soothing vocal communication or eye contact for a neurotypical child may not be so for an autistic child, but in fact may be overstimulating and disturbing. We also know that autistic children may pick up many sensory inputs that neurotypical caregivers and peers might not see, hear, or feel.

Both the caregiver and the autistic child can become frustrated and exhausted. The effort that both child and caregiver expend to span the neurobehavioral divide between them is great, and failures to soothe and come into co-regulation are difficult for both parties. Oral-motor problems are more common with autistic children, resulting in more difficulty with breastfeeding, which also affects the parent–child bond and the regulation that comes from needs being met. Caregiver touch may be overstimulating to the child as well, and again the bonding that is usually supported by skin-to-skin connection becomes a source of pain and sadness. This does not mean the child does not want connection, but that they and their parents struggle to navigate the sensory issues that intrude upon this desired connection. Connection and relationship can become associated with distress, which can push both child and parents into more avoidant or frustrated behavior with each other. Despite these difficulties, many parents develop loving and supportive relationships with their autistic children.

Difficulty with social communication, including vocal tone and inflection, facial and head movement, and vocal prosody present challenges to non-familial relationship development. While caregiver and child may develop their own ways to share connection, these ways often don't map onto relationships outside the family, which rely upon neurotypical ventral vagal facility. It is this neurological functioning difference, along with cognitive processing differences, that cause so many relational problems from childhood to adulthood for autistic people. Tendencies to talk with little change in tone, for too long or too short a time, too loudly or too quietly, or with too strong or too faint facial expression cause social rejection, bullying, and loneliness that all the love and acceptance of supportive primary caregivers cannot erase. Many autistic people try to cover or compensate for nonverbal differences without understanding the subtle rules of behavior that neurotypical people may never think about. Attempts to camouflage internal experience or to be a chameleon, matching others' behavior, often backfire.

Adriel Eliora Smith, an autistic non-binary person, writes in their poem "Passing Strange" about their experiences of "passing" and "not passing" socially.

I was hated the day I was born.
I am not "normal."
(What does that mean? I cannot divine the magic formula
rule book cheat sheet even enough to know how I am
breaking it.)
Years later I will know there were
a thousand signs
And a thousand fears barely known that make me
Not like them
I will realize this was always there and I was always me
As I struggle to breathe behind my mask.
But I am invisible
Or else they do not care to look. (Smith 2017)

Smith's words reflect the common autistic experiences of not being seen or included: of being seen and welcomed only if they perform "neurotypical" well enough, or of being seen as they are—and rejected. A lifetime of these three types of social experiences in family and/or peer relationships feeds both avoidant and anxious attachment styles in many autistic people. They then bring these attachment styles to their relationships and close friendships, longing to be understood and met, afraid to show themselves, and pretending to be who they aren't so they won't lose the friendships and social acceptance they may have. Many neurotypical people have unexplored assumptions and expectations about behavior and communication, along with a low capacity or willingness to reach beyond comfortable neurotypical communication to make connection across neurotypes. This is the neurodivergent/neurotypical relationship divide. To bridge this gap, both neurodivergent and neurotypical parties must work to understand minds and experiences unlike their own.

Transgender–cisgender attachment challenges

Being transgender adds another twist to attachment dynamics and relationship development. Transgender people—in being seen, reflected, and treated as a gender other than their identified gender (from baby announcement to coming-out day and far beyond)—often feel unseen. Because of their gender dysphoria, they may have dissociated from their internal experiences, including the experiences of their emotions. Recognizing that their relationships are most often linked to their assumed genders, they experience the reasonable fear that if they were to be themselves they would lose relationships. One anonymous youth respondent in a survey of transgender youth wrote:

> Since I was born female I feel like I get lost in translation. People can't understand what they're seeing when they see me so they label me as something I'm not and I have to keep the lie alive in order to avoid being perceived in a negative light. (Baum *et al.* 2014, p.64)

Many transgender people experience loss and rejection—at least initially, and often permanently—when they do come out. In a survey of LGBT experience in the UK, only a quarter of respondents said they were supported by all family members who knew they were transgender (Bachmann and Gooch 2017). The presence or absence of relational support is the primary determinant of depression and suicidality in transgender youth and adults (Bockting *et al.* 2013; Travers *et al.* 2012). We all need our families and communities to reflect and affirm us. Healing relational bonds when possible, and forming new supportive relationships, are major components of the emotional work of transgender autistic people and of the people who love them.

Other marginalizing experiences

Many transgender autistic people have additional experiences of being "othered." Many autistic people also experience conditions such as epilepsy, deafness, or medical disabilities that result in exclusion and discrimination from society and from transgender spaces. Some of these are subtle, such as vision or balance issues that affect ability in sports and games, and in riding a bicycle or driving a car. All of these disabilities set them apart, especially when the physical abilities are seen as markers of ability or maturity.

Race, class, and immigration status, while usually shared within family and often close community, can affect feelings of belonging or alienation within school, work, trans spaces, autistic spaces, and society at large. There is a tremendous gap in services for transgender and autistic people who lack the wealth or information access to secure support for their needs. Some needs are met by public insurance and nonprofit programs, but many are not. For example, a gender-affirming surgery may be accessed through public health insurance, but electrolysis and facial feminization surgeries, which are so important in reducing gender dysphoria, are not covered and are unaffordable for many trans women.

Many of my clients speak of feeling like impostors. When asked, they explain that when they were children they felt like impostors because they did not act or fit in with their peers; after coming out, they felt like impostors as trans people because their narrative did not fit the established trans narrative. This narrative excludes non-binary transgender people, those who came out as adults, and those who fit neither male nor female stereotypes before or after transition to identified gender. Daily misgendering is a powerful contributor to the impostor experience, particularly for non-binary people. Autistic clients also speak of feeling like autistic impostors, again because they don't fit the narrative developed through medical and media representations of

autistic people. Andrea Michael, an autistic artist who was first diagnosed in their 30s, wrote:

> I wasn't prepared for the imposter syndrome that set in after my autism diagnosis. Why? Possibly because, after my diagnosis, I scoured the Internet for autism material, found too many opinions that my version of autism wasn't "real autism"—and heard more often than not that if I was late diagnosed, that meant I was at the very edge of the diagnosis, just a mild case with no "real" challenges. (Michael 2016)

For people who were not diagnosed until they were teenagers or adults, whose autistic traits were identified as moral failures and who are frequently told they don't seem autistic, this impostor experience contributes to feelings that they don't deserve support or understanding. Social camouflaging plays a role in this impostor feeling, as people present as neurotypical to protect themselves. In a study of 92 autistic adults, participants conveyed that the relationships they had while they were camouflaging autistic traits, while they may have been successful in reducing rejection or giving a sense of connection, also felt false, as they were built upon a camouflaged self. Consequently, these relationships resulted in loneliness because the autistic person knew they were not based on truly being known or understood. The authors noted that many respondents reported that not only was this camouflaging isolating, it was also extremely stressful and exhausting—resulting in respondents needing time alone to be themselves and to recover from the effort, resulting in further isolation (Hull *et al.* 2017).

SUPPORTING AUTHENTICITY WHILE CREATING SAFETY

Trans autistic people experience both acute trauma and minority stress within their homes, schools, workplaces, health care settings, and in society in general, as described in Chapter 4. Trauma research has demonstrated that the strongest component of resilience to trauma and stress is secure attachment and the support of family members (Center on the Developing Child at Harvard University 2015). This strong support is even more important for trans autistic individuals due to the alienating experience of being both autistic and transgender in a neurotypical cisgender world. However, this support is more easily compromised for trans autistic youth, as their gender differences are not perceptible to caregivers, and their cognitive and communication differences make connection with parents much more difficult.

The long-term effect of being perceived inaccurately impacts the ability of transgender people to come into trusting relationship with others. This is why it matters so much that others get pronouns, names, and other terminology right. Similarly, being seen as non-empathic or as weird by others who perceive autistic people as less than fully human can negatively affect the desire to connect. These experiences of misgendering and misperceiving trans autistic people result in identity traumas—traumas that are experienced because of *who we are*, not because of something that happened to us. They exact a deep sense of shame, of being unwanted and unworthy of being a member of a family, community, or even of being alive.

Physiologically, shame is inhibitory. In shame, we pull back from the expression of ourselves. Societal shame is meant to keep people behaving within community rules, a social form of survival. The rules are based on the belief that if everyone follows them, we are more likely to hold our society together and stay safe. However, shame acts against societal outliers and minorities. The more society becomes afraid of difference, the less it allows individual expression that differs significantly from the norm. Developmentally, when a young child experiences shame, it is essential to their physiological and emotional wellbeing that the rupture caused by shaming is repaired and a connection with caregivers is restored. The child learns that what they did was not acceptable, that it is important to not do it in the future, but that they are still loved. If there is no repair, the rupture can lead to traumatic shame memories (Matos, Pinto-Gouveia and Costa 2013). When social rules invalidate the identity of the child, and when the child is continually unable or unwilling to give up their identity to meet social rules, then repair and reconnection are lost and resiliency is reduced.

Before exploring strategies for supporting the development of resiliency, it is important to understand what individuals do to function when resiliency cannot meet the stress and trauma load. Resilience is usually held to be a personal quality. In fact, it is largely created by society, community, and family—all interacting to make the world safer. When people experience the developmental trauma of not being met or seen, and of being rejected or shamed for who they are, they do the best they can do: they camouflage, withdraw, and compartmentalize. These strategies may help a trans autistic person keep their job, avoid attack, or board the city bus. The strategies work, but at a heavy cost. Underneath the

functional self—the one who shows up at work after being harassed on the bus—freeze or hyperreactivity states are in operation.

Releasing the holding that has been required to maintain an acceptable level of functioning is a formidable endeavor. Often what is held below the surface feels like a Pandora's box, closed so long ago that the contents are unknown and the combination to the lock is forgotten. Yet, for intimacy, self-knowledge, and wellbeing, some loosening of this management strategy must occur. The protective management strategy of creating an apparently functional self is referred to as "faux regulation," or as staying in the "Faux Window of Tolerance" (Kain and Terrell 2018). The term "Window of Tolerance," first coined by Siegel (1999), is used by many developmental trauma specialists to refer to the space in which one can be engaged and responsive, yet not agitated or shut down. I prefer to follow Bill Bowen's terminology of "Window of Creativity" to denote this zone of human function (personal communication 2008). The "Faux Window" is the space in which we appear to be functioning without sympathetic activation or freeze, but are truly experiencing one or both of these trauma states.

Trans autistic people, their loved ones, and their providers often find themselves trying to find their way from the Faux Window to the true Window of Creativity. As they begin to open up to buried feelings and the physical sensations and impulses that go with them, they find their faux regulation slipping away. This can be very frightening. The trick is to build the capacity to tolerate these sensations while carefully attending to and adjusting the amount of time spent with strong sensations and feelings, so the individual does not become overwhelmed and retraumatized along their way to fuller integration, authenticity, and intimacy.

Sometimes trans autistic people knowingly enter this work with a therapist, as they seek to reduce anxiety and depression, heal wounds, and feel more authentic in their bodies. Many times, underlying feelings slip through unexpectedly outside of the therapy room or group, as the trans autistic person shares intimacy or as old hurts are rekindled by current events. Faux regulation, not being true regulation, can be unreliable. A school project, a touch of a partner, a group exercise, a social media posting, or yet another misgendering may cause it to break down, resulting in panic attacks and tremendous waves of grief and pain—Pandora's box opened too quickly and without the requisite internal tools to deal with all that was held inside. In response, the individual may double down on protecting themselves, becoming more anxious, perhaps taking on obsessive or compulsive characteristics, or shutting down more forcefully. At this point all that can be done is to back up, slowly re-establish trust, and resume building the tools needed to tolerate feelings so the individual can work with what has come up.

Suggestions for different ways to do this work are provided later in this chapter. Chapter 6 will provide more guidance on building connection within the family so that trans autistic youth are able to establish true regulation, and with it, greater resiliency for the ongoing stress of living in a cisgender, binary, neurotypical world.

INTIMATE RELATIONSHIPS BEYOND CHILDHOOD

Trans autistic people experience challenges in developing intimate relationships with neurotypical cisgender people. Even if their developmental experience has been fortuitous, and even as the fortunate heal their childhood wounds, trans autistic people will still be dealing with difference, and with being a small minority of the population. When transgender people form relationships, their life experiences guide these relationship choices, with the result that their relationships may look quite different from the cisgender normative experience, particularly the cisgender heterosexual experience.

For similar reasons and for the fact of their different sensory, cognitive, and interpersonal traits, autistic people will also develop intimate relationships that feel natural to them but are different from those that neurotypical people form. These relational differences may be treated by others and by professionals as dysfunctional or immature because neurotypical forms serve as the unexamined standard against which relationships are compared. Autistic forms of relationship may carry some protection or management of trust issues resulting from childhood and ongoing societal wounding. They may also carry healing for the pain and shame of not being seen, as autistic people assert their true natures and their desires around friendship, intimacy, relationships, family, and sexuality.

While professionals may provide some help in resolving trust issues and some guidance around relating to neurotypical people, they will only do harm if they try to guide trans autistic people toward relationship styles that are not native or satisfying to them, or away from relationships that providers do not understand.

Friendship and chosen family for trans autistic people

Friendship or the lack of it is a common theme with my clients, particularly teens and young adults who may have had little success with developing the relationships that were expected of them. Most or all friendships are online, often with people who live far away. Many times, these friendships are formed around shared interests in gaming or fan fiction, or in sharing the autistic trans experience on Tumblr or other social media sites. Coming out as transgender can open up a new world to explore, one where they may meet others like themselves. When this works it is wonderful, but when it doesn't it is especially painful, because not fitting into your own identity group is worse than not fitting in with the general population.

Responses in the Neuroqueer Survey to the question *What would you like to say about peer response to your autistic identity/diagnosis?* fall into three categories: (1) "I don't have peers"; (2) "Most of my friends are autistic and they are very supportive"; or (3) "Non-autistic friends were dismissive of my autistic diagnosis." Given the support offered by autistic friends, it is strongly recommended that providers support trans autistic people in accessing online and community spaces where other autistic people can be found.

Another venue for increasing peer support is transgender spaces. Unfortunately, these spaces present challenges to trans autistic people, as activities such as Trans Pride marches and trans support groups can be overstimulating and full of neurotypical transgender people who do not have awareness or skills in shifting the environment and communication to be more inclusive of autistic people. By making transgender spaces more inclusive and supportive of autistic and other disabled people, great progress could be made in the growth of the trans autistic voice in the transgender community.

Due to high unemployment rates and disabilities, trans autistic people often live with their parents or other family members for a longer time than neurotypical transgender people. The positive spin on this longer-term cohabitation is that parents and children have more time to work through family relationship challenges and to provide a safe and calm landing place. Many transgender autistic people do not have the fortune of this family support because their parents can't afford to provide it, or because of rifts between parents and children due to transgender or autistic identities or other factors. These are the people most at risk—the ones who have the hardest time working through the system, or developing the support system needed to maintain mental and physical health and to go through social and medical transition. Whether homeless, couch surfing, or living in residential care, the jail or prison systems, this population especially needs support in understanding relationship dynamics so they can protect their safety and gain lifesaving support.

Finally, some trans autistic people are able to live on their own or with partners, housemates, or chosen family. When living with others, the constant negotiation of chores, expectations around communication, and managing stimuli continues to be a theme, and early and ongoing relationship issues arise and need to be dealt with. For therapists supporting autistic people working through relationship issues, it is particularly helpful to read autistic writers' accounts of neurotypical people, to assist you in providing your client with an understanding of why neurotypical people do the things they do. Multiple neurodivergent people have written online posts about their understandings and observations of neurotypical people. Once neurodivergence is recognized as difference—not pathology—shame is reduced. The reduction of shame and being found at fault allows for greater ease in negotiating differences in social relating, without clients feeling that providers are forcing a neurotypical agenda.

A notable trait of autistic people is their openness and compassion with regard to differences in others, particularly if those differences have resulted in the other person being marginalized. It is not uncommon for autistic people to connect well with people from other countries who may also be confused by dominant cultural communication and behavioral norms and nuances. Additionally, autistic people understand others who have experienced trauma and loss or who have been outcast by society. When working with trans autistic people, it is helpful to recognize these traits of openness, inclusiveness, and empathy, and to encourage clients to continue to seek out friends in the places where they have had the most success. For younger trans autistic people, it may be helpful to relate stories of older trans autistic people who have successfully made friends with people who share interests and nonjudgmental attitudes.

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find out more about their experience. They spoke of their evolution in working with relationship and camouflaging:

> At this point in my life I've grown into a place where I'm trying to be me as publicly as possible… I try to pay attention to when I'm stopping myself from stimming (for instance) and do what my brain wants me to do instead. I think that pretending to be someone I could never be was killing me, and that applies to my gender identity as well as to being Jewish and autistic… I'm still disabled, still chronically ill and autistic, and still a spoonie, but when I was trying to pass as someone else there was a kind of hopeless, dragging weariness that shut out everything good, and I don't feel that anymore. (Adriel Eliora Smith, personal communication 2018)

Sexuality and intimate relationships

Intimate relationships can be intimidating for cisgender neurotypical people; they are another level of difficulty up for transgender autistic people. If trans autistic people want intimacy with others, and most do, they will often look among people who are somewhat different from them, who may be neither transgender nor autistic. One downside is that because they are in a small minority and their behaviors in the relationship may be less normative, they can be blamed when things are not going well. They may blame themselves as well. In addition, trans people must carefully consider the best time to share their trans identity with a cisgender person, because this information always affects how a potential partner relates to you, sometimes in ways that threaten safety, and often in ways that risk losing the relationship before it has a chance to be established. It's very important that providers and allies disabuse everyone involved of the attribution of blame for relationship issues to transgender, autistic, or other minority-related identities or characteristics.

It is not wrong for a transgender man or woman to withhold disclosure of their gender history. They are a man or a woman and want to be treated as such. Similarly, neurotypical people in relationships with autistic people do not stand on a relationship high ground just because their partners' ways of relating are less common. When counseling couples who live on either side of a neurotypical/neurodivergent divide, it is important to establish parity and not to pathologize autistic characteristics, but rather to help each person communicate their experience and understand the other's experience. Similarly, it is critical to not privilege the experience of either the transgender or cisgender partners, nor that of binary or non-binary partners. Often this requires the partner in the socially dominant position to dismantle internalized prejudice. Providers can also make the mistake of discounting the needs of the cisgender, binary, and neurotypical partner, particularly if they do not share these identities with their clients. Relationship work between people with different levels of societal privilege takes careful work in creating a truly nonjudgmental space for partners to explore their own experiences and the painful and often unseen ways that internalized oppression plays out in the relationship.

There has been little research on the kinds of relationships that are satisfying to autistic people. My experience with transgender and autistic people is that their desires around relationships are generally more heterogeneous than those of the neurotypical population. It is not unusual for autistic people to be queer, asexual, aromantic, polyamorous (open to intimate relationships with multiple people), and/or to be involved in bondage, discipline/domination, submission/sadism, masochism (BDSM) (Galupo, Henise and Mercer 2016). Transgender people are more likely to be non-heterosexual, with only 15% of those surveyed in the *US Transgender Survey* identifying as heterosexual (James *et al.* 2016). Autistic people also are predominantly non-heterosexual, with a recent large online survey of autistic adults finding that 69.7% of respondents were not heterosexual (George and Stokes 2017).

Providers who work with transgender and autistic people should develop a familiarity with asexual and aromantic orientations (also known as ace/aro spectrum) so that they are able to talk about these orientations without pathologizing them. Similarly, providers can learn about polyamorous relationships and recognize these as valid relationship styles that are often held as wrong by society, family, and religious institutions. BDSM, frequently referred to as "kink," is a kind of relationship intimacy that may or may not include sex. Because many people hold BDSM to be violent or transgressive, clients may be reticent to share that they engage in BDSM practices. Again, this is an area where mental and medical health providers can serve their clients by becoming familiar with BDSM practices and common language. Many autistic and transgender people find the BDSM community to be more accepting

of diversity. In addition, the kink community offers a degree of safety and structure through established protocols for negotiation of activities, educational workshops, safe words, safe facilitated spaces, and a culture of care for participants. By knowing the expectations and practices in the kink community, providers will be able to explore issues such as how BDSM does or does not meet relationship needs and desires, and how to maintain safety and care of self and others.

Because of clients' reluctance to share kinky or polyamorous relationships or ace/aro spectrum sexuality, it is important both to become educated about these sexualities and relationship styles and also to explore and resolve any countertransference you may have regarding asexuality, non-monogamous relationships, or BDSM. This education will guide you in changing your language when you ask about relationships, and in changing language on websites and forms that indicate your awareness and support for a range of sexuality and relationship styles.

This education pertains to teen clients as well as to adults. Many people still carry the misinformation that autistic youth are not sexually active. Consequently, sex education is often delayed or absent for autistic youth and young adults, and when offered it is generally presented in ways that are not consonant with the autistic experience (Barnett and Maticka-Tyndale 2015). While sex with others may be delayed for some autistic people, and a higher percentage of autistic people are asexual, all autistic people (regardless of level of intellectual disability) need opportunities to gain understanding of sex and intimate relationships (Samowitz 2010). This information should include exploration of a range of sexual and romantic orientations, delineating sexual from romantic orientation, and introducing the possibility of being on the ace/aro spectrum. Exploration should also include openness to non-monogamous relationships and BDSM practices. Special attention should be given to areas of concern and interest to autistic people, including how to work with heightened sensory sensitivity and how to negotiate desires in relationships and sex, given any communication disabilities or communication differences with their prospective partners. In light of the high rate of sexual assaults and domestic violence for autistic people of all genders, it is especially important to discuss how to recognize signs of coercion and abuse, how to communicate boundaries, and how to safely access help if sexually or relationally victimized.

STRATEGIES TO SUPPORT REGULATION AND RELATIONSHIP

Note: Parent–child relationship strategies will be explored in depth in Chapter 6.

- Imagine growing up autistic and transgender, and consider how these experiences might have affected your relationship with your caregivers. Compare your thoughts with the writings of trans autistic people (see Chapter 1 Resources).
- Identify your challenges in verbal and nonverbal communication and relationship building with autistic clients. Look at what you expect in communication, and the ways in which receiving something different affect you. With your client, notice when you do better and when you do worse at meeting them. Together, identify what you are doing that makes it better or worse. Make a practice of moving toward the more successful strategies and continuing to check in with client to repair experiences when you are off track.
- Share passages from articles, poems, or postings by trans autistic people and ask trans autistic clients if and how their experiences relate to those of the writers. Support your clients in writing or expressing their experience in other art forms. Excellent sources include: anything by Autonomous Press, including their journal *Barking Sycamores*; the book *All the Weight of Our Dreams: On Living Racialized Autism*; and blogs and websites by trans and/or autistic youth and adults (see Chapter 1 Resources).
- Attend training on developmental trauma, online or in person, and consider how this material relates to your trans and autistic clients and how it might diverge from their experiences. Bring up the identity trauma experience of your clients in the training so that trauma therapists also begin thinking about and including the experiences of autistic people and sexual and gender minorities.
- Work with clients to develop self-soothing skills that work for them in moments when they are in relationships, including texting and online connections. You may discuss how neurotypical people use facial, vocal, or breathing strategies that are often less available

or less helpful to autistic people; and note that autistic people have their own strategies. These strategies may include informing the other of their needs related to autism (e.g., more time to make decisions, to be asked before being touched), taking a break, stimming in a way that works in social situations, etc.

- Review articles on structural dissociation (Fisher 2014; Nijenhuis, van der Hart and Steel 2004) that describe faux regulation or protective management styles. Discuss with a friend or colleague what you are learning and how it relates to your work.
- Explore with clients what has been most satisfying to them in friendships and connection with others. Be sure to include relationships with animals, and with others through music, games, art, and other interests, as well as brief moments with strangers that were satisfying. If relationship development is an important goal of the individual, look together at what worked well in these situations and find ways to enhance these experiences.
- Validate clients' experience regarding not being met. Give them time to unpack the experience of not being seen and of not fitting in. Check with them when you sense that you have not understood an experience, and endeavor to understand as best you can. Support a wider range of verbal and nonverbal expression so that clients can be met on their own terms and do not have to perform neurotypically to work with you.
- Team up with a colleague to read reference material or attend trainings on non-monogamy, BDSM, and asexuality. Discuss your thoughts and feelings with a colleague and role-play having a conversation with a client or patient about sexuality and relationships that opens the door to a nonjudgmental discussion of these relationship experiences.
- Provide guidance to trans support groups or autistic support groups so that you will have basic strategies for welcoming and retaining participants who are both transgender and autistic. Encourage the groups to involve trans autistic people in developing a social communication and independent living curriculum that is meaningful and affirming.
- Support peer mentoring relationships or programs that match trans and/or autistic people who have more experience navigating the system with trans autistic people who need help accessing care, attending support groups, or meeting the community online (see Resources).

RESOURCES

Trans autistic creative writing and performance

Search online for "neuroqueer slam poetry," "genderqueer slam poetry," and "transgender slam poetry."

Peer mentoring examples

Trans-buddy program: peer-to-peer trans health care support: https://genderqueer.me/2017/07/11/fv-trans-buddy-program

Big Brothers/Big Sisters: pilot mentoring program for trans adult to trans youth: www.santacruzmentor.org/our-programs/transmentoring