

Supporting Neurodivergent Gender Diverse People: Evidence-Based Support Strategies

By Kai Schweizer

Sensory Processing

Subtrait	Neurodivergent Experience	Intersection with Gender Diversity	Evidence based support strategies
Tactile	Heightened sensitivity or active seeking of specific textures.	Tactile sensitivity can limit some gender affirming practices (for example binding, tucking, shaving, hair removal, medical touch, certain fabrics). Sensory pleasing textures and garments can also be strong sources of gender euphoria.	Work together to map a tactile sensory profile for clothing, binders, tucking garments, shaving, hair removal, and medical touch. Explore sensory friendly gender-affirming options (e.g., softer fabrics, different binder designs or sizes, gradual wearing schedules, and planned breaks). Always use clear consent practices for physical touch, including medical exams, and remind people they can pause or stop touch at any time.
Auditory	Sensitivity to noise, difficulty filtering sounds, or strong auditory seeking.	Noisy, echoing, or unpredictable environments in clinics, schools, and community settings can increase overload and avoidance. Misgendering, deadnaming, and hostile gendered language act as acute auditory triggers that combine sensory and minority stress. Gender-affirming voice work may be complicated by sensitivity to one's own voice, recordings, or feedback.	Reduce, where possible, sudden or intense sounds in services, including loud televisions, music and machinery. Offer quiet waiting options, the option to wait outside with phone or text notification, and permission to use headphones. Use consistent, correct names, pronouns and gendered wording, as gender affirming language is linked to better mental health and reduced distress. For voice work, follow gender affirming speech pathology guidance: set goals collaboratively, monitor fatigue and discomfort and respect autistic or ADHD communication styles rather than pushing masking.
Visual	Sensitivity to light, flicker, visual clutter or complex visual scenes.	Visual overload in waiting rooms, classrooms and group spaces can increase shutdown or avoidance. Visual focus on dysphoric body parts, mirrors and photographs can be hard to tolerate, while affirming visual self expression (for example hair, tattoos,	Adjust lighting where possible, using softer or indirect light and reducing flicker and glare. Reduce visual clutter and provide clear, consistent signage. Offer choice about mirrors and body exposure in clinical and therapeutic work, including options to cover dysphoric areas, use handheld mirrors or avoid mirrors entirely. When people want to work on body image, use gradual, collaborative approaches that combine sensory informed and

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		clothing) is often central to gender euphoria.	trauma informed practice. Support affirming visual self expression (clothes, hair, makeup, tattoos) as protective for mental health and embodiment.
Olfactory	Strong aversion to or craving for particular smells; smell can strongly affect comfort and distress.	Scents linked to gender expression (for example perfumes, colognes, deodorants, hair products) can be either dysphoria inducing or euphoria producing. Hormone treatment can change sweat and body odour, which may alter olfactory experience and comfort over time.	Provide, where possible, fragrance free or low fragrance environments in services and clearly label scented products. Recognise that strong odours from cleaning agents, perfume or food can be barriers to care. When exploring gender expression through scent, use small samples in controlled, time limited ways and respect a person's choice to avoid scent entirely. During medical treatment, including hormones, check in about changes in smell sensitivity and odour and adjust shared space expectations and product recommendations accordingly.
Gustatory	Restricted, highly specific or intense food preferences; strong reactions to taste, texture or temperature.	Sensory aversions to taste or texture can coexist with eating disorder concerns, dysphoria about weight or shape and hormonal shifts that change appetite and taste. Gendered expectations about eating, body size and muscularity can influence which foods feel safe.	Use sensory informed nutrition approaches that respect safe foods, textures and temperatures, as supported by autism and ARFID research, rather than insisting on standard meal plans. Work collaboratively to broaden food repertoires slowly from established safe options. In assessment, distinguish between mainly sensory avoidance and mainly body image or weight focused restriction, while acknowledging they often interact. Use eating disorder treatment approaches that reduce weight normative pressure where possible and centre predictability, safety and collaboration, consistent with trauma informed and neurodiversity affirming care.
Interoception	Difficulty noticing, interpreting or trusting internal bodily sensations such as	Autistic and alexithymic experiences of interoception can amplify or mask dysphoria and distress. Dysphoria, trauma and high anxiety can lead to	Draw on interoception and mindfulness research by offering structured, low demand interoceptive practices (for example brief body scans, breath awareness, guided noticing of specific sensations) adapted with concrete language and visual supports.

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	hunger, fullness, pain, fatigue and arousal.	disconnection from the body, while gender affirming care can support renewed connection and trust in bodily signals.	Introduce any body focused work slowly and with explicit consent, given the potential for dysphoria and trauma activation. Invite reflection on how social and medical gender affirmation change internal signals (for example breathing after chest surgery, hunger or heat with hormones) to build self knowledge and regulation, rather than to question gender identity.
Alexithymia	Difficulty identifying and describing emotions or linking physical sensations to feelings.	High rates of alexithymia in autistic and neurodivergent people can complicate emotional communication and are closely tied to interoceptive differences. For trans people, this may make it harder to name feelings about gender, but it does not reduce the validity of gender identity.	Use concrete emotion language, visual tools such as emotion wheels and body maps to help link sensations, thoughts and context to emotion words. Research supports structured emotion support over assumptions of emotional absence. Separate clinical curiosity about emotion from questioning gender identity, and make explicit that difficulty naming feelings is common and does not weaken someone's account of their gender. Offer alternative modes for communicating emotion and dysphoria, such as writing, rating scales and creative methods, which are often preferred by alexithymic and autistic people.
Proprioception	Atypical awareness of body position, size and movement; clumsiness; difficulty judging force or distance; strong seeking of pressure or movement.	Changes in body shape due to puberty, hormones or surgery, and gender affirming practices such as binding or tucking, can alter body map and proprioceptive feedback. This can affect balance, pain, fatigue and comfort during movement.	Refer to or collaborate with occupational therapists and physiotherapists who can provide proprioceptive supports such as deep pressure, resistance activities and tailored movement plans that also respect gender goals. Provide education on safer binding and tucking that includes posture, breathing and movement guidance and clear limits on wear time. In groups or clinics, normalise varied sitting, standing and movement patterns and avoid gendered assumptions about how people should walk, sit or gesture.
Vestibular	Motion sensitivity such as dizziness, nausea or	There is little direct research on vestibular processing and gender	Apply sensory regulation principles by offering flexible seating and positioning options, allowing people to choose where to sit

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	<p>imbalance, or strong vestibular seeking such as spinning and swinging.</p>	<p>diversity, but vestibular overload can compound the stress of navigating hostile or invalidating gendered environments, such as crowded services or community spaces.</p>	<p>or stand (including near exits or walls) and to use gentle movement when needed. Reduce unnecessary sudden movement, crowded layouts and visually complex corridors in service design where possible. Provide options to step out of groups or queues and return without penalty, which can reduce both vestibular strain and social stress.</p>
Sensory seeking	<p>Active seeking of particular sensory experiences (for example touch, movement, sound, light, smell or taste) for regulation and comfort.</p>	<p>People may intentionally seek gender affirming sensory experiences such as particular fabrics, scents, voice work, movement styles or tattoos to reduce dysphoria and increase gender euphoria.</p>	<p>Draw on research that frames stimming and sensory seeking as legitimate self regulation rather than pathology. Help people identify sensory experiences that feel both regulating and gender affirming and build these into daily routines, therapy and care plans. Ensure policies allow safe use of sensory aids such as fidgets, weighted items, comfortable clothing and movement in waiting rooms and groups, and educate staff that these are support tools, not behaviour problems. Screen for rare unsafe forms of sensory seeking such as self injury or pica and respond with appropriate medical and psychological support rather than blanket suppression.</p>
Sensory overload	<p>Shutdowns, meltdowns or withdrawal in response to cumulative sensory, social and cognitive input.</p>	<p>Gendered spaces such as bathrooms, changerooms, waiting rooms and school or workplace toilets are well documented sites of harassment and anxiety for trans people. This can combine with sensory overload to drive avoidance of essential activities such as toileting, medical care and education.</p>	<p>Implement sensory friendly and gender affirming environmental changes where possible. This includes reduced noise, clearer signage, shorter and more predictable waiting times, options for quiet waiting and clear signals about when interactions will occur. Develop simple, non punitive overload plans that include permission to pause or leave, access to quieter spaces and follow up that does not penalise people for overload. Advocate for and, where possible, design inclusive toilet and changeroom options (for example all gender or single stall facilities), and provide collaborative safety and regulation planning for people who must navigate unsafe or discriminatory environments.</p>

Executive Function

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Task initiation	Difficulty starting tasks, even when the task is important or desired. May look like procrastination or avoidance.	Anticipatory anxiety about gendered contexts such as clinics, schools or workplaces can make starting tasks harder. Internalised transphobia and trauma can add shame or fear to first steps in gender care, such as booking appointments or filling forms.	Use standard executive function supports such as breaking tasks into small, concrete steps and externalising these into written lists, visual sequences or digital reminders. Clinicians can complete first steps together with the person in session (for example making an initial call or submitting a form) to support follow through. Frame initiation difficulties as an access issue rather than doubt about gender. Address trauma and minority stress that increase avoidance through validation, graded exposure to services and peer or family support for early steps.
Planning and organisation	Difficulty structuring tasks, information and time; trouble keeping track of multi step processes and multiple appointments.	Gender affirming care often involves complex pathways with several providers, assessments and referrals. Autistic and ADHD trans people describe this complexity and gatekeeping as overwhelming and as a barrier to care.	Provide clear written summaries, flowcharts or diagrams of the care pathway with estimated timeframes, key decisions and contact points. Offer a consistent main contact person or case coordinator where possible to reduce cognitive load. Integrate autism and ADHD related support with gender care rather than treating them as separate streams, so that planning needs are addressed within transition work. Reduce unnecessary bureaucratic steps where policy allows and avoid duplicated assessments to minimise executive burden and inequity.
Time perception	Difficulty estimating, monitoring or feeling the passage of time. May miss appointments or	Long waits for gender affirming care and repeated delays can distort a sense of time, increase urgency or hopelessness and fuel rumination about	Encourage use of external time supports such as alarms, calendars, countdown timers and visual schedules for appointments, medication, eating and rest. Normalise these as standard tools for neurodivergent people rather than as signs of failure. Services can send clear reminders, give approximate

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	underestimate how long tasks will take.	dysphoria. Shutdowns and meltdowns can create periods of “lost time”.	wait times and provide updates about delays, which reduces anxiety and helps realistic planning. In therapy, validate the impact of long waits and uncertainty on time perception and motivation, and co create paced plans that focus on what is controllable now.
Working memory	Forgetting steps, instructions or information once a task has started. Difficulty holding several pieces of information in mind at once.	Chronic stress from discrimination, hypervigilance and unsafe environments can further reduce working memory capacity. Complex consent forms, multi provider plans and frequent changes are harder to retain.	Provide written instructions, checklists and summary letters as routine practice after appointments rather than relying on verbal recall. Use repetition and chunking when explaining information and check understanding with simple summaries. Invite people to record sessions, take photos of plans or use shared digital documents if they wish. Name the impact of chronic minority stress on concentration and memory and integrate trauma informed strategies such as pacing, grounding and predictability alongside standard cognitive supports.
Task switching	Difficulty shifting between activities, topics or roles. Tendency to stay immersed in one focus and find transitions jarring or exhausting.	Switching between gender expressions, names or pronouns in different environments, or between masking and more authentic presentation, adds extra task switching demands. Moving between appointments, school, work and family roles while managing dysphoria can increase overload.	Allow longer transition times between tasks and avoid unnecessary multitasking. Structure sessions with a small number of clearly signposted topics and clear openings and closings. Where possible, schedule demanding gender related tasks (for example appointments or form completion) with planned decompression time afterwards. Work together to identify contexts where switching between gender expressions is genuinely needed for safety and where it can be reduced to preserve executive resources.
Prioritisation	Difficulty deciding which tasks are most important or urgent. May focus on immediate interests and crises	In unsupportive settings, gender related needs are often deprioritised or treated as less important. At the same time, the urgency of dysphoria and distress	Use collaborative priority mapping that explicitly includes gender care alongside housing, food, physical health, mental health and safety. Adapt values based approaches for neurodivergent people to show that gender affirmation is a

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	while long term needs are neglected.	around gender may overshadow other health or life tasks.	legitimate health priority. Support people to turn these priorities into concrete, ranked task lists and to communicate them to services and family, for example through support letters or care plans that highlight the importance and time sensitivity of gender related tasks.
Emotional regulation	Difficulty recognising, modulating or recovering from intense emotion. May experience rapid escalation or prolonged distress.	Dysphoria, misgendering and minority stress are powerful emotion dysregulating experiences. Studies consistently show improved depression and anxiety after gender affirming care, suggesting affirmation and access are central to emotional regulation.	Combine emotion regulation work with advocacy for timely access to social and medical gender affirmation. Use regulation strategies that respect stimming, movement, sensory tools and authentic emotional expression, rather than suppressing these. Apply trauma informed approaches that validate anger, grief and fear in response to discrimination. Train staff that strong emotional responses to misgendering or disrespect are understandable, and that the goal is safety and support rather than emotional flattening.
Impulse control	Acting quickly without fully considering consequences. Difficulty pausing between urge and action.	In hostile or unsafe environments, rapid decisions about presentation, disclosure or leaving a situation may be survival strategies rather than simple impulsivity. Exploration of gender expression or identity change may be wrongly labelled impulsive.	Distinguish safety driven rapid responses from broader patterns of risky impulsivity. Validate protective actions in unsafe contexts and focus on increasing options and safety through safety planning and realistic role play. Provide simple tools for building in brief pauses before non urgent decisions (for example checklists or short grounding steps). Avoid pathologising gender exploration or identity shifts as impulsive behaviour. Instead, support informed, collaborative decision making paced to the person, consistent with gender affirming guidelines.
Motivation	Fluctuating engagement with tasks. Starting and sustaining effort is hard, especially when	Motivation is often higher in affirming environments and after transition goals are met, and lower in invalidating or	Reframe apparent lack of motivation as a possible sign of burnout, depression or chronic invalidation rather than laziness. Design services and environments that are visibly trans

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	tasks lack intrinsic meaning or feel overwhelming.	unsafe settings. Unmet gender needs and repeated barriers can contribute to burnout and hopelessness that may be mistaken for low motivation.	affirming and neurodivergent friendly, as these settings are linked to better engagement. Use interest based and strengths based approaches, drawing on special interests, advocacy and community connection to make tasks more meaningful. Break larger transition processes into small, achievable steps so that people experience regular success, which supports motivation.
Mental energy	Persistent fatigue from cognitive load, sensory demands and emotional labour. Feeling drained even by everyday tasks.	Autistic and trans people both report burnout from constant masking, vigilance and navigating discrimination. Combined autistic and trans burnout reduces energy available for executive tasks such as paperwork, appointments and study.	Explicitly recognise autistic and trans burnout in assessment and care planning. Adjust expectations for productivity, homework and appointment load. Support energy conservation strategies such as reducing unnecessary appointments, coordinating care to minimise repeated retelling of stories, using telehealth where appropriate and creating predictable routines. Integrate rest, joy, special interests and community connection as core parts of care, not rewards for productivity.
Self monitoring	Difficulty tracking one's own performance, behaviour or errors in real time; may under monitor or over monitor.	Many trans people feel pressure to continually monitor their gender expression, voice and body to reduce risk of discrimination. For autistic trans people, this constant self surveillance can use up cognitive resources needed for learning or work.	Reduce reliance on self monitoring for safety by creating explicitly inclusive environments, for example through pronoun sharing, visible policies and staff training. Help people identify contexts where they can safely reduce social performance and practise less effortful ways of being. Use feedback that is specific, kind and concrete and avoid shaming or punishing minor social differences, as this increases self surveillance. Where self monitoring is needed, externalise it using simple checklists or self reflection prompts rather than continuous internal tracking.
Sensory and emotional links	Executive functioning is strongly influenced by sensory load, interoception	Dysphoria, gendered trauma and sensory invalidation in places such as bathrooms and clinics can destabilise emotions and	Use integrated formulations that link sensory processing, interoception, trauma history, minority stress and executive function instead of treating them as separate. Support sensory

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	and emotional state. Overload or shutdown impairs planning, memory and inhibition.	bodily states, which in turn disrupts executive functioning. Affirmation and safer environments support overall cognitive capacity.	regulation and gender affirmation as valid ways to improve executive functioning alongside tools like planners and reminders. Encourage communication between gender clinics, mental health services and occupational or educational supports so that changes in one domain (for example starting hormones, reducing harassment) are recognised as affecting concentration, memory and planning in others.

Communication and Socialising

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Direct communication	Preference for honest, precise, often literal communication, with less emphasis on small talk or indirect phrasing.	Can clash with gendered expectations of politeness, deference or vagueness. Autistic trans people report that their gender is sometimes questioned because their communication style is different or very direct.	Apply the double empathy framework by treating misunderstandings as mutual and adjusting clinician communication rather than expecting only the neurodivergent person to adapt. Use clear, explicit invitations to state name, pronouns and goals, and reassure people that directness about gender, needs and boundaries is welcome and will not be punished. Offer options to share gender history or boundaries in writing, by email or through pre session forms if speaking directly feels risky.
Literal interpretation	Difficulty inferring implied or figurative meaning; reliance on explicit statements to understand others' intentions.	Subtle microaggressions or ambiguous misgendering may be harder to recognise, while equally subtle affirmation may not register. Clear,	Use unambiguous language when affirming or discussing gender. State policies about names, pronouns and documentation plainly rather than implying them. When misgendering or other harm occurs, name it directly, apologise

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		explicit affirmation is more reliable than hints or symbolic gestures.	and explain what will be done differently, instead of relying on indirect “signals” of repair. Check understanding in both directions with plain language questions, in line with communication guidance for autistic adults.
Nonverbal cue use and interpretation	Differences in reading facial expression, gesture and eye contact, and in how these are expressed. Many autistic adults prefer explicit verbal or written communication over nonverbal cues.	Gendered assumptions based on nonverbal presentation (for example facial hair, gesture, eye contact, pitch, clothing) can lead to misgendering or to gender identity being doubted in assessments. Autistic presentation may be wrongly pathologised as inconsistent with being trans.	Train clinicians not to use eye contact, facial expressiveness or “typical” social reciprocity as proxies for authenticity, capacity or readiness for gender affirming care. Invite people to say how they would like their nonverbal communication to be understood, and treat stimming, reduced eye contact and flat affect as neutral differences. Ensure access to gender markers, names and gender affirming care is not contingent on staff perceptions of nonverbal “congruence” with stereotypes.
Monotropic interests	Deep, sustained focus on particular interests, with difficulty dividing attention across many topics. These interests can be central to identity and wellbeing.	Gender identity, trans history, queer theory or advocacy may become a focused interest, especially during early discovery or transition. This is sometimes misread as “just a special interest” rather than genuine identity.	Draw on monotropism literature by respecting deep interests as valuable rather than pathologising them. Invite discussion of gender related interests and use these as a basis for education, advocacy and community connection. Avoid treating intense focus on gender as evidence against identity; recognise that deep engagement is a common way autistic people explore self. Where the person wants more balance, support them to build in rest and other sources of meaning without invalidating the importance of gender related interests.
Delayed processing	Longer time needed to process spoken language and formulate responses; pauses in conversation that can be misread as disinterest.	In gendered social or clinical contexts, delayed responses may be misinterpreted as uncertainty about gender or lack of engagement. Processing misgendering or	Slow the pace of interaction in appointments, ask one question at a time and allow extra time for responses without rushing to fill silences. Normalise that people may need to think before speaking. Offer written or asynchronous follow up for questions and decisions that emerge after the session,

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		discrimination, and working out how to respond, may also take extra time.	including around consent for gender affirming care. When someone raises distress about misgendering or discrimination after a delay, treat it as valid rather than “out of the blue”.
Social scripts	Reliance on learned scripts for conversation and difficulty improvising in unfamiliar situations. Scripts are often used to manage anxiety and predictability.	Gendered social scripts (for example “ladylike” behaviour or stereotyped masculinity) often do not fit autistic communication or movement patterns. Autistic trans people report that not performing stereotypical gender roles has been used to question or delay access to care.	Do not require adherence to gendered social scripts as a condition for being recognised as trans or accessing gender affirming care. Co create simple, practical scripts for situations such as correcting pronouns, coming out at work or asking for accommodations, using language that fits the person’s communication style. Provide education to families, schools and workplaces about neurodivergent communication so that the pressure to follow narrow scripts is reduced.
Masking and camouflaging	Consciously or unconsciously hiding autistic traits, stims and communication styles to appear more “typical”, often at significant emotional and physical cost.	Many autistic trans people also mask their gender in unsafe settings. This “double masking” to hide both neurodivergence and gender diversity is linked to exhaustion, burnout, identity confusion and delayed help seeking.	Validate masking as a survival strategy in unsafe environments while also helping people map where it is genuinely necessary and where it might be reduced. Make services explicitly welcoming of autistic communication and diverse gender expression so that, wherever safety allows, masking is not required. In therapy, explore the impact of masking on mood, identity and relationships and support the person to build contexts where greater authenticity is possible.
Small talk aversion	Preference for focused, meaningful topics and difficulty or discomfort with superficial small talk, which can be effortful, confusing or boring.	Important gender topics may be avoided in small talk, so services that rely on informal chit chat may miss distress or support needs. People may be misread as unfriendly or disengaged when they are conserving energy for meaningful conversation.	Begin sessions with clear, collaborative agenda setting rather than prolonged small talk. Ask directly what the person most wants to talk about today, including whether they wish to discuss gender, sensory needs, health or something else. Use brief check in tools, such as short written prompts or visual scales, so people can signal priorities without navigating small talk scripts. Educate staff that limited small talk is not

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			rudeness and that engagement may look different from neurotypical norms.
Sensory affected interaction	Ability to communicate varies with sensory environment; noise, lighting, crowds and smells can significantly impair processing, speech and regulation.	Gendered spaces such as toilets, changerooms and waiting rooms often combine sensory overload with fear of gender based harassment or misgendering, making it harder to communicate clearly, advocate for needs or consent to care.	Adapt environments for key conversations about gender and treatment. Wherever possible, hold assessments and consent discussions in quieter rooms with manageable lighting and few interruptions, and allow sensory tools such as headphones or fidgets. Provide alternatives to crowded, gendered group spaces and ensure access to all gender or single stall toilets so that communication and decision making are not taking place while the person is in a state of heightened threat and sensory distress.
Prosody and perception of voice	Atypical voice patterns such as monotone speech, unusual intonation, pitch or volume are common in autistic people and often misjudged by others. Prosody does not reliably indicate internal emotion or conviction.	Prosody differences interact with vocal dysphoria, hormone related voice changes and gendered expectations of how men, women or non binary people “should” sound. Clinicians may wrongly read flat tone or limited affect as lack of certainty about gender identity.	In gender affirming voice and communication work, combine established speech pathology approaches with neurodiversity affirming practice. Co create goals that focus on comfort, safety and authentic self expression rather than erasing autistic prosody, and respect sensory limits around vocal effort and feedback. Make it clear that voice training is optional and support alternative gender expression (for example clothing, hair, gesture) when voice work is not desired or is distressing. Educate clinicians that atypical prosody is a communication difference, not evidence for or against a person’s gender identity.

Thinking and Learning

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Monotropism	Strong, sustained focus on a small number of interests or tasks. Difficulty dividing attention across multiple competing demands, especially when tasks feel low in personal meaning.	Gender identity, gender history, transition pathways or trans advocacy may become central focuses during exploration or change. This deep engagement can be protective and organising when supported, but may feel isolating if others pathologise it or if there is little affirming community.	Follow monotropism informed guidance by designing environments and care plans that respect deep focus and minimise forced multitasking. Where possible, schedule fewer, longer appointments that allow immersion in the person's main concerns, including gender. Use intense focus on gender, research or advocacy as a strength for self education and community connection, while also helping the person notice signs of exhaustion and set boundaries to prevent burnout. Explicitly validate deep focus on gender as a common, natural way for autistic and ADHD people to process identity rather than as obsession.
Cognitive inertia	Difficulty shifting attention or thought patterns once engaged, including getting started, changing course or stopping. Tendency to stay with the current track even when change is desired.	Gender related stress, trauma and anticipatory anxiety can strengthen inertia. People may feel stuck in painful situations, such as using an old name, or paralysed when contemplating major transitions. Transition fatigue, repeated assessments and systemic barriers can further reduce flexibility.	Support graded change that respects inertia by breaking transitions into small, concrete, predictable steps. Where safe, prioritise low risk social changes first and allow time to consolidate between changes rather than expecting constant forward motion. In therapy, allow repeated discussion of the same themes, recognising that returning to familiar material can be an important part of processing rather than resistance. Build planned pause points and consolidation periods into transition processes so that people can rest and assess how changes feel.
Nonlinear thinking	Associative, intuitive and non sequential thought processes. Ideas may connect through metaphor, image or pattern	Nonlinear thinking can support creative exploration of gender, fluid identities and multiple possibilities. It can clash with rigid, binary or gatekeeping	Use flexible, narrative and creative methods in assessment and therapy. Invite stories, metaphors, branching timelines, diagrams and drawings to describe gender experience. Make explicit that there is no single correct narrative or linear

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	rather than strict stepwise logic.	frameworks that expect a single, simple gender story.	pathway to a valid gender identity and that complexity, change and apparent contradictions are common. Advocate for service policies that do not require simplified, binary stories of gender or fixed timelines to access care, as these disadvantage people whose natural thinking is nonlinear.
Pattern recognition	Strong drive to detect patterns, rules and systems and understand how things fit together.	This can help people recognise how gender norms operate, notice who feels safe or unsafe and critique binary expectations. It can also lead to rigid internal rules about what a “real” trans person is or how they must present, which may increase distress.	Invite people to use their pattern recognition skills to map gendered systems and identify safer contexts, supportive people and predictable processes in services. When patterns become rigid self rules (for example narrow ideas of masculinity, femininity or non binary expression), use collaborative, gentle questioning to explore exceptions and alternatives while respecting the value of structure. Encourage engagement with diverse trans narratives, including neurodivergent and culturally diverse stories, so that the internal pattern library for gender is broader and less tied to stereotypes.
Detail focused processing	Preference for details, specific features and concrete information over broad generalisations. Strong memory for specific examples, procedures or rules.	Detail focus can support nuanced understanding of gendered embodiment, clothes, pronouns and social dynamics, but can make it harder to generalise from one situation to another. Small discrepancies, such as body features or social reactions, may carry significant weight.	Provide clear, concrete information about gender affirming interventions, including step by step descriptions, timelines, risks and benefits, in written form that can be revisited. When teaching advocacy, safety planning or communication skills, use specific examples and role plays, then explicitly support generalisation to new settings by practising with varied scenarios. Emphasise that differences within trans communities are normal, and that no single detail (such as body hair or voice) determines whether someone is “really” trans.

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Visual or spatial thinking	Tendency to think in images, maps or spatial arrangements. Visual information may be easier to process than spoken information alone.	Visual thinking may shape gender expression through aesthetics, fashion, body art and environment. Visual dysphoria or euphoria around mirrors, photographs or specific body parts may be especially strong.	Use visual tools such as body outlines, collages, moodboards, diagrams and timelines to explore gender, dysphoria and euphoria in ways that fit visual thinking. Support people to design visual environments, clothing and accessories that feel congruent with their sense of self, drawing on occupational therapy and environmental design principles. When visual dysphoria is intense, collaborate on paced approaches to mirrors and photographs, use affirming imagery and clothing and ensure that work with images is consent based and focused on safety.
Verbal reasoning and narrative	Strengths in language, storytelling and external processing through speech or writing. Some neurodivergent people describe thinking mainly in words.	Language can be a powerful tool for articulating gender and advocating in systems. Limited or invalidating vocabulary, or categories that do not fit, can create distress and a sense of erasure.	Encourage use of writing, narrative, poetry or dialogue as ways to explore and communicate gender. Integrate approaches from narrative and queer therapy that centre the person's own words and meanings. Provide and model affirming language and terminology, including culturally specific and community generated terms where appropriate, so that people have rich vocabulary for their experiences. Advocate within services for accurate use of the person's language for their identity in records, conversations and forms, rather than forcing them into limited categories.
Information seeking	Intense drive to understand topics of interest in depth, including reviewing large amounts of information and comparing sources.	Many autistic and ADHD trans people extensively research trans history, community knowledge, gender theory and medical pathways. This can strengthen self advocacy and resilience but can also expose them to hostile or pathologising materials.	Provide detailed, evidence based and community informed resources about gender, neurodivergence and health, recognising that many people will read beyond introductory materials. Support critical appraisal of sources, including recognising trans hostile or pseudo scientific content, as part of harm reduction. Help people translate their knowledge into concrete actions if they wish, such as preparing written

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			questions for appointments, planning advocacy strategies or sharing accessible resources with peers.
Contextual motivation	Motivation and engagement increase when tasks are clearly meaningful and aligned with personal interests and values. Tasks that feel arbitrary or imposed are much harder to initiate or sustain.	Learning about gender diversity, participating in community or doing advocacy can strongly enhance motivation and resilience. Environments that demand compliance without meaning, or that deny the importance of gender, tend to reduce engagement and increase burnout.	Design interventions and supports that explicitly link tasks to the person’s own values and goals rather than relying mainly on external reward or compliance. In education, therapy and services, incorporate gender related interests, community work or creative projects when desired, as this can improve persistence and wellbeing. Minimise unnecessary busywork and duplicated processes (for example repeated basic psychoeducation) and respect existing knowledge and lived experience.
Processing speed	Thinking and responding may be fast, slow or variable. Speed changes with fatigue, anxiety, sensory load and task type.	Gender related stress, dysphoria, anxiety or trauma can slow processing, while relief and affirmation can improve clarity and efficiency. Some people report changes in concentration and mental energy when starting or changing hormone regimens, though research findings are mixed and individual.	Allow flexible pacing in appointments and educational settings. Offer extra time, repetition and breaks when processing is slower and avoid pathologising periods of rapid thinking that may reflect high arousal. Recognise that minority stress and dysphoria reduce processing capacity, so improvements after social and medical affirmation should be understood as meaningful outcomes of care. When discussing possible cognitive effects of hormones, provide balanced, evidence based information and invite ongoing feedback, adjusting demands and supports to the person’s actual experience.
Written versus spoken preference	Many neurodivergent people find written communication easier for precision, processing time and emotion regulation. Spoken interaction	Writing may feel safer than speech for discussing gender identity, dysphoria, trauma and discrimination, especially when there is fear of being interrupted, disbelieved or judged.	Offer written options by default for intake, feedback, questions and some therapy tasks. Where secure and appropriate, use email or messaging for preparation and follow up. In sessions, invite people to bring pre written notes about their gender, questions or recent experiences and make

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	can be more tiring and harder to organise in real time.		time to read and respond. For difficult conversations, collaboratively plan whether to begin in writing, face to face or a combination, and respect the person's preference. Summarise key points in writing at the end of sessions so the person has a record.
Sensory and cognitive links	Sensory experiences strongly shape concentration, memory, problem solving and self talk. Overload and shutdown impair mental flexibility and learning.	Gendered sensory experiences such as voice, clothing, hair, binders, tucking garments and bathrooms influence how people think about themselves, how safe they feel and how much cognitive capacity they have for learning or therapy.	Use formulations that explicitly integrate sensory processing and cognition when planning supports. Acknowledge that sensory aspects of gender expression and environment have major effects on learning and thinking, particularly in schools, workplaces and clinics. Offer educational and therapeutic environments that match sensory profiles, for example quiet rooms, predictable lighting and minimal smell for complex discussions. Support people to intentionally seek out sensory experiences that feel congruent with their gender and thinking style as part of identity consolidation and regulation.
Executive overlaps	Thinking and learning are strongly affected by executive function (for example planning, working memory, sustained attention). High cognitive load in one area reduces capacity in others.	Transition related demands such as appointments, forms, advocacy, family negotiations and managing discrimination add substantial executive load and can reduce capacity for study, work or therapy.	When transition related demands are high, adjust other expectations where possible rather than assuming performance will stay the same. Coordinate between educational, mental health and gender services so that supports for learning explicitly factor in current transition tasks and appointments. Use executive function supports such as planners, reminders and task breakdown in ways adapted for autism, ADHD and eating disorder contexts, and that respect neurodiversity. Emphasise flexibility and self compassion rather than pushing for conformity to normative productivity standards.
Emotion and cognition links	Mood, anxiety and trauma history significantly affect	Dysphoria, transphobia, family rejection and structural discrimination all impair	Use trauma informed and minority stress informed formulations that explicitly link mood, discrimination and

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	<p>attention, memory, decision making and learning confidence.</p>	<p>cognitive functioning and increase risk of depression and anxiety. Studies of gender affirming care show that affirmation is associated with better mental health and functioning.</p>	<p>cognitive symptoms, so that attention and memory difficulties are not mislabelled as lack of effort or interest. Treat access to gender affirming care and social affirmation as central components of cognitive support, not as extras. Where possible, support anti stigma and policy change work and advocate for safer environments in schools, workplaces and services, recognising that reducing discrimination is a population level intervention that improves cognitive and educational outcomes for trans neurodivergent people.</p>