Dealing with “Disorder”: Examining Interventions Aimed at Reducing Self-Stigma and Improving Well-Being in Gender-Diverse and Gender-Typical People with Autism Spectrum Disorder

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Abstract

Two Western social norms that greatly impact society at the individual and institutional levels are neurotypicality (most people do not experience neurological untypicalities) and cisnormativity (most people have a male or female gender identity that is congruent with their sex assigned at birth). Neurodiversity, particularly autism spectrum disorder (ASD), and gender diversity (GD) are two norm-defying concepts that affect one's identity development process. While both ASD and GD have been studied separately, little is know about their interaction and effects on identity development. Thus, the current paper seeks to bridge this knowledge gap and further investigate what facilitates identity development of both gender-typical and GD people with ASD. A qualitative study and interviews GD people with ASD (n=5) were conducted. The thematic analysis framework was used to investigate the content of the interviews and three potentially beneficial psychological interventions. Findings indicated that the identity-related needs of GD people with ASD mainly revolved around having supportive environments (friends, family, professionals) and medical support (e.g. interventions for reaching a congruent physical appearance with their affirmed gender). The three interventions investigated were found to be appropriate for gender-typical people with ASD, in supporting their identity development process. Gender-typical and GD people with ASD need safe, open environments where they can explore their identities. Further research needs to focus in ASD and GD from a strengths perspective, since both concepts are forms of diversity deserving of understanding and appreciation.

Keywords: autism spectrum disorder, gender diversity, needs, interventions, qualitative study

Dealing with “Disorder”: Examining Interventions Aimed at Reducing Self-Stigma and Improving Well-Being in Gender-Diverse and Gender-Typical People with Autism Spectrum Disorder

Living outside societal norms poses ongoing challenges throughout people’s lives. Social norms are (unwritten) rules deemed appropriate by the majority or dominant culture (Forsyth, 2014) and they have always been subject to change. Nonetheless, one aspect of social norms that has remained constant throughout time is their critical role in guiding people’s judgments about appropriateness, which became rather problematic along history. For instance, the norm of Western society seems to be white, cisgender (male or female), male and Western. Research in the field of Psychology is dominated by WEIRD samples (Western, Educated, Rich, Industrialized, Democratic; Henrich et al., 2010), while research including non-Western cultures is not as wide spread.

Two impactful Western norms are neurotypicality and cisnormativity. The norm is that people do not suffer from neuro-developmental untypicalities and those who do, are outside normative spaces (thus, non-conforming). Cisnormativity implies that most people have a gender identity that is congruent with their sex assigned at birth and they identify themselves as either male or female (cisgender; Russo, n.d.). Neurodiversity and gender diversity (GD) are two norm-defying concepts. Consequently, people who show these types of diversities risk being negatively impacted by neurotypical and/or cisnormative social norms, especially regarding their identity development process. One way this could take place is through the labeling process. While neurodiversity and gender diversity are neutral in their valence, the labels and negative connotations assigned to them through the social norms (Link & Phelan, 1999) turn neurodiversity and GD into stigmatizing identities. Thus, people bearing these identities are more likely to internalize the stigma attached to their labels, which in turn lowers their self-efficacy beliefs, self-esteem (Mak & Cheung, 2010), and their quality of life in the long run (Markowitz, 1998).

Autism Spectrum Disorder (ASD) and Identity

ASD is a form of neurodiversity and is characterized by social communication and social interaction untypicalities across contexts and by restricted, repetitive behaviors, interests or other activities (American Psychiatric Association, 2013). These characteristics pose a great deal of challenges to people on the spectrum, such as having socially less accepted ways of communication, responsiveness towards verbal and nonverbal cues (Paul et al., 2009), understanding others' emotions (Frith, 2003) or being less able to live autonomously (Howlin et al., 2004) Research also shows that people with ASD are more likely to suffer from depression and anxiety in comparison to their neurotypical counterparts (Sizoo & Kuiper, 2017), sometimes also as a result of social exclusion or lack of meaningful relationships, as cited in Smith and White (2020). People who have a classification of ASD according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) may come to integrate it as a crucial part of their identity (Bagatell, 2007). This integration can have both positive and negative consequences on the stages of identity development, with the balance between the two aspects changing over time, in an effort to reach an equilibrium of cognitive development (Piaget, 1957). Nevertheless, given its potential importance in shaping one's identity development process, it is likely that positive and negative perceptions of ASD can deeply impact one's identity. While some people find relief and strength in having an ASD classification, other people may feel that this classification is charged with negative, stigmatizing values and their self-concept may be negatively influenced. Such values may be a result of the labelling process and the ubiquitous societal focus on neurotypicality.

GD and Identity

GD encompasses all people whose gender identities, expressions and roles are not cisnormative (American Psychological Association, 2015a) and it will be used throughout this paper, in order to include and validate all various gender identities that people have. First, gender is defined as “the attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex” (American Psychological Association, 2012). Thus, when one’s behavior and expression fall in line with gendered cultural expectations, it is categorized as gender-normative and gender-typical. Gender identity refers to the internalized sense one has towards a gender and this can be different from the sex assigned at birth (American Psychological Association, 2015a). Transgender refers to people who identify with a different gender than their sex assigned at birth and their affirmed gender may be binary or non-binary (American Psychological Association, 2015b).

GD comes with both interpersonal and intrapersonal difficulties. On one hand, people may stigmatize, negatively judge and invalidate one’s nonconformity to cisnormativity. On the other hand, questioning one’s own identity can be difficult for the people themselves, since self-discovery is a challenging road with ups and downs and self-understanding is a life-long process, especially when navigating a space less accepted by society. For instance, research provided support for the lowered mental health transgender people suffer from, showing that they have more frequent episodes of depression, anxiety, and suicidality (Reisner et al., 2015, Peterson et al., 2017), in comparison to their gender-typical counterparts. Transgender people are also over-represented in the foster care system (Baams et al.,2019), with many being rejected from their own homes and ending up in an out-of-home placement or without a home (Ryan et al., 2009; Winter, 2012).

ASD, GD and Their Interaction

Together, ASD and GD can co-occur and result in multiplied challenges for someone who is both on the spectrum and GD (George & Strokes, 2018; Strang et al., 2021; Strauss et al., 2021). Studies have found support for the over-representation of GD people in the ASD population, with a rather high frequency of co-occurrence (Nabbijohn et al., 2019; van der Miessen et al., 2018). Not only does ASD intertwine with GD, building further challenges in one's life, but such an interaction is also likely to yield novel, unique circumstances for this population. Few studies investigated this interplay. Findings support the lowered mental health of people who are GD and have ASD (Strang et al., 2021; Strauss et al., 2021). Cooper et al. (2021) found that transgender people with ASD struggled with body distress, including depression and anger related to gender dysphoria, however they also struggled with putting these feelings to words due to their ASD. Participants also needed more time and energy to integrate and understand their gender identity, as well as their autism identity (Cooper et al., 2021). This research shed light on competing needs that transgender people with ASD have, for example the need for going through the gender affirmation process, while needing consistency (Cooper et al., 2021). There is also a need to prevent the added stigma of this intersection of identities and for professionals to acknowledge both identities in one individual, without this hampering their access to ASD and/or GD care (Cooper et al., 2021; Strang, Meagher et al. 2018). This is a concern raised by other transgender people with ASD participating in a different study (Strang, Powers et al., 2018), where they feared their affirmed gender was contested by family and/or providers due to their ASD; some participants discussed their GD identity being perceived by others as an obsession characteristic to ASD, or an "autism thing". In a similar line of work, Cloeman-Smith et al. (2020) worried that gender diversity may be perceived a "symptom" of ASD, given the theoretical frameworks research on ASD is being conducted in: cognitive rigidity, unusual interests, GD occurring as “a sequel to autism”, as cited in Coleman-Smith et al. (2020). Another unique difficulty this population may have is the reduced ability to understand and manage aspects of GD, due to social functioning problems specific to ASD (Strang et al., 2021). ASD characteristics, such as limited executive functioning and central coherence (Frith & Happé, 1994) can also hinder the ability to conceptualize, communicate and achieve GD needs and goals that one such individual may have (Strang et al., 2020; Strang, Powers et al., 2018).

The Minority Stress Model

Such described mental health disparities and stigmatization of people with ASD who are either gender-typical or GD may be partly explained by the Minority Stress model. This framework was initially developed to investigate the marginalized position of sexual and gender minorities, and the negative consequences they face due to their marginalized status (Meyer, 2003). It has recently been extended to the context of people with ASD as well (Botha & Frost, 2020).

The Minority Stress model posits that certain minority stressors (discrimination, internalization of stigma, victimization), which are characteristic to each minority group, affect the livelihood of minorities and lead to disparities between the dominant culture and minorities, by placing them in marginalized positions (Meyer, 2003).

Botha and Frost (2020) looked at the Minority Stress model and its ability to explain health disparities between allistic people and people with ASD. They found that, indeed, minority stressors were associated with diminished well-being and heightened psychological distress. Minority stressors included masking (i.e. concealment of autistic behaviors), expectation of rejection, outness (the extent to which participants expressed their identity to people around them), victimization, internalized stigma, discrimination and physical concealment. These findings generalized beyond the regular stress levels people encounter on a daily basis, supporting that people with ASD are a marginalized group who suffers from added stressors specific to their minority, compared to the majority group (Botha & Frost, 2020).

The Current Study

Progress have been made in the understanding of ASD and developing interventions aimed at optimizing healthy identity formation processes. For instance, Cognitive Behavioural Therapy has been tailored for people with ASD, as well as mindfulness techniques (Benevides et al., 2020; Gaus, 2018). Progress can also be seen in the gender-related area of mental health, as nowadays it is more accepted that gender is a spectrum and it is possible for people to ask for help in their gender exploration process from professionals and people around them. However, there is little research investigating interventions tailored to fit the needs of GD people with ASD. To our knowledge, Strang et al. (2020) are the only ones to have so far published work on creating an intervention tailored for the specific needs of GD people with ASD.

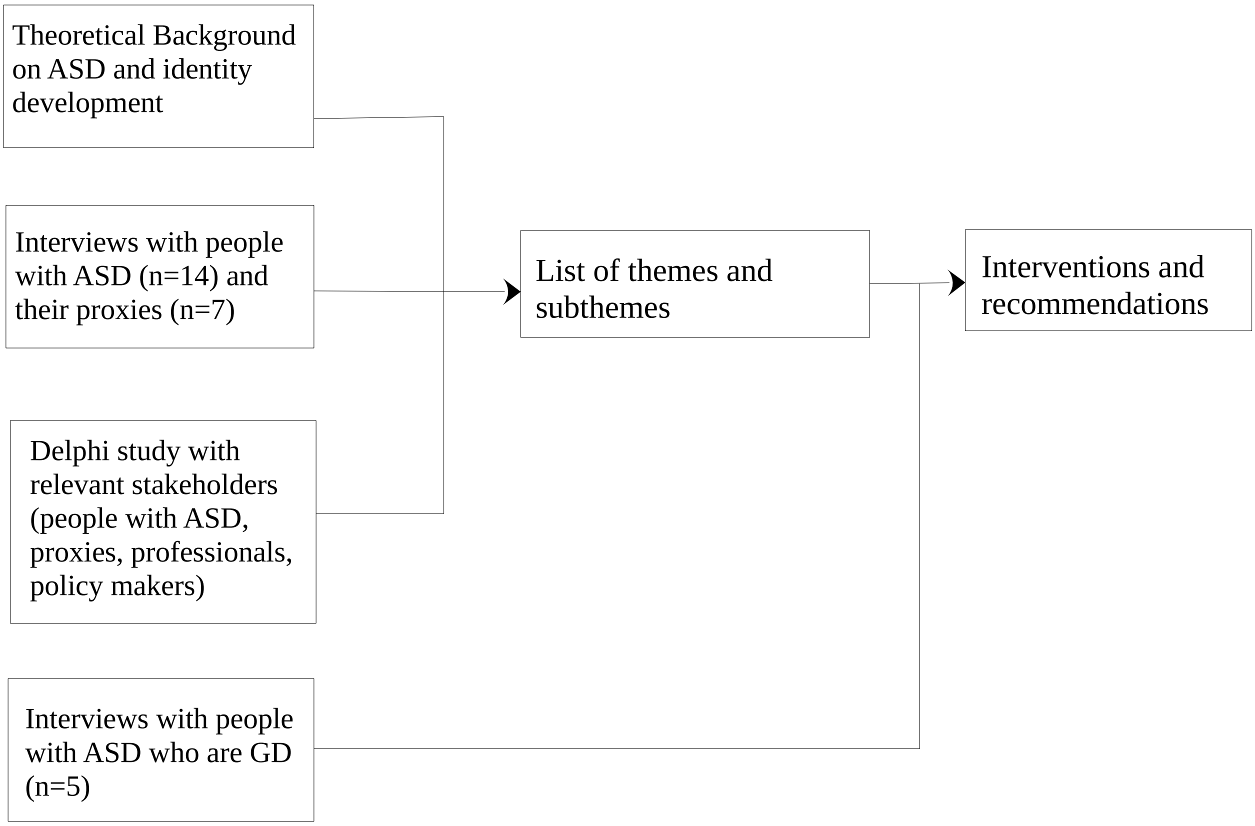
The current paper seeks to contribute to the understanding of lived experiences of GD and gender-typical people with ASD, by including the voices of this population in the research process, to listen, value and build on their actual needs. As such, the goals of this participatory study are: a) to interview GD people with ASD about their (unmet) needs/desires, b) thematically analyse the interviews, to explore facilitating factors for their identity development process, and c) thematically analyse potentially beneficial existing interventions, to formulate recommendations for the delivery/optimization of intervention options for gender typical people with ASD.

Method

The current research has an experiential qualitative design, as it “seeks to understand people’s own perspectives, meanings and experiences” (Braun & Clarke, 2013). This paper investigated how people make sense of various aspects of their lives, particularly identity formation, stigma, learned coping strategies, default reactivity and overall needs, regarding their ASD and GD. We included the voices of the relevant stakeholders in the process, to ensure that knowledge yielded by the current project is relevant to the population of interest. Moreover, the current paper was reviewed by a sensitivity reader, Eden van den Branden, who is part of the target population, to ensure appropriate, accessible and sensitive writing throughout the paper. This study was part of an overarching project (AppendixA).

Figure 1

Method Overview



Participants

In order to reach out to the population of interest (GD people with ASD), convenience sampling together with snowballing methods were used. Participants offered voluntarily to take part in the current research by answering to a message describing the topic, goals and the needed sample for the current research. The message was posted in the group chat of a political organization from Groningen, The Netherlands, whose purpose is to bring about equity to marginalized groups of people and has in its composition many GD members with ASD. Its members shared the message within their close circles. Inclusion criteria were (1) having an official classification of Autism Spectrum Disorder according to the DSM-5, (2) identifying as GD, (3) being fluent in English, (4) not having cognitive and language impairments and (5) aged 18 or older. Participants were excluded in cases of current episodes os severe depression or severe mania, and in cases of current psychosis. An official diagnosis of gender dysphoria was not requested, to capture a broader spectrum of experiences. GD is not necessarily characterized by gender dysphoria, an idea supported by the existence of gender diverse people who do not feel dysphoria towards their bodies. Therefore, it was considered sufficient for people to state that they identify as gender diverse. The final sample consisted of five Dutch participants, aged between 20 and 29 years old. Four participants identified as transgender non-binary, one participant was female, transgender. Two participants graduated from Master's program and three participants graduated from high school as their last educational level achieved. All participants had other diagnoses besides ASD, such as Attention Deficit/Hyperactivity Disorder, Attention Deficit Disorder, Posttraumatic Stress Disorder, Dyslexia, Generalized Anxiety Disorder, Major Depressive Disorder, Dysthimia, and Other Specified Feeding or Eating Disorders. Only two participants had a Gender Dysphoria diagnosis.

Ethical Considerations

The project was judged by the ethics committee of the University Medical Centre Groningen and not found to be WMO-plichtig, and thus approved for conduction.

Procedure

Semi-structured interviews with GD people with ASD were conducted to explore the perspectives and experiences of participants in relation to identity formation, external and internalized stigma about their identity as GD with ASD, their needs from several parties involved in their lives (family, friends, therapists) and their current coping strategies. The iterative process of developing the interview schedule resulted in 22 main questions and in-depth follow-up questions based on how each interview went and the suggestions of the sensitive reader (Appendix B). Questions used in the interviews were based on several relevant sources (e.g. Coleman-Smith et al., 2020; Strang et al., 2020). Interviews lasted between 60 and 120 minutes and were audiotaped with permission.

Before the start of the interviews, an informed letter about the project was sent to the participants and all questions/concerns regarding the research were addressed. All participants signed the informed consent form. Compensation in the form of cinema vouchers was given to the participants for taking part in this study. Data generated by the interviews were stored safely and
anonymously on the duration of the research project.

The overarching project yielded a list of potentially useful interventions/approaches for people with ASD, out of which three were analysed in the current paper.

Data Analysis

The thematic analysis framework (data analysis, Apepndix A) was used to investigate whether and how three potentially beneficial interventions to gender-typical and GD people with ASD satisfy the needs of gender-typical and GD people with ASD. Additionally, we thematically analysed the content of the interviews with GD people with ASD.

One intervention this paper examined is mentalization based therapy (MBT). The main focus of MBT is to enable participants to understand their own minds and those of the people whom they interact with (Bateman & Fonagy, 2016). This intervention was created for people who are diagnosed with Borderline Personality Disorder. It starts with assessment of the individual, then progresses through MBT-Introductory (MBT-I), group MBT (MBT-G) together with individual MBT. Given the social difficulties and needs people with ASD experience, skills taught during MBT may benefit their interactions and self-knowledge.

The second intervention analysed is dialectical behavioural therapy (DBT). DBT entails four modules of training (Linehan, 2015), however this paper will closely look at the interpersonal effectiveness (IPE) skills module and emotion regulation (ER) skills module. The Mindfulness skills training coincides to some extent with the scope of the Emotion Awareness Skills (EASE) program and the Distress Tolerance skills is somewhat covered by the MBT. IPE skills refer to the ability to interact with other people, with different goals in mind (e.g. maintaining a relationship, making requests, expressing refusal etc.). This also entails opportunities for participants to practice the learned skills. In the ER training, people with ASD can learn various strategies to deal with their own feelings (e.g. mindfully attending to their emotions, replacing negative emotions with more positive ones).

The (EASE) Program aims at improving one’s emotion regulation and thus reduce behavioural disturbance through the mechanisms of mindfulness (Conner et al., 2019). Mindfulness involves attending to one’s own thoughts and feelings in a non-judgmental way, in a purposeful manner and it uses tools such as meditation (Baer, 2003; Kabat-Zinn et al., 1985). This intervention can increase awareness and help people with ASD better deal with crisis situations, negative feelings and better regulate their own emotions.

Results: Interviews with GD People with ASD

Seven main themes and 10 subthemes were identified. The participants were numbered from one to five, to refer back to them. Participant 1 is a non-binary transgender person who presents more feminine. Participant 2 is a non-binary transgender who identifies more as gender fluid. Participant 3 is a transgender woman. Participant 4 identifies as non-binary transgender. Participant 5 is gender queer.

1. It is an Inner Feeling that Something is Missing

One common answer all participants gave to the question "when did you first feel you were gender diverse?" is that they have always known. They have felt different from other people, sometimes just gender-wise and sometimes in other ways that they could not pinpoint at that time, when such feelings started to come to surface. Nonetheless, later in life they got diagnosed with ASD and/or gender dysphoria. Participants describe "Well, it's been there, like forever. (…) I'd been questioning for a long time", "Well that I've known since ever. I've always known something was different from, well, other boys. But I didn't know the term "transgender" until I was 15 years old. Or 14 years, maybe?"

Some participants discovered they were gender diverse before getting an ASD classification, other participants first got their ASD classification and then started exploring their gender. However, it has been difficult for most participants to separate the two moments when they knew that they had ASD or that they were GD.

"When I got the diagnosis of autism, I just thought, 'Oh, I'm an autistic woman'. So that must be why I feel so different from other women, and not just other people. But when I started to completely read up on autism and I read up on feminism, like, oh, all the things that a woman could be, then I still noticed ‘No, something’s still different’. I just had to understand the scope of what it could be meaning to be a woman, and what it could be meaning to be autistic. And then I was like, ‘Okay, there's still something missing’.”

2. Brain-Body Mismatch

A recurrent idea across interviews consisted of the mismatch between the sex assigned at birth and the affirmed gender identity of the participants. This mismatch has shown itself in different ways for different people. Participant 1 started taking estrogen six months ago to achieve a more feminine body. They described how different the emotion regulation process is for them, when not being able to take estrogen. When having more estrogen in their body, they feel more able to cry, they can deal with difficult situations better and with anxiety.

“It's kind of like there's a fundamental biological mismatch between my brain and the hormone levels that I naturally produce. And I don't know if there's any basis. Might just be completely psychological, of course. But it's like, my brain just doesn't accept that testosterone based hormone [emotion] regulation.”

Participant 3 also discussed the difference between her brain and her body, in the context of ASD. She got her ASD classification when she was 21.

“I present more in a more female way with autism. I do think that is a bit more recognized nowadays. But because I was presenting as a boy in the past, it didn't [get recognized]. If I presented as a girl back then, it would have been more obvious I had autism because it presented more in a female way. But because I was presenting as a boy and my symptoms are more feminine. it didn't match and was less clear that is there.”

Participant 5 described how they are not concerned with whether they have a female or a male body, when they are not presented with it: “So my brain (…) is a genderless blob. If I am just in my head, and I'm not aware of my body, I don't have a male or a female body. I'm just like, it doesn't really [matter] (...). And then when I see my body, I'm like, oh, there's breasts there. Where did they come from?”

3. Having Access to Information

The inner feeling of something being different gained more clarity the moment they had the necessary information, such as words to describe their identity, the fact that there are people that are outside male and female genders and that people can indeed feel different from their sex assigned at birth, and other aspects concerning the LGBTQIA+ community. Some participants were first met with information about ASD and started exploring that aspect of themselves, before their gender. Other participants first accessed information about gender and so this is how their exploration started, prior to learning about ASD.

“It’s so difficult, too, when you're different. And you are not informed about any of these things. Like, you know what they are, it's like, you get to explore and discover yourself. Later in life. It starts when you get the information and I got the information about autism a lot earlier than I got about gender diversity.”

Participant 5 discussed with their psychologist that they might have ASD, as they were informed about it, knew people with ASD and recognized in themselves ASD characteristics. After suggesting this hypothesis to their psychologist, they indeed received an ASD classification.

A. Informed Professionals

Participants stated the importance of professionals being informed about the high co-occurrence of ASD and GD. Whether people go to gender teams for their gender-related needs, or they go to people specialised in ASD classifications and treatments, both parties should be knowledgeable about both concepts.

“I think that it's just important that autism professionals know about the bigger percentage of gender diversity in the autism community. So it's a very important aspect to help their clients with or their patients with. And also, I think if a gender specialist is not informed about neurodiversity, and about the bigger overlaps, then I feel like you're not very informed about the field you work in. So I think just being informed and making it part of the conversation helps.”

Participant 1 expressed their worry in regards to how having different other diagnoses/classifications, including ASD, may potentially slow down the process of them getting a gender dysphoria classification, as a result of gatekeeping (the role of gender-work professionals to evaluate the eligibility and readiness of transgender people to undergo transition, according to a set of rules) (American Psychological Association, 2015b): “They’re [gender teams] like ‘Oh, you have autism? Maybe you're not really trans’ (…) I haven't had diagnostic phase yet. But a lot of people report that for an autism diagnosis or something, their diagnostic space will just be lengthened”

“There's plenty people who could just go there, have a few weeks of like examinations and everything. And you can just have them sign an informed consent form for hormones. And then you're fine. Other people will need more guidance. But right now, what they're doing isn't really giving guidance. It's gatekeeping.”

This could also be illustrated by what participant 3 described about not diagnosed with ASD when she was a child, because she presented as a boy, but her autism looked like what professionals would generally see in girls.

B. Social Circles and Other Contexts

Information access was facilitated by becoming part of queer groups, therefore this is how some participants started learning about GD. These groups were friend groups and various organizations that brought together people with similar interests. Participant 2 described how they got to explore their gender in terms of expression as well through taking part in an event organized by one such an organization:

“As a kid, I always wanted to wear skirts and my mom didn’t let me (…) Then in summer we went to a holiday to place where we were making art outside (…) and I was like ‘maybe we should also dress up for a special occasion. Why don’t we all go in skirts?’ And then everyone was very enthusiastic. And I asked [their girlfriend] if she was okay with me wearing a skirt and she was like ‘sure, why not?!’ and she recalls it as if I were surprised that all of a sudden this was okay.”

Other participants, although they have been questioning their gender identity for a long time, did not know they were transgender. They understood what it was that they were feeling when first met with the word “transgender”: “Well, I saw someone on TV, who was transgender; really simple, actually. It was the immediate click actually”, “Well for me... It was a lot of starting to actually talk to trans people. (…) And I had some very good friends who were very affirming and everything.”

Participant 5 felt the need of coming out as who they are towards their family and other people, however they have not settled on a specific gender identity:

“I kind of at some point made a decision: ‘Okay, I'm not going to figure it out right now. But I still want to come out as the person who I am at this point, and with the knowledge that it might change in the future’. So that's why I came out to everyone as gender queer. And I came out as still figuring it out, basically. (…) That decision kind of made it okay for me to just stop rushing through the exploration and being okay with ‘maybe I'll do that in a few years’, you know?”

The general idea expressed by all participants was that it helped them being exposed to more diversity, as this made information reach them and it helped them make some sense of what they were feeling.

4. What Helped with Gender Identity Exploration

A. Neurodiversity

The fact that the participants are neurodiverse, therefore perceive the world differently from what neurotypicals see, is a recurrent aspect across interviews. The main strength all participants expressed is the detachment from the social norms and what they impose on people, especially ones surrounding gender. For instance, participant 4 compared gender with knowing how many kisses to give on a birthday. Participant 5 has already been struggling with gender expectations, before learning about ASD and GD.

“I was already kind of struggling with the social expectations around gender. So it was actually pretty easy for me to let those go and identify all the ones that I kind of had been struggling with for a while because I didn't really understand them.”

“Maybe it starts with the fact that your brain is just not...not intuitively assuming everything about other people’s thoughts before you think yourself. I’m born with a penis but does that mean that I also have to be that strong, masculine person that overrules and dominates the family?”

B. Supportive Family

One difference that stood out between participants, was their environment in which they grew up. Three participants (1, 2, 3) stated having a supportive family of both ASD and gender exploration. Participant 3 started transitioning when they understood they were transgender. The mother of participant 2 was the one who caught up on the fact that her child may have ASD. Such openness on the part of the family can facilitate further exploration and a sense of safety in one’s environment. Participant 1, who has been on the waiting list for the diagnosing process done by gender teams for almost a year, received subcutaneous hormones from their mother, who is a medical professional. They feel much happier with themselves now that they are approaching a more congruent physical image with their gender identity. At the opposite end, participant 4 discussed their struggles with accepting their ASD diagnosis, also due to a detrimental family environment.

“It really depends on what background you have. Like I come from a neglect situation at home, and an abusive situation. So I had to do everything by myself. So like, I can imagine it goes a bit differently than when you have a very big support system, where there is acceptance of such a diagnosis.”

C. Supportive Social Contexts

All participants stated the importance of having a supportive group of friends or to have people that like them. Participant 2 described how they do not notice when people react negatively to them and they feel accepted, because people generally like them, they value their opinion and people listen to them. They volunteer for various organizations which are either queer or have a lot of queer members. Therefore, they focus on positive interactions. All participants mentioned the idea that they need people around them who are open minded, understanding and able to accommodate their needs (e.g. feeling overstimulated and needing rest from social interactions, being listened to, not being judged etc.), same as they themselves behave towards other people.

“Everyone that I interact with needs to be aware of my access needs, just like I am with theirs (…) A lot of neurotypical people just aren't aware that we accommodate them a lot all the time. (…) it's weird to have an autistic person say this, but I think they [other people] need to be flexible with me. Because, you know, my abilities are very varying. Like, I don't have the same social or executive functioning skills every day".

5. Timing Matters

Across interviews, another pattern that became apparent is that participants' identities were more impacted by the most recent "discovery". Two participants (1 and 2) who got their ASD classification prior to finding information on GD, showed that gender identity was a more potent part of their identity as a whole. When asked to describe themselves in five words, one of the words was "queer", while no reference to their autism was made. This may point towards the fact that they have become used to their ASD and it is no longer something that (strongly) defines them.

Participant 4, however, found it difficult to separate the moments when they began feeling different because of ASD and because of their gender identity. Despite getting their ASD classification before finding out about GD, they identify stronger as neurodiverse.

"I think autism, like being autistic, is the way that I understand the world and how I relate to the world. Like, that's 100%. And gender. I think maybe 0%. Is like, if the only way I encounter gender is when I'm with other people, that it plays a part."

Participant 1 also did not differentiate between the two moments as to when each started becoming apparent, showing how intertwined GD and ASD are. They began feeling different both in terms of gender and neurodiversity, from an early age. They got their ASD classification at the age of 3 or 4 years old, therefore their gender identity and autism are deeply rooted in who they are. Nonetheless, when asked to describe themselves in five words, the word "queer" was the first one to be mentioned. Participant 1 also stated "I mean, you can't really divorce it from my personality [the autism part]. It's a big part of who I am. Yeah. Now it's really shaped my personality."

Participant 5 received their ASD diagnosis four years ago and learned that they were GD two years ago. Both findings are relatively recent, hence they strongly identified with both aspects. They also were the only participant who used the words “autistic” and “queer” when asked to describe themselves in five words.

6. Internalized Stigma

A. Being Wary of Social Interactions

Most participants described being more attentive to who they interact with, evaluating whether they can be themselves around and understood by new people. Most of the time, this uneasiness when approaching social interactions is a result of negative past experiences that the participants have faced. Whether they were called insulting names, or people reacted negatively towards their gender identity, most participants have become more attentive to what people they befriend. Participant 1 stated, “I am a little wary often. Because if I don't know from the start that someone is actually cool, I will watch out about it.”.

“I mostly stick to my friend groups and everything. And people who I know, are just as weird as me. Yeah. So you don't really run into any problems. But you know, a lot of cis people will come into a conversation and already have decided what they want to hear. And I usually just try to end those conversations as quickly as possible, because I'm just not interested in that. (…) A lot of them, you know, want to hear that you're like, one of the good ones, you know? (…) Not causing too much of a [noise]. Not actually campaigning for any of your rights.”

Participant 3 described “I only tell it when I’m comfortable and if it's relevant, otherwise, I don't. (…) When people found out that I am transgender, especially some men, can act completely different. Most women don't care.”

Participant 4 described avoiding social interactions that risk being negative, or when feeling unwell, due to the risk/expectation of unpleasant interactions with other people. This points towards an expectation that they have regarding people reacting negatively when talking to them. In their case, they referred to their autism and how people might think they are “weird”:

“Like when people see me, they think, Oh, she must be very fun to talk to and as soon as they try, they often notice that I respond maybe differently than they expect. And then I can just see them. If I can see it in their faces like, “okay, she's odd”, or maybe like, “this is awkward”. And I, it happens every day. Like, every day I talked to someone, it's awkward for both of us, I guess.”

“It makes me insecure sometimes. And I also avoid social contact if I feel like I can't handle a negative experience, because it’s possible that I get one. And also, I don't have any other tools or choice than the ones I'm dealt with. So I feel like for neurotypical people, it's a lot easier to maybe interact with me on my level, than the other way around. It's not like I can pretend to be neurotypical. I've been doing that my entire life, and I keep failing, whatever I do, so...”

Participant 1 dropped out from their studies also due to being bullied by their classmates, when they came out as transgender.

Nevertheless, all participants stated enjoying social contact, depending on how they feel and whom they interact with.

B. Always Presenting as Themselves, but It Depends on the Context

When asking the question “how often would you say you present your true self to other people?”, the immediate answer was “always” from most participants. Nevertheless, when discussing this question in more depth, each participant had at least one moment when they needed to conceal their gender expression, due to various reasons.

Participant 1 described being in smaller villages, passing by certain streets during the day, when the children would go back home from school again. During those times, it would often happen for the participant to be yelled at and called names, due to their gender expression. They also mentioned certain neighbourhoods where people are less understanding and therefore they present in a more masculine way, not to attract their attention in any way.

Participant 3 mentioned how she does not discern well anymore what aspects of herself are actually results of masking and what aspects are part of her true self. She started concealing aspects of her autism due to the belief that people might find her weird. Since she is and presents as a woman, therefore she is "passing", people do not make remarks about her being transgender.

"Difficult question, actually. I do think I try to hide things most of the time that I sort of know instinctively "Okay, well, this is different. So I'm not bringing it to the four holes quite often. (…) I've done it so long now, that I can't really stop it anymore. "

A similar experience was shared by participant 5:

"I made myself hide a lot of my traits. And, you know maybe odd things about me that apparently are part of my autism, mostly. Because I had been taught that I should not show them, but not because people were very clearly like, 'Oh, this is an autism thing, you should hide your autism', but just like, it's not socially acceptable to do this. And if I had a very subtle cue about that something is unacceptable, I would immediately make it a rule (…) that is why I'm so good at masking, is because I pick up on all those rules and very strictly keep repeating them for myself as well. Which I am now really, really working really hard to let go of because sometimes I need to be a little bit odd. I need to show my autism, to let it be, for myself to be healthy”.

Participant 5, who studies psychology, also discussed interactions with their classmates and teachers at university, during classes:

“[people] can make jokes about trans people in a classroom, because they feel like there couldn't be anyone in this classroom that, you know, has an experience about that. That is kind of surprising to me. And I feel like that is also partially why I am trying to be more visible about it and more outspoken about it [ASD and GD], because I kind of want to be that person who is visibly autistic and visibly queer, even though I am not fitting any of those expectations that you have. So I have also been talking about my autism, for example, in the classroom with my classmates, and with the teachers as well, because I just noticed that they are very uncomfortable with the idea of considering an autistic person as their peer, instead of just their client”.

Despite people reacting negatively to their gender identity, all participants continue to be themselves most of the time, continue to interact with people and find the strength to overcome such difficulties. Participant 1 said “If someone has a problem with that, they can just leave and not talk to me! Like bye. I'm not gonna stop openly being me. (…) I will continue being openly queer.”

7. Gendered Care

Some participants face gender dysphoria, others are somewhat dissatisfied with some aspects of their physical image. Nonetheless, all participants showed the importance of having a congruent physical image with their gender identity.

A. Hormone Therapy and Other Transitioning Processes

All participants mentioned the struggle of getting the interventions they need to reach their desired physical image. They explained how clinics are working with insurance companies and gender oriented interventions are covered by one’s health assurance only if there is a diagnosis of gender dysphoria. Participant 1 is buying estrogen by themselves, since they have been on the waiting list for gender dysphoria diagnosis process for almost a year. They explained how much better they feel now that they started this hormonal process. Participants 1 and 2 stated that they would like to get facial hair removal interventions and breast removal, for they would feel more comfortable with their own bodies. Participant 5 discussed more in-between physical appearance needs, such as breast reduction and tailored hormone dosage. In a follow-up conversation, participant 5 also reflected on the interaction between their eating disorder and their perception of their body changing from a feminine shape, to a more ambiguous one:

“Right now I have a relapse in my eating disorder making me to loose weight, which also changes my body. For example my breast size has gone down a lot lately which is one example of an unhealthy way to reach the body that I kind of need. And of course for me the reason that I started loosing weight is not get smaller breasts, but they are smaller now and that does make me feel better. And that might be a reason to keep being unhealthy and that is something I have seen around myself as well”.

B. More Non-Binary Gendered Help

Participants 1, 2 and 4 mentioned several interventions they would like to undergo, in order to get closer to the desired physical image. Participants 1 and 2 wanted to get their facial hair removed. Participant 4 wanted to undergo breast removal surgery, one of the reasons being the assumptions people make about their gender, based on their breasts. Their goal is for people not to see them as their gender: “And if people make a big deal out of out of breasts or body parts, it also feels very invasive. That's my body, that's mine. Leave it alone.”. All these interventions require a gender dysphoria diagnosis, in order to get compensated. Nevertheless, some of them do not really struggle with gender dysphoria.

“I also struggle a lot with this that the rules really stimulate only binary transitions. You can only go from man to woman and from woman to man and if you want to be somewhere in between then it's really difficult (…) if I wanted to go into transition, I cannot just only have my beard removed. This is something I would really like to have it removed with lasers. That would be really awesome”

The story of participant 5 also illustrates how the necessity of having more non-binary oriented gendered care.

“So there's also a lot of questionnaires that can help you and workbooks and stuff, but they're all very focused on people going from one part of the binary to the other, basically. So then if you are like non binary transgender, or gender queer, there's not a lot of resources and tools out there yet, which is also a concern for me in the future, if I do want some medical treatments, because I know that the hospital here in [city name], for example, they really struggle to give you the fitting care if you are not going very explicitly from one to the other.”

C. For Professionals

Participants discussed the importance of having well informed professionals about ASD and GD together, but also a deep understanding of the struggles of people exploring their gender outside the realms of male and female. They want professionals that will not judge them and their (unhealthy) coping mechanisms. For instance, the participant taking hormones by themselves wishes to find a practitioner who will be understanding and will not judge their self-medication: “There's a lot of people who will say bad things about doing your hormones yourself. But at the same time, what else am I supposed to do? Yeah, it was life saving for me”. Participant 5 also stated the need for safety when discussing their gender struggles and their eating disorder. In addition to this, it is of great importance for the professionals to recognize and validate one’s gender identity and to refer to them using the right pronouns. Participant 4 said that “whenever people call me ‘she’, it kind of feels invasive, almost like you don't have to gender me at all”. Participant 2 stated “It's more that I feel gender euphoria whenever people refer in a neutral way to me or maybe it’s more that I feel respected and that feels very good.”

When it comes to discussing the ASD classification, one participant mentioned that professionals should not describe ASD as a deficiency or disorder; there is much negative feedback on neurodiversity from the world.

“Getting my diagnosis, I thought it was like, similar to getting a depression diagnosis. I thought it was a disease that you can fix. I didn't know that it was neurological. Well, I don't even believe it's a neurological condition. I just think it's natural diversity. But it was so explained to me, like in a pathologized way that I thought, ‘oh, it's like depression. If I work hard enough, I can be just like other people’. So when I got my diagnosis, I tried even harder to fit in and to get better.”

Results: Interventions for Gender-Typical People with ASD

MBT, DBT and EASE were analysed following the themes and subthemes generated by the interviews with relevant stakeholders during the overarching project (Appendix A). Each theme was numbered from one to four, and each subtheme was given a letter (a, b, c, d). When referring to specific themes/subthemes throughout this section, these numbers and letters will be used. For example, when describing how a specific part of an intervention relates to gaining insight into one’s own potential, this will be referenced as theme 1a, the number suggesting the theme and the letter representing the subtheme.

Table 1

Themes and Subthemes

Themes (i.e. desires)	Subthemes	Intervention components
1. Knowing one's self	(a) Gain insight into your own potential	MBT (assessment)
	(b) Gain insight into the bodily signals of stimulus balance	MBT (assessment), MBT-I DBT (ER Skills) EASE(mindfulness exercises)
	(c) Find a personal meaning in your diagnosis	MBT (assessment), MBT-I DBT (IPE), DBT (ER)
	(d) Learn from the experience of others	MBT-I
2. Accepting one's self	(a) Focus on success experiences	MBT-G DBT (IPE), DBT (ER) EASE
	(b) Learn how to deal with (existential) fears	DBT (ER) EASE
	(c) More acceptance/positive feedback from one's environment	DBT (IPE)
	(d) Find a balance between feeling and body, thinking and doing	DBT (ER) EASE
3. Reaching one's desired self	(a) Learn to use one's own potential	MBT-I DBT (ER)
	(b) Ensure optimal stimulus balance	DBT (ER) EASE
	(c) Find meaning in one's life, by findings a suitable day schedule, working environment, guidance to achieve one's full potential (Learn to use one's own potential meaningfully)	MBT-I DBT (ER)
	(d) Dare to indicate your limits, learn to ask for clarity, find appropriate approach to social situations	MBT-I DBT (IPE), DBT (ER) EASE
4. Self-regulation and support	(a) Find support	MBT-I DBT (IPE), DBT (ER)

		EASE
	(b) Have loved ones in your social environment informed about ASD (tips for handling everyday life, tuned support, realistic expectations, dealing with stigmatization, discussing sensitive topics) = tips/tools for relatives and social environment	DBT (IPE)
	(c) Seek support in times of transformation	MBT-I DBT (IPE), DBT (ER) EASE
	(d) Let care providers inform about ASD, in regards to tuned support, working on empathy, realistic expectations about one's self, dealing with stigmatization, discussing sensitive topics.	DBT (IPE)

Mentalization Based Treatment (MBT)

Assessment

In this phase (MBT, Appendix C), in collaboration with the client, diagnoses are provided, goals for the client are established and other aspects of the therapy are discussed and agreed upon. This phase is built around psychoeducation, therefore the goals related to gaining insight into one's potential (theme 1a) and learning about one's diagnosis (theme 1c) are satisfied by this part of treatment.

Given that MBT focuses on the mentalization abilities of both the practitioner and the client, the diagnosing process is conducted from a mentalizing stance at all times on the part of the practitioner. The mentalizing stance requires that the therapist is concerned with the client's mind, rather than the content of what the client is saying (Bateman & Fonagy, 2016). This stimulates the client to actively think and reflect on what they are told and to look for aspects in themselves that may or may not match with diagnosis characteristics (theme 1c). The collaboration between the practitioner and the client, as well as the mentalizing stance facilitate the participant with ASD to identify their potential (theme 1a). Discussing diagnoses, some questions suggested by the author “What are your best features as a person?”, or “How would you describe yourself as a person?” open the conversation about one’s own strengths, values (what one finds important), what one can and cannot do (competencies). During this process, the practitioner evaluates the information and feelings clients have about their diagnosis of personality disorders. This can further lead the ways of exploring meaning in their diagnosis/diagnoses (theme 1c).

The diagnosis part is followed by discussing the treatment plan and case formulation. In the latter phase, a crisis plan is developed for the client and it involves strategies to deal with unhelpful thoughts and behaviours. This means that the client could learn to recognize early signs of an emerging crisis. Therefore, this is a starting point for a person with ASD to learn to recognize fatigue and over-/under-stimulation and learn how to deal with this (theme 1b).

MBT-I

This part entails 12 modules, is delivered in an open group setting and it introduces the participants to each other, to MBT, its principles, the structure of the sessions, and core aspects of MBT (e.g. what mentalization is, emotions, attachment relationships, what a personality disorder, anxiety and depression are) (Bateman & Finagy, 2016). Only relevant modules were discussed in this analysis (for more, see MBT, Appendix C).

Module 1 discusses what mentalizing and mentalizing stance are. During this phase, participants find out more information about their diagnoses in the context of mentalizing. Mentalizing involves regulating one’s own feelings, learning and practising self understanding in regards to one’s goals and their values, self-monitoring of one’s thoughts and feelings in various contexts, and learning about one’s own wishes and needs. These functions of mentalizing facilitate finding personal meaning in the diagnoses (theme 1c), learning to use one’s own potential, converting knowledge about their competencies and the steps needed to achieve their goals (theme 3a). This kind of self-monitoring also allows for exploration of meaning in life, through finding a suitable day schedule, a suitable working environment and guidance for achieving one’s own full potential (theme 3c).

The group leader also explains that mentalizing is useful for when “you are going to console a friend who is sad”, “to communicate well with your friends” (Bateman & Fonagy, 2016). Therefore, mentalizing facilitates seeking support both in regular moments and in moments of major transitions or more severe times (theme 4a, theme 4c). When seeking support, one needs to know what kind of support they need, whom and how they can ask for it, which can be helped by one’s mentalizing abilities.

The group activity and homework in this part (Bateman & Fonagy, 2016) also facilitate the skill of noticing and naming feelings/sensations and emotions. Given the abstract nature of feelings/sensations and emotions, practicing recognizing and differentiating them from one another makes these concepts more concrete and observable, consolidates learning and thus helps participants to further their mentalizing abilities. This in turn can enhance the ability of participants to recognize emotions inside their bodies as well (theme 1b).

The fourth module addresses mentalizing emotions and discusses how to deal with emotions and feelings within one’s self and within others. Emotional regulation is discussed as well, as a way of dealing with emotions and feelings. Better recognition skills are useful for one’s self. Participants can learn to identify and indicate their own boundaries to other people(e.g. if something does not feel right, it might be because a personal boundary is threatened) (theme 3d). Such emotion recognition skills help with balancing stimuli (theme 1b), given how closely related emotions are to bodily signals. Emotional regulation is done in this part through relaxation techniques to reduce bodily tensions, temporary distraction and through recognizing one's own automatic thoughts and their effects.

MBT-G

This part of MBT provides a training ground for mentalizing skills of participants, through open group sessions. Group members' interactions during sessions are monitored by the group leaders and discussed during individual MBT sessions. The not-knowing and mentalizing stances are encouraged for the group leader to adopt. The not-knowing stance entails that the group leader does not make assumptions about a client's experiences, works with the information the client gives them and encourages reflection of the topic at hand. One example of this stance is socratic questioning. Because all group sessions target problems encountered by participants in their daily lives and discussion from a mentalizing stance is encouraged for all group participants to adopt at as much as possible, this creates learning opportunities from people with similar difficulties, or people who do better (who can set a positive example), people who do worse (whom others can help). These ongoing interactions between group members help them learn from each other (theme 1d), see/realize that they are not the only ones, and perhaps some may learn that they are actually doing relatively well and are able to help and understand others as well. This ties into the need of people with ASD to focus on success experiences (theme 2a). Seeing that one can help others may increase competency beliefs and self-confidence.

Dialectical Behavioural Therapy (DBT)

DBT's Interpersonal Effectiveness (IPE) Skills training and Emotion Regulation (ER) Skills training are delivered in group settings and the duration varies as a result of the decisions made by the practitioners.

IPE Skills

This training program has three main goals (Linehan, 2015). The first one is for participants to learn to achieve their objectives, while maintaining their relationships and self-respect (objective effectiveness). The second goal is for them to develop and maintain relationships (relationships effectiveness). The third goal is learning to balance both change and acceptance in relationships (self-respect effectiveness). This training part entails 17 sections which target the three main goals as follows: the first nine sections target the first goal, while the rest of the sections target the second and third goal. IPE skills training partly fulfils themes 1, 2 and 3, and fully meets theme 4.

The first section starts out with an overview of the IPE skills. What follows is the section that targets factors that reduce interpersonal effectiveness. This section differentiates between ability and motivation to have IPE skills, which emphasises the fact that the environment in which some people grew up did not provide them with opportunity to learn, observe and rehearse certain IPE skills. This is a starting point for the IPE skills mentioned by people with ASD during the interviews, such as finding an appropriate approach to social situations (theme 3d) and seeking support both in regular and difficult times (theme 4a, theme 4c). It gives the chance to people who do not come from very prosperous social environments to observe their level of social skills and to understand why they are necessary, if the mentioned goals are to be achieved. It does so by discussion points (Linehan, 2015) that encourage participants to look at their own skill levels and their areas of difficulty.

The third section offers a theoretical overview of the three main IPE skills trained during DBT and strengthens the rationale behind learning IPE skills. This can further motivate participants with ASD to actually and/or adequately voice their needs/desires, ask the people around them for adjustments/clarifications and for respect when it comes to what they need (theme 3d). Discussing relationship effectiveness may be especially helpful for maintaining an appropriate social network that shapes the participants with ASD (theme 3d). By paying attention to which relationship is worth keeping and improving, they can identify helping factors in a relationship and what to look for in further relationships, building a useful, healthy network for themselves. This section touches upon extreme behaviours as well, such as violent acts. This discussion may help participants recognize such behaviours in other people, transforming the conversation into how they could deal with such acts and what they should/could do (e.g. reach out to authorities, family, and/or friends to talk about what happened, stand up for themselves in a safe and effective manner). This eventually contributes to a healthy network (theme 3d) and seeking support skills (theme 4a, theme 4c).

The section focusing on the self-respect effectiveness goal can be carried out from a successful experience standpoint (that is, let participants discuss success experiences when feeling self-respect, when feeling appreciated by others; theme 2a).

The objective effectiveness, relationship effectiveness and self-respect effectiveness are achieved by learning the DEAR MAN, GIVE and respectively FAST skills (Linehan, 2015), which are covered by the next sessions. DEAR MAN (Describe the situation, Express clearly, Assert wishes, Reinforce, (stay) Mindful, Appear confident and Negotiate) may be especially useful for participants to show their full potential in social situations (theme 3d). This skill may help people express their needs in relation to other people, how to impose their boundaries in a clear, respectful manner and how to maintain a healthy network. Analysing an interaction mindfully and adjusting their behaviour accordingly, while fulfilling their needs is beneficial for relationship development as well, which in turn creates a space of people whom they can ask for support (theme 4a, theme 4c) in their circles of friends, family or other people.

Relationship effectiveness can be achieved through GIVE skills (be Gentle, act Interested, Validate, use an Easy manner). These skills are especially helpful for establishing boundaries, straightening social networks (theme 3d) and seeking support (theme 4a, theme 4c). Self-respect effectiveness is achieved by learning the FAST skill (be Fair, no Apologies and be Truthful). Particularly the no Apologies skill may serve as a reminder for some people, while for others it might be the first time they hear this and it can be encouraging to be one's self with other people, to speak one's mind and emotions (theme 3d, theme 4a, theme 4c). The next sections focus on building relationships and skills needed for ending destructive relationships. This as a whole may be useful for seeking support both in regular and difficult times (4a, 4c), as well as maintaining a healthy network (theme 3d). What follows is training on the mindfulness of others, which involves observing and attending to other people. This skill contribute to forming healthy social networks (theme 3d). This section provides guidelines for how to mindfully attend to other people. Suggestions such as "let go of over-focusing on self" and "stay in the present" might be especially relevant for highly anxious participants.

The next session focuses on how to end relationships. Its didactic approach may be especially helpful. Ending relationships may be difficult for a majority of people. The suggestion of having a script about how to end a relationship may increase the likelihood that things go according to plan and that the person will actually end a detrimental relationship. In addition, it is helpful that it considers severe cases and talks about safety and the inability to sometimes stop loving someone, even though they are bad for them. Addressing these points is of incredible value for maintaining a healthy social network (theme 3d), but also for dealing with stigma, and seeking support (it helps with knowing whom to ask for support and whom to cut off from one's life; theme 4a, theme 4c).

The following sections focus on skills that help people manage themselves and their relationships through walking the middle path. The covered skills here are dialectics and validation skills. Discussing dialectics mai contribute to finding meaning in one's diagnoses (theme 1c). Concepts such as "change is the only constant" refer to the idea that truth evolves over time; one's values change over time, as their context changes. Receiving a diagnosis may change the image someone has of themselves, however, this change does not need to be negative. By identifying which aspects of their diagnoses would contribute to a positive self regard, participants can take the needed steps to get there. On the way, they might change some of their values, parts of who they are and thus they develop, evolve and change. "Make lemonades out of lemons" concept could also be an opportunity for people to learn from negative experiences and evaluate what they gained as a result (theme 2a). These topics of dialectics and validation may also be useful to clinicians and proxies in the environments of people with ASD. Given that this part is all about connectedness, seeing from the other person's perspective, this may be more useful for neurotypical people who interact negatively with people with ASD (theme 2c, theme 4b, theme 4d)

Emotion Regulation (ER) Skills

This training program focuses on "understanding and naming emotions", "changing unwanted emotions", "reducing vulnerability to emotion mind" and "managing extreme emotions" (Linehan, 2015). Emotion regulation as a whole is needed for forming and developing relationships (theme 3d, theme 4a, theme 4c). It is also needed for identifying boundaries (theme 3d), for finding meaning in one's life and for learning to use one's own potential meaningfully (theme 3c). Since some people with ASD stated needs related to knowledge of optimal stimulus balance, ER can serve as a first step here to identify these emotions and differentiate them from others (3b). ER also deals with how to change cognitions, take action and how to let go of negative thoughts and activate positive ones (theme 2d). ER helps with self-validation (Linehan, 2015) as well, thus finding personal meaning in the diagnosis may be facilitated by this (theme 1c). By validating who and how one is, they can also find meaning in what they are, through accepting it, valuing it and trying to make the most out if it, without shame or being held back.

All sections provide rationales for the concepts they teach and offer skills to achieve ER. Same as with IPE skills training, there are discussion points and group activities that facilitate learning of the covered skills. After explaining and training each set of skills, there is a troubleshooting section for explaining what to do in case a skill was not helpful.

This training module starts off with goals of ER, what ER is and how to regulate emotions. The following sections focus on how to understand and name emotions. Emotions serve three functions, those of motivating action, communicate and influence others and one's self (Linehan, 2015). Communicating to others through emotions is important for understanding what effects one's emotions have on other people. This contributes to strengthening the relationships or facilitates forming new ones (theme 3d). Communicating to one's self may direct attention to signals that some things need to be checked out, for instance feelings of fatigue or over-/under-stimulation (theme 1b). Once identified, one can work on finding how to regulate these signals in a balanced way (theme 3b). The idea that emotions and the information they provide is not always accurate may be very relevant in helping participants with ASD identify people who are appropriate to befriend. Since people with ASD are likely to be victims of stigma, discrimination, bullying and other acts of violence, they need to pay attention to what people they have around them, whom they can trust and ask for friendship and support (theme 3d, theme 4a, theme 4c).

The following section provides a model of emotions, including characteristics, components and types of emotions (primary and secondary). All these aspects are relevant for the goals of maintaining a healthy social network, seeking support both in regular and difficult times (theme 3d, theme 4a, theme 4c). Additionally, the component of emotions called “aftereffects” may be particularly relevant for learning to tolerate existential fears (theme 2b). The idea here is that people become hypervigilant to cues and events that could set off the same (negative) emotions and attention is narrowed towards information that is incompatible with that emotion. Monitoring these aftereffects can help people change subsequent emotions, therefore not fearing encountering the main negative emotion anymore and by widening the attention focus to helpful aspects.

The next section deals with describing and naming emotions. One aspect of the rationale of the importance of emotions constitutes learning “to be separate from emotions”, meaning that emotions do not describe who someone is. This may be helpful for finding aspects of one’s diagnoses that do not concern the person themselves (theme 1c) and for learning how to deal with existential fear (theme 2b). For the first goal, participants can learn that even though their ASD characteristics may make it harder for them to make sense of emotions and to have intense emotions sometimes and low intensity other times, this does not define them. For the second goal, learning that people are not their emotion gives them space to process that specific emotion, in this case fear/anxiety, and it facilitates transforming it into a more adaptive emotion.

The following sections focus on changing emotional responses, by checking the facts, engaging in opposite action and/or problem solving and ends with troubleshooting. These are all useful skills for ER, therefore fulfil the above mentioned goals of showing full potential in social situations (theme 3) and seeking support both in regular and difficult times (theme 4a, theme 4d).

The next sections are about reducing vulnerability to emotion mind (i.e. when one's reasoning is overtaken by emotions) (Linehan, 2015) and provides a set of skills called ABC PLEASE (Accumulate positive emotions, Build mastery, Cope ahead). PLEASE is a set of skills that helps participants take care of their mind by taking care of their body and to find meaning in their life (theme 3c). When discussing accumulating positive emotions short-term and long-term, these parts may be especially relevant for the goal of people with ASD to focus on success experiences (theme 2a). It also encourages people to be mindful of positive experiences when they happen. On the long-term, accumulating positive emotions can also facilitate learning to tolerate existential fears, by helping the person value the good parts of their life and not worry about any existential aspects (theme 2b). It is also relevant for finding meaning in one's life (theme 3c), by changing their life to accumulate positive experiences, find their values, their competencies and to fit their desired way of living. Similarly, PLEASE skills benefit gaining insight into one's own potential (theme 1b).

Building mastery and coping ahead are the topics of the following sections. Building mastery is especially relevant for building self-confidence and focusing on success experiences (theme 2a). The more they overcome difficult situations (that is, they have success experiences), the more competent they come to feel and they can strengthen their self-confidence. The section about PLEASE skills (treat PhysicaL illness, balance Eating, avoid mood-Altering substances, balance Sleep, get Exercise) may be useful for finding a balance in stimuli (theme 3b).

The following sections focusing on "managing really difficult emotions" can help with learning to let go of negative experiences in one's body and learning to activate positive thoughts (theme 2d). These sections use skills of mindfulness of current emotions and managing extreme emotions. Mindfulness gives space to a person to let go of negative thoughts, by just experiencing them and letting them pass. Then, they can learn how to redistribute their attention to more positive thoughts. Mindfulness also strengthens the ability to attend to bodily signals, thus recognizing and balancing fatigue and over-/under-stimulation (theme 1b, theme 3c).

Emotion Awareness and Skill Enhancement (EASE)

EASE is targeted towards adolescents and young adults aged between 12 and 21 years old that have an ASD diagnosis and are cognitively able (White et al., 2020). The goal of EASE is to improve self-regulation skills, by becoming mindful of one’s own emotions, values and goals and by behaving in congruence with them. Mindfulness exercises both during the sessions and outside of them are a core aspect of EASE therapy. Through mindfulness, one becomes more aware of their emotions, their automatic thoughts and their behaviour.

Another important aspect of EASE is that it incorporates the social milieu of the participants into the treatment. It does so because emotional dysregulation is thought to occur most often in social situations, therefore the participants needs to hone their skills in actual social challenges (White et al., 2020). Therefore, EASE makes use of community sessions in which the therapist goes outside the clinic with the client and gives the client the opportunity to practice the learned skills in social situations. Each training section of EASE ends with community sessions. Parents are also an active part of the therapy. They are brought in at the end of almost every session for practicing mindfulness exercises together with their child. During the session, the parents will be in a different room, going through the content of the session their child if following in real time, on an online intervention platform.

Self-regulation is developed and improved through the use of ABCD skills: Awareness, Breathing, Change, Distract. EASE entails six large sections, divided in subsections. Each section deals with one ABCD skill. Every session starts and ends with a mindfulness exercise. After each session, the client receives homework which entails practice of mindfulness exercises and practice of the skill/s learned during the session. The face-to-face therapy is aided by the emotional-Coach (eCoach) which is an online platform for both the children and the parents. The eCoach platform offers theory and practice to both parents and children of what is learned during each session.

The fact that EASE places great focus on mindfulness, it is a useful for learning people with ASD to identify fatigue and over/under-stimulation (theme 1b). Mindfulness may also be a way of coping with these emotions (theme 3b). It also helpful for learning to let go of negative experiences and activate positive thoughts (theme 2d). The core idea of mindfulness is to attend non-judgemntally to our thoughts, feelings and body, therefore finding a balance between all these elements. Through mindfulness, existential fears may become easier to bare (theme 2b) Additionally, self-regulation helps with social interactions, as all the content of EASE is placed in the social context. Therefore, though EASE people with ASD may learn to show their full potential in social situations (theme 3d) and learn to seek support both in regular and difficult times (theme 4a, theme 4c). The focus on change and distraction is highly inspired from Cognitive Behavioural Therapy, which focuses on the influence of automatic thoughts on emotions and behaviours. Therefore, focusing on success experiences (theme 2a) may be achieved through such techniques of thought analysing and replacing.

Discussion

The present paper explores the identity development process that gender-typical and GD people with ASD go through, while looking for answers to the following questions: a) what unique needs GD people with ASD have in their process of identity development, b) what facilitates this process for them, and c) whether and how MBT, DBT and EASE fulfill the needs of gender-typical and GD people with ASD. It has been shown that both gender-typical and GD people with ASD have increased risks of depression, low quality of life and decreased self-esteem due to internalized stigma (Mak & Cheung, 2010; Markowitz, 1998; Peterson et al., 2017; Sizoo & Kuiper, 2017). When adopting the Minority Stress framework, both ASD and GD potentially posit minority stressors to people who identify as ASD and/or GD (Botha & Frost, 2020; Meyer, 2003). Some of these minority stressors are victimization, rejection expectation and internalized stigma (Meyer, 2003).

The Needs of Gender Diverse People with ASD

The interviews conducted with GD people with ASD did not yield unique needs as a result of the interaction between ASD and GD. On the contrary, their needs when it comes to identity development are mostly similar to those of any person going through this process, with a few exceptions. All participants described the need of surrounding themselves with people who are understanding, accepting and non-judgmental, and being supported by their family, friends, and professionals. All participants ended the interviews by stressing the fact that they are just human beings and they need what everyone else needs. One exception concerns medical needs (surgeries, hormone therapy).

Participants stressed the fact that professionals should be well informed in regards to GD and ASD, and the various forms they take in different people. This is in line with other studies that discussed the importance of professionals being aware of GD and ASD co-occurrence and interaction (Strang, Meagher et al., 2018). Participants also voiced the need for more gendered care tailored towards non-binary needs, for instance tailored hormonal treatments, facial hair removal, breast reduction/removal. This is in line with what a panel of experts during a different study concluded, acknowledging the need for more personalized medical care (Strang, Meagher et al.m 2018).

Participants also strongly believed that GD is not and should not be considered a pathology. In this regard, some participants addressed the gender dysphoria diagnosis and the barriers it imposes on identity development. In order to have access to gendered care in terms of transition processes and hormone therapy, one needs to be diagnosed with gender dysphoria. There are several issues with this procedure. First, not all participants experienced gender dysphoria, however they felt some levels of discomfort towards their physical appearance, which could be alleviated by undergoing interventions such as facial hair removal, breast removal. They would prefer these interventions to be covered by their health insurance, however this is not possible, given that insurances require gender dysphoria diagnosis and they do not experience enough dysphoria to be diagnosed. Second, in the Netherlands, as stated by the participants, there are extremely long waiting lists for starting one's gendered care, which further delays getting a gender dysphoria classification and the benefits this may add to the identity development process. Participant 1 worried that their ASD classification may slow down further the process of getting a diagnosis of gender dysphoria, one of the reasons being professionals' gatekeeping. Other studies found similar concerns GD people with ASD had. Participants in one study (Strang, Powers et al., 2018) discussed their gender identity being perceived as just an "autism thing", thus being invalidated. Cloeman-Smith et al. (2020) discussed why GD may be perceived a "symptom" of ASD. Participant 3 exemplified how gender expression may impact professionals' perceptions of ASD characteristics one has, through her diagnosis story.

Facilitating Factors for Identity Development of GD People with ASD

In regards to what facilitates identity development of GD people with ASD, this depends from person to person. Having a supportive social environment (family, friends), having access to information, and having positive life experiences encourage the development of identity in a prosperous way. All the needs mentioned by the participants have to do with the social world, rather than with internal abilities. Regardless of the interventions people choose to undergo, they should benefit from the support they need, including support regarding gender identity exploration. Safety is especially relevant. One participant mentioned taking hormones without a prescription, which can be rather dangerous if not monitored by health professionals. Another participant described how losing weight makes them look more ambiguous, which gives them some comfort. Both stories illustrate negative ways of coping with one's gender related struggles and point towards the high relevance for professionals to be open-minded and available to offer the support their patients need, in a safe, non-judgmental manner.

Interventions and the Needs of People with ASD

For gender diverse people with ASD, conclusions cannot be drawn as to whether MBT, DBT or EASE fit their needs engendered by ASD and GD combined. The ASD side of identity may be aided by these interventions in similar ways to gender-typical people with ASD and they may also be tailored to address GD (e.g. education on gender diversity, support for gender exploration, forming MBT and DBT groups with other GD participants).

When discussing the needs of gender-typical people with ASD, no psychological intervention fully fitted their needs. Nonetheless, all interventions tackled subthemes from every theme listed (table 1): knowing one's self and potential (theme 1), accepting one's self (theme 2), realizing one's desired self (theme 3), self-regulation and support (theme 4). MBT mostly fulfilled needs related to theme 1 and theme 3. This intervention places great importance on understanding who one is and what one can do, both in terms of their diagnoses and their own abilities. Furthermore, these goals can also be fulfilled due to the focus of MBT on the mentalizing abilities of both the client and the therapist. Given the double empathy problem (Milton, 2012), which states that people with ASD lack understanding of neurotypical people and neurotypical people lack understanding of people with ASD, this double focus on therapist and client may bridge the knowledge gaps people have in relation to neurodiversity and neurotypicality. MBT also seems the best suited for the goal of knowing one's self due to its mentalizing stance, which provides a great amount of space to explore one's identity, values and goals. Adaptations of MBT's assessment phase should be made, in order to cover information about ASD classification, besides the information given about personality disorders, depression and anxiety. Similarly, module 1 of MBT needs to include a discussion about mentalization in the context of ASD.

DBT is the intervention that is most comprehensive, as it addresses the most subthemes. Together, IPE skills training and ER skills training addressed almost all subthemes of each main theme. The IPE skills module tackles the goal of self-regulation and asking for support (theme 4) in its entirety. Given its focus on how to handle interpersonal relationships, asking for support, asking families and professionals information on what one needs are facilitated by the skills learned during that module. These actions are based on communicating one's needs, therefore IPE skills are of utmost relevance. ER skills contribute to self-regulation goals, but it fully addresses the goal of realising one's desired self (theme 3). A drawback of DBT is that its guidelines for learning especially IPE skills, come from a neurotypical perspective; they were written by neurotypical people for neurotypical people and interactions. Therefore, neurodiverse people may not benefit from such guidelines, as they have different ways of relating to the world and interacting with it. For specific examples, see points of consideration, DBT: IPE Skills Training (Appendix C).

EASE mostly fulfills the goal of accepting one’s self (theme 2). Due to its main emphasis on mindfulness, participants can learn to focus on positive experiences, to deal with existential fears and not to give in into negative thoughts. Mindfulness exercises are practiced throughout the whole intervention and they are also part of the participants’ homework, thus mindfulness has great chances of being consolidated thorough knowledge and practice. A drawback of EASE is that it requires access to internet, possession of a tablet/computer/smart phone and parents that are willing and can afford being part of the therapeutic process of their child. While nowadays, most people have access to internet and gadgets, this is not true for everyone. Therefore, people that may most need this intervention risk lacking access to it.

All interventions naturally have the individual as their focus and pose great importance on changing how one thinks and acts. Nonetheless, change must be supported by one’s environment as well. EASE is the only intervention that integrates the social milieu into the sessions, by having the parents of participants be an active part of the interventions. However, not all people with ASD have supportive families and if they do, not all of them afford becoming an active part of their child’s therapy. Therefore, interventions that strive to help people with ASD should also address neurotypical people and discuss ASD from a diversity point of view, rather than from a perspective of deficiency. As one participant stated: “we [people with ASD] deserve more than just not be in a crisis”. This is in line with the subgoal of people with ASD to receive more positive/accepting feedback from their social environment (theme 4c), tackled by no intervention. The module on validation, that is part of DBT IPE skills training, may also be of great relevance and help to the proxies of people with

ASD (e.g. parents, teachers, friends), but also to professionals who start working with people with ASD. For more additional potential benefits of IPE skills training, see appendix C.

Recommendations

For Professionals

MBT, DBT and EASE have the potential to help people with ASD understand themselves, interact with people around them in ways they are comfortable with and how they themselves should respect, support and understand the people they interact with. These interventions may need adaptations to be more accessible to people with ASD, depending on the needs of the clients (e.g. simpler wordings, more/less time per session, fewer members in a group etc.). Nonetheless, these interventions were not analysed in order to offer a clinical solution to ASD. They are rather examples of helpful approaches in working with people with ASD and fulfilling their needs. Each approach has its main strengths that could inform professionals in their work (e.g. the mentalizing stance of MBT, the emotion regulation skills of DBT and the mindfulness skills of EASE). If people with ASD who are also GD undergo these approaches, GD aspects can be incorporated within these frameworks and explored just as any other part of someone's identity.

Additional, critical points of recommendation are information and safety. Being thoroughly informed about the co-morbidity of ASD and GD can help understand what causes certain discomforts and why someone feels troubled with their body or gender roles (since it might not be just that people with ASD cannot make sense of social rules). As pointed out by the participants, safety is also vital; professionals should assure their clients that the client-practitioner relationship is a safe, open and non-judgmental environment. Such awareness and openness towards ASD and GD on the side of professionals can also help prevent their clients from suffering from more severe mental health issues in the future.

For Family, Friends and Other People

The social context of a person with ASD and/or GD bears great responsibility and importance. Having a supportive family, group of friends and other social groups (e.g. classmates, supervisors etc.) can make a sensible difference in how one perceives interactions with other people and how one perceives themselves. Therefore, people within the social milieu of a person with ASD and/or GD should be informed about what these concepts mean, the advantages and disadvantages they bring, how they can listen and attend to the needs of these people. One participant stated that they feel accepted when people around them are not reluctant to ask questions about their ASD and gender identity. This made them feel acknowledged. Thus, being genuinely curious, respectful and interested may be strong starting points.

Limitations & Future Research

The current paper faces several limitations. While the paper addresses neurodiversity and gender diversity, the sample was not diverse enough in terms of socioeconomic (SES) backgrounds, cognitive abilities and cultural backgrounds. These limitations tie into the idea that identity exploration is a process that comes from a position of privilege. If one's primary needs are not met, one will not be able to explore who they are, due to lack of resources (material and/or spiritual). Another limitation of the sample is that all the participants were navigating the informational space of GD and ASD rather well; they were either activists and/or generally outspoken about GD and ASD. Thus, this paper did not gain insight into the needs of less knowledgeable people when it comes to GD and/or ASD. Access to information facilitates identity development and so, it would have been worthwhile to find out how to aid people without access to so much information.

The current study also has some methodological limitations. The small sample and the qualitative approach to this subject do not allow for any inferences of causation, association or any other relationship between the investigated concepts. Thus, while there is great value in exploring and understanding people’s personal experiences, this line of work would benefit from being supported by quantitative research as well, investigating hypotheses derived from qualitative work.

Future research should take all these aspects into account when investigating GD and ASD. Light needs to be shed on less privileged communities and their identity development processes, in order to reach people who are in great need of help. Additionally, further research should focus on GD and ASD from a strengths perspective rather than a pathologic one. The inclusion of less cognitively able people with ASD holds great value, since not much is known about their identity development process, let alone the interaction between GD and ASD in such a population.

Conclusion

The current paper cannot give exact answers to all the research questions. Nevertheless, the main idea is that identity is a fluid concept; it never stops evolving and people need to find their identity, in order to understand who they are and who they want to be. No one is born knowing exactly who they are and people may never stop evolving. Learning about one’s self contributes to a more meaningful life and it is helpful to know one’s self when none of the surrounding things seem to make sense. The world entails so much diversity and it should accommodate and value all forms of diversity. GD is not a disorder or something that needs to be treated. It is someone’s identity and way of relating to themselves and to the world; one participant said GD is a spectrum, but not a linear one. Every person can express their identities radically different from each other. And the same stands for ASD.

ASD is not a deficiency or a disorder; it is also just a form of diversity, which in the current world, is a disability, due to the neurotypical norms that are so powerful and govern policies, expectations, institutions and behaviours. As one participant put it:”disabilities are only disabilities when there's no accessibility, because if we automatically catered to the diversity that is on the planet, we wouldn't have the obstacles that we face today”.

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Appendix A: Method

The overarching project used the Adapted Intervention Mapping was used to collate relevant information regarding the experiences of people with ASD and their needs/current coping in the context of the healthcare and social systems. Interviews with people with ASD were conducted (n-14), as well as focus groups with people with ASD (n=5) and their proxies (family; n=7). A Delphi study was conducted with a panel of experts, proxies and policy makers. All the resulting content was analysed using the thematic analysis framework and a list of themes/goals that were considered relevant for healthy identity development in people with ASD was generated. Parallel to the analysis of the interviews, a list of potentially beneficial/efficacious approaches for people with ASD was compiled, based on the input received from the Delphi study.

Data Analysis

The thematic analysis was conducted following the 6 steps of this methodology (Braun & Clarke, n.d.). First step was familiarization, hence transcripts of all interviews were made and read to immerse with the content and have it readily available for the next step: coding. All interviews were coded using key words identified throughout the interviews. Codes were reused when needed and new codes were added to the list, depending on the information retrieved from the interviews. Next, initial themes were generated, by collating all the codes and dividing them in themes, trying to organize them in patterns. The fourth step involved developing and reviewing themes. The goal of the current analysis is to find patterns that fit the experiences shared in the interviews, that have a sense of logic. Codes that proved to be irrelevant to the goal of the paper were discarded. Then, the themes were refined, defined and named, using key or summarizing words from the collated experiences. The final step was to write the analysis up.

Appendix B: Interview Schedule

Initial information:
- How old are you?
- What is your highest level of education achieved?
- What is your nationality?
- Do you have other medical diagnoses besides ASD?
- Are you currently taking any regular medication?

Identity formation:

1. Could you describe yourself in 5 words?
    - Why did you choose these ones?
    - Would you say these five words describe you as you really are? What's missing?
    - Was the you of ten years ago different? How?

2. When did you first encounter the feeling of being gender diverse?
    - What happened then?
    - How did you feel then?
    - How do you feel now? (e.g. gender incongruence and/or dysphoria); what changed?
    - Do you feel different about yourself now as opposed to how you felt then?

3. When did you get diagnosed with ASD?
    - Age;
    - Process of getting in contact with a psychologist.
    - Sequence with GD (what came first?)
    - Did ASD pose barriers to finding your GD identity? If yes, what barriers?
    - Did GD pose barriers to being diagnosed with ASD? If yes, what barriers?

4. How did you feel when you received your ASD diagnosis?

5. Do you feel like you have found your “final” gender identity?
    - Yes → how? Did you feel like your ASD interacted with the process of finding your gender identity?
    - No → how come? (ASD, explore needs, safety and other reasons for not finding one’s identity)

6. What is it like to be in your body?
    - Do you feel comfortable with your body? Why yes/not?
    - When do you feel most comfortable/uncomfortable?
    - What is missing for you to be more or fully comfortable in your body?/What makes you feel comfortable in your own body?
    - Is there a **mismatch** between your brain and your body?

7. How much are ASD and GD part of your identity?

Stigma:

8. How do you experience social interactions (in terms of acceptance, stigma, misconceptions, disadvantages etc.)?
   - If stigma, misconceptions, discrimination are there: do these aspects play a role in your social interactions?

9. How often do you present your true self to other people around you?
   - Does it make a difference if the person is family, friend or stranger? What difference?
   - In what circumstances can you easily express your identity as you want to, to other people?
   - What can you do to make it easier for you to express who you truly are?

10. How often and under what circumstances do you express yourself differently to other people?
   - Are there ever things you consciously don't do when you're around people? Do you ever camouflage yourself? (masking)
   - When do you feel more accepted; when you present yourself as you really are, or when you pretend to be different? Why?

11. To what extend do you disclose to people your ASD diagnosis and/or GD identity?
   - Who do you tell and who do you not tell?

12. Does people's perception of you change when/if you tell them you have ASD and are GD?
   - If yes, then who are those people? What are the circumstances in which their opinion changes?

Interventions/Needs:

13. Do you have support at the moment?
   - Formal and informal social support; if yes, who are those people?
   - Psychological support; if yes, how is it going?

14. What are some identity-related needs that you have, facing both ASD and GD? (What support do you need?); examples:
   - ➢ help with coming out (process, when meeting new people);
   - ➢ gender focused therapy (gender reassignment, hormonal treatment, psychological needs) integrating ASD and GD in your identity;
   - ➢ gender incongruence and/or dysphoria.
   - ➢ Finding your place in society and purpose in life?
   - What do you need from your family, friends, therapists?

15. (If they have psychological support through treatments) Do current treatments cover such needs?
   - Are they optimal? Do they need improvement? If yes, how?
   - Is the **diagnosis** of GD needed?

Ending (to blow off steam, end on a light note)

16. What do you think people still don't know about ASD and GD and they must know?
17. What advice would give to yourself before embarking on the ASD and/or GD journey?

Appendix C: Interventions

MBT

Assessment

During the assessment phase, clinical interviews are used to assess the client's mentalizing abilities, past and current attachment patterns, relationships, and the nature of their complaints (i.e. context, severity). The manual (Bateman & Fonagy, 2016) does not offer specific measuring tools, however examples of relevant questions are provided, mainly for evaluating mentalizing abilities: "How has your relationship with your parents changed since childhood?", "In what important ways have you changed since childhood?" (for more, see Bateman & Fonagy, 2016). A contract is settled, which covers responsibilities both the client and the therapist must uphold (e.g. the therapist will deliver the intervention, the client will engage with it), rules regarding sexual relationships between group members of MBT, use of alcohol and drugs, violence and other challenges that may interfere with the treatment (Bateman & Fonagy, 2016).

MBT-Introductory

The remaining eight modules of MBT-I discuss attachment, personality disorders, motivating the participants to adopt a mentalizing stance, anxiety, depression and conclusion. While these part do not directly satisfy the needs of people with ASD, they consolidate the MBT as a whole, therefore they should be followed.

MBT-G

Group sessions are held weekly, they are 75 minutes long and there is a group leader (Bateman & Fonagy, 2016). The groups are open, meaning that new members can join at any time.

Each group session starts out with a summary of the previous group session, continues with problem exploration of all participants, then a synthesis of all problems is worked out by the group leader and group members and together they choose a problem to explore. Closure and post-group discussion are the ending parts for the group sessions. The purpose of these sessions is to help people learn about mentalizing, practice it, learn from each other and learn about attachment. Problems need to be presented and discussed from a mentalizing perspective and seek solutions to problems in terms of not becoming dysregulated (Bateman & Fonagy, 2016).

Additional Potential Benefits:

MBT-I has several modules that may help people with ASD (Bateman & Fonagy, 2016). Module 2 addresses problems with mentalizing. Module 3 focuses on emotions (basic and social emotions; primary and secondary emotions). Given that there is a great body of research on the alexithymia people with ASD experience, this specific part may be helpful for participants with ASD. This part involves the participants in the explaining process of physical sensations/emotions, therefore the abilities of the group participants can be evaluated while exploring what emotions are, what relevant information physical signals entail, what functions emotions and sensations have, and their purposes. Especially when discussing primary and secondary emotions (i.e. basic emotions which are the first responses to events happening and emotions that occur on a deeper level and have more complex meaning), understanding this distinction can give great insight into why people react a certain way.

DBT: IPE Skills Training

Points of Consideration:

Section IX lays down skills and guidelines for finding potential friends. For participants with ASD, while it may be useful to reiterate on these skills, they most certainly know how to befriend people if they are in safe, healthy circumstances (e.g. around understanding people, around other people with ASD). It might be more beneficial to ask them if they have troubles making friends, how they go about making friends and what they need help with. They need to have a social network (theme 3d, theme 4a, theme 4c), but they might be more than able to do so already.

One suggestion made in section XVI named Validation Skills (Linehan, 2015) is "read minds". This refers to inferring the emotions someone may have in reaction to an event. While some reactions are very obvious (e.g. grief at a funeral), some are not. Any kind of mind reading needs a level of assumption on the part of the mind reader. People with ASD are not particularly good at this and they should not have to be either. It is fine to ask someone if they understood them correctly. It is validating to make sure one understands the person they interact with.

Sections regarding relationship effectiveness (VI), mindfulness training (XII) and self-respect effectiveness skills (VII) offer several guidelines for building and improving relationships, and self-respect, with a rather didactic approach. Nevertheless, such guidelines may not be entirely suitable for people with ASD. On one hand, people with ASD may already have these skills. On the other hand, these guidelines were written by neurotypical people for neurotypical types of interactions. Everyone has their unique ways of interacting and making friends, and because a neurodiverse person may not approach a situation in a way neurotypicals expect them to, does not mean that their way is wrong and they should be taught to act differently. This section should be less didactic and more personalized, since its essence is helpful.

For instance, when teaching the GIVE skills, the guidelines for the V (Validate) skill may not be of high relevance for people with ASD. One concrete guideline is to act interested, despite not being truly interested. This may not be actually helpful for a person with ASD (for whom authenticity is a core value). There are alternative, honest, gentle and still polite ways of terminating such a conversation; for instance, conversational skills to do this are taught in the PEERS intervention (Laugeson & Park, 2014). This might be more helpful for participants with ASD, given their tendency to be less influenced by norms/conventions, especially those about neurotypical interactions. They should be free in stating their boundaries/disinterest at all times and if attending an uninteresting conversation that tires them, rather than helps them is a boundary, then they should be able to state these issues without any negative consequences, respecting the other person's boundaries as well. Other skills include reading and validating one's non-verbal signals. While this is helping the other person feel more validated, this again seems rather like a neurotypical standard for interactions. Both parties involved in an interaction would benefit from stating how they show validation and what makes them feel validated, so they can create realistic expectations from one another, in terms of expressing validation.

Guidelines about building relationships (section X) raise the same issue discussed above. While such guidelines may be useful for some participants with ASD, facilitating a more clear understanding of the social contexts, such "guidelines" might seem irrelevant for other participants with ASD, since they might already have their own social skills needed for building relationships. For example, when two people share the same hobby, they might get excited about each other and ask and respond to questions and follow all these guidelines naturally. Making small talk is not needed for a good conversation. As long as people truly respect each other, find each other interesting and worth their resources (i.e. time, energy), such guidelines (e.g. making small talk) may perish in relevance. When discussing attending to other people, there are also a few suggestions that may not be appropriate for people with ASD. For example, "stop multitasking" is a valid thing to ask for in an interaction, however it depends on what multitasking means. Sometimes, people with ASD may feel uncomfortable in an interaction and would need to stim to release some of the tension. This may come across as multitasking to a neurotypical counterpart, depending on the stimming activity, however they should be allowed to do it, since it takes pressure away. In the long run, it actually facilitates more attention and focus on the interaction.

Additional Potential Benefits:

The section targeting self-respect effectiveness (VII) may be especially useful for dealing with stigma (social judgement, negative evaluations) and preventing it from becoming internalized by the participants with ASD. The main point here is to analyse various interactions participants had and check how they feel about themselves afterwards. By discussing the concept of self-respect in-depth (importance, pitfalls), as well as discussing instances when their behaviours enhanced their self-respect, is a good starting point for keeping this objective in mind and enabling this skill when faced with a stigmatizing interaction/conflict. By finding ways to deal with such interactions while maintaining or perhaps improving one's self-respect, it can be very empowering and it could make them feel more independent, autonomous, brave and self-efficacious, which in turn improves their self-respect.

Sections XV and XVI about dialectics and validation may be of great relevance because of the information offered in the "recovering from invalidation" part. This is an opportunity for participants with ASD to understand if and why they feel stigmatized, why it is internalized and what the effects of not being validated are. This can be a starting point for dealing with stigma and healing from it. The IPE skills training ends with offering strategies for behaviour change.