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Affirming EMDR at the Intersection of Gender Identity and Neurodiversity

By Cathy Hanville

Neurodivergent (ND) individuals face many challenges with traditional

therapeutic approaches, and that translates into challenges with EMDR therapy. Research shows that neurodivergent clients respond best to ND-affirming therapy (Kroll et al., 2024; Camm- Crosbie et al., 2024; Chapman & Botha, 2024; Jones & Kargas., 2023). This research shows that therapeutic interventions using a neurotypical framework are, at best, ineffective for clients and, at worst, create additional trauma. SaraRose Hogan, LCSW, defined ND-affirming care as provided through a "client-centered, neurodiverse-affirming lens that does not impose subjective ideas on individuals. It does not approach neurodivergent diagnosis or traits as problems to be solved, but instead, it embraces the diversity of minds and thrives on collaboration" (Hogan, 2023). All clinical work, including EMDR, needs adaptations to work effectively with our ND clients.

This article explores how therapists can adapt EMDR for clients who are both neurodivergent—such as individuals with autism, ADHD, or other neurological differences—and identify as transgender-gender diverse (TGD), along with highlighting the importance of providing affirming therapy that addresses clients' experiences at the intersection of neurodiversity and gender-diversity.

The author focuses on using the standard EMDR protocol with specific adaptations for ND and transgender gender-diverse clients rather than developing a new protocol. The standard protocol is effective, and since our ND and TGD clients present in many ways, we cannot develop a protocol that will fit all of their needs.

Many therapists received no training in assessing for neurodivergence in their therapy programs. Additionally, they absorbed media and other cultural messages that may have shown them ND people in a way that oversimplifies or demeans neurodivergence. For example, many learned that Autistic people do not make eye contact or that they often have physical tics such as arm flapping. Those behaviors are not something all Autistic people exhibit. However, if that is what therapists expect to see an Autistic person do, then when they come into contact with an Autistic person who does not have these behaviors; they might not believe they are Autistic. Therapists denying clients identities traumatize them by creating

Autistic. Therapists denying clients identities traumatize them by creating an experience that invalidates their being and understanding of the world (McVey et al., 2023).

One result of this lack of training and understanding is an underdiagnosis of neurodivergence. Women, in particular, are undiagnosed or misdiagnosed. Research estimates that as many as 80 percent of Autistic females are not diagnosed by age 18 (McCrossin, 2022). ADHD is also underdiagnosed in females. Doctors diagnose boys three times more often in childhood than girls, but by adulthood, they distribute diagnoses evenly between genders (da Silva et al., 2020). This change in prevalence indicates that many girls are not getting diagnosed as children but instead receive their diagnoses as adults. One reason is that young girls tend to have more inattentive symptoms than hyperactivity (Quinn & Madhoo, 2014). This results in girls receiving diagnoses of depression and anxiety rather than ADHD. Society also socializes girls to behave in specific ways, encouraging them to hide their symptoms (Quinn & Madhoo, 2014).

Without a diagnosis, people struggle into adulthood, navigating a neurotypical society and not understanding why they are not able to meet neurotypical expectations. Research shows that the effects of a misdiagnosis or lack of diagnosis are substantial (Attoe & Climie, 2023). Self-esteem, the ability to form relationships, emotional regulation, and depression rates were all adversely affected (Attoe & Climie, 2023). While this author does not support diagnoses that pathologize ND people, it is imperative to understand how clients' brains interpret information to work effectively with them.

While the author found no research on how each type of neurodivergence intersects with gender identity, there is research showing that transgender and gender-diverse people are between 3.03-6.36 times more likely to be autistic than cisgender (non-transgender) people (Warrier et al., 2020). For therapists to provide neurodivergentaffirming EMDR care, therapists also need to provide gender-affirming care.

To provide affirming care, we need first to understand its language. For this

article, the author uses the term transgender-gender-diverse (TGD). Recent research states that it is the most preferred term for people with lived experience (Zwicki et al., 2024). Those who identify within that definition use many other terms, such as gender non-conforming, genderqueer, gender fluid, gender spicy, and nonbinary. Therapists should always honor the client's language, but this article will use TGD (Chang, 2017).

Dr. Nick Walker, a queer Autistic scholar, defines neurodivergent as people whose cognitive functioning deviates significantly from the dominant societal standards of "normal" (Walker, 2021, p. 38). Walker defines neurotypical (NT) as having neurocognitive functioning that aligns with societal norms and defines neurodiversity as "the diversity of human minds." Walker emphasizes that it encompasses the brain and the nervous system (Walker, 2021, p. 34). It is essential to distinguish between neurodiversity as a concept relating to an entire community and neurodivergence, which refers to individuals.

Dr. Walker also believes the existing dominant paradigm defining neurodiversity is one of pathology (Walker, 2021, p. 16). A pathology paradigm asserts there is only one correct or usual way of being. If someone does not function that way, they are not considered 'normal.' Walker proposes shifting to a neurodiversity paradigm, which asserts that diversity in minds is healthy and valuable and does not need treatment. She also discusses the neurodiversity movement, which seeks 'civil rights, equality, respect, and full societal inclusion for the neurodivergent' (Walker, 2021, p.33).

An essential aspect of a neurodiversity paradigm is using identity-first language. First-person language sends a message that there is a problem with the person and is part of the pathology paradigm we are trying to move away from (Botha & Williams, 2023). Identity-first language uses Autistic people instead of people with autism. Person-first language sends a message that there is a problem and is part of the pathology paradigm we are trying to move away from (Botha & Williams, 2023).

The research on outcomes for EMDR with ND clients shows it can be highly

effective (Barol & Seubert, 2010; Guidetti et al., 2023; Kosatka & Ona, 2014; Leuning et al., 2023). There are some issues that EMDR for ND clients may successfully address. Many ND clients have had experiences of chronic invalidation and internalized ableism. Dr. Megan Neff, an Autistic-ADHD psychologist, defines internalized ableism as "our beliefs and prejudices that come from living in an ableist society. These beliefs often form our expectations about ourselves. For example, 'I should be able to work a 40-hour work week' or 'I shouldn't need accommodations.'" (Neff, 2024). Using EMDR to address this can increase self-acceptance and acceptance of ND challenges so that they can feel empowered to ask for the things that they need rather than telling themselves there is something wrong with them and making them inclined to hide their neurodivergence.

If an ND client experiences anxiety or sensory overload, EMDR may be able to help reduce that. If clients have any self-directed goals for emotional regulation, therapists can use EMDR to minimize stress in triggering situations as opposed to having to mask their neurodivergence.

The author did not find any research specific to EMDR and TGD clients. However, Dr. Sand Chang wrote a chapter titled "EMDR therapy as affirmative care for transgender and gender non-conforming clients" (Chang, 2017). Dr. Chang discussed three categories in which EMDR can support gender-diverse clients.

- Gender-related concerns include coming out, gender dysphoria, or using therapy to access gender-affirming care.
- Addressing societal reactions such as anti-trans biases or abuse.
- Trauma for something unrelated to gender identity.

With the understanding of what our TGD and ND clients might seek treatment for, we will examine areas of overlap between the two groups, which can guide our affirming EMDR care.

The first overlap is masking. Dr. Neff defines Autistic masking as an adaptive phenomenon in which people develop intricate strategies to

navigate an allistic (non-autistic) society, seamlessly blending in like chameleons in their surroundings (Neff, 2024b). Masking can involve forcing oneself to make eye contact, repressing stimming behaviors, or memorizing specific responses and using them in situations (MacInnis, 2024).

TGD people often wear similar protective masks to hide their gender identity and stay safe. Although people have not applied the term 'masking' to the LGBTQ+ community, they have used the term 'coming out of the closet.' 'Coming out' refers to someone becoming open about their gender or sexual identity (Human Rights Campaign Foundation, 2022), while people describe someone who is not open as 'in the closet'" (Ariane Resnick, 2021).

The effects of masking can be profound. Imagine moving through a world where one must always be hypervigilant to those around them, constantly adapting to others' expectations and needs rather than acting comfortably or as their true self. It is exhausting. The trauma of masking can cause substance use to cope, perfectionism, dissociation, and burnout (MacInnis, 2024).

Our ND and gender-diverse clients also experience a high level of identity trauma. Early reporting from the 2022 *U.S. Transgender Survey* indicates that three percent of the respondents experienced physical harm in the last 12 months, 30 percent reported verbal harassment, and 10 percent reported denial of equal treatment (James et al., 2024). Statistics are less available with ND people, but we know neurodivergent people have often experienced cumulative trauma, beginning in childhood from societal correction and invalidation. For instance, a child with ADHD may receive thousands of corrective comments by age ten (Jellinek, 2018).

Sadly, both the medical and therapy fields have had a history of traumatizing these groups (James et al., 2024; Doherty et al., 2022). As a result, clients often come to us with a strong sense of mistrust. When a provider in a position of power misgenders a person or tells them that they are not who they know they are, it is demeaning to the person and can

trigger a shame spiral or other negative consequences.

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One way clients may have been traumatized by the medical field is having an experience of being entered into therapies that coerced them into behaving in ways inauthentic to who they are. Neurodivergent individuals may have received Applied Behavioral Analysis (ABA), a treatment that aims to train children to exhibit neurotypical behaviors, such as making eye contact when speaking with someone. The Autistic community increasingly views ABA as abusive, and currently, there is discussion within the medical community about the need for more compassionate, evidence-based care (Gibson & Douglas, 2018; Enright, 2023; Hanville et al., 2023). ABA currently remains a widely endorsed treatment for Autistic minors.

TGD clients may have engaged in conversion therapy, also known as reparative therapy or gender identity change efforts (GICE). GICE has an

explicit goal of changing someone's gender identity to match the gender assigned at birth. Interestingly, Ole Ivar Lovaas both created ABA and practiced conversion therapy on gay people (Gibson & Douglas, 2018; Hanville et al., 2023).

Mental health organizations have discredited conversion therapy. In early 2024, The American Psychological Association made a strong statement on using Affirming Evidence-Based Inclusive Care. The APA advocates for noncoercive, evidence-based clinical care that is adaptive to and centered on the needs of the individual receiving care and rooted in psychological and clinical science, including recognition of gender diversity as a part of normal human diversity (APA, 2024, p 2). The American Association for Marriage and Family Therapy (AAMFT) recently issued a statement that GICE was "harmful, unethical, and in direct violation of the AAMFT Code of Ethics" (American Association For Marriage Family Therapy, 2024).

EMDR International Association (EMDRIA) has a position on conversion therapy for sexual orientation change efforts (SOCE). EMDRIA prohibits using SOCE by its members, EMDR Certified Therapists,™ EMDR Consultants,™ Credit Providers, and EMDR Trainers™ (EMDRIA, 2024). Despite the opposition of these professional organizations, many therapists have treated clients with therapies that attempted to change their gender identity, causing significant trauma.

The research on the intersection of neurodivergence and gender dysphoria has a focus on Autistic individuals. Autistic TGD clients may experience gender dysphoria differently (Cooper et al., 2022). They may have heightened sensitivity to discomfort or distress in how they experience their bodies or are accepted in the world (Cooper et al., 2022). These sensitivities can intensify the experience of dysphoria, making it more challenging for them to navigate (Cooper et al., 2022). Cooper used an example of a participant who wanted to wear a binder to address their gender dysphoria but was not able to because of their sensory sensitivities (Cooper et al., 2022).

The research on younger Autistic people showed that rigid thinking

patterns were challenged by the lack of clear and timely transition plans and the obstacles they faced (Cooper et al., 2023). Puberty was tough for these youths as their bodies changed without an explanation or in the manner in which they understood or desired (Cooper et al., 2023).

Once an Autistic person comes to accept that they are TGD, they must navigate a healthcare system that may tell them things such as:

- it is a phase that they will grow out of, and that will cause them to regret any transition.
- it is a response to trauma
- they are attention-seeking
- they are confusing a specia interest with their identity.

The recent anti-transgender backlash has influenced the healthcare system in the United States; some states, such as Missouri, explicitly cite autism as a reason for restricting genderrelated care (Huckins, 2023). These laws remove autonomy from Autistic people to make decisions about their health and well-being and cause them more trauma. With an understanding of the issues that ND and TGD clients face, the author will move to recommendations for gender-diverse neurodiversity-affirming EMDR work.

To start we will begin with suggestions for developing an affirming framework.

1. **Acknowledge the harm experienced by neurodivergent and gender-diverse clients:** Therapists must confront their internal biases and strive for cultural competency. Clients cannot engage safely in trauma work if they feel the need to correct or educate their therapists about neurodivergence or gender identity. If there is a lack of understanding, it may undermine the therapeutic relationship and impede healing (Hanville, 2024).
2. **Adopt an affirming framework for gender diversity and**

neurodiversity: Clinicians can integrate Dr. Walker's diversity paradigm and view neurodiversity through a strengths-based lens, recognizing the value of cognitive differences instead of pathologizing (Walker, 2021). Similarly, therapists need to approach gender identity with this affirming perspective.

3. **Move beyond the absence of prejudice:** Affirming care requires more than a lack of prejudice. It requires addressing internal bias and reaching cultural competency (Hanville, 2024). Reaching this competency requires training that is, at minimum, informed by people of lived experience and better if provided by those with lived experience (Hanville, 2024). This competency requires therapists to challenge any biases about either group.

Let's look at specific recommendations for affirming EMDR therapy through each phase.

Phase 1

HISTORY TAKING

Begin phase one by incorporating questions about neurodivergence and gender identity into the intake process. Many clients have self-identified as neurodivergent, and it is essential to respect and affirm self-diagnoses, given the systemic barriers to formal diagnosis, including financial and emotional costs (Lewis, 2017). Misdiagnosis and experiences of ableism can further complicate clients' therapeutic experiences, and clinicians must remain vigilant not to create those dynamics. Therapists can also incorporate questions that might reveal symptoms that could indicate ND, such as high anxiety, rigid thinking, impulsive behavior, executive functioning struggles, and a pervasive feeling of not belonging (Strang et al., 2023).

For TGD clients, respect self-identification and use the name and pronouns the client requests (Chang, 2017). If a legal name needs to be on billing paperwork, indicate the reason, so clients understand why the therapist requests it. It is crucial that intake forms normalize diverse experiences

rather than introduce additional obstacles or microaggressions. The intake process is the time to provide a safe and secure sensory environment (Jones, 2024). Neurodivergent individuals may experience heightened sensory sensitivities and have different communication preferences (Jones, 2024). Ask all clients about their sensory needs to ensure none get overlooked. Specifically, inquire about temperature, lighting, olfactory needs, executive functioning issues, and auditory needs. Research has shown that clients value therapists asking them about any accommodations they need at the beginning of treatment rather than the client having to bring it up (Jones, 2024). Ask these questions within a framework of clients' needs rather than as a need for accommodations. Doing this normalizes the process and can make clients feel seen. As therapists learn about clients' sensory needs, they will understand which bilateral stimulation method (BLS) might work best for them.

During intake, it is essential to establish clear and explicit communication and ensure that clients understand the expectations. Many ND clients reported that open-ended questions were hard to understand (Jones, 2024). They also wanted ease in initial contact as many have challenges with phone calls (Jones, 2024).

While taking the history, take the time to learn about the client's strengths and interests. The therapist can use this information for future adaptations or resourcing. It can also help determine what method of BLS will work best for the client. Therapists should affirm clients' lived experiences as many will have past encounters of invalidation and disbelief. A way to do this is with appropriate self-disclosure, which is another way to affirm clients' experiences. Research on non-binary clients' experience of therapy showed that they felt it essential to know their therapist's gender identity and sexual orientation (Rosati et al., 2022). This disclosure can build attunement, confidence, and safety with clients, especially if the clinician has lived experiences or identities like the client.

Phase 2

PREPARATION-RESOURCING

Understanding the sensory profiles of neurodivergent (ND) clients is helpful to therapists' ability to tailor the EMDR process to meet the client's needs. Research indicates that many neurodivergent individuals experience *aphantasia*—the inability to visualize (Dutta, 2022). Many are unaware they have aphantasia until something makes them aware that others can visualize. Many people with aphantasia have developed strategies to compensate. Assessing whether a client can visualize is essential in the preparation stage of EMDR. If visualization proves challenging, exploring how clients have previously navigated this experience is invaluable for creating adaptations to support the client. Adaptations might include using tangible objects, such as holding a calming fidget or another sensory item, to establish a resource connection.

Using concrete visuals, such as a photo or drawing, can also be a way to connect with memories or resources. These adaptations honor the client's sensory preferences and foster a more inclusive and effective therapeutic process.

When resourcing with TGD clients, be mindful of language when creating visualization resources, ensuring they are free from hetero- or cis-normative terms. TGD clients may want to avoid visualizing or resourcing their younger selves, who looked differently. Dr. Chang recommends never using this technique without thoroughly conversing about these issues with the client. Dr. Chang articulates the confusion that may arise when transgender people visualize themselves as children. Do they visualize what they appear like or themselves as they wish they were (Chang, 2017)?

Autistic clients may also have a higher rate of alexithymia (Kinnaird et al., 2017). In broad terms, this term refers to people having difficulty identifying and describing emotions (Neff, 2022). One of the questions asked in the standard EMDR script is: What emotion goes with that (Shapiro, 2001)? ND clients may not have an answer to that question. Assessing that ability beforehand allows the therapist to avoid frustration during the processing. Adaptations can include asking clients if they associate a color with their experience or finding another way to get at how

the client relates to the memory, such as through art or music. Go with whatever they bring to the session. The therapist and client can use the strengths established during the history-taking phase at this point.

If therapists ask them to do things that do not work for their brains, it can trigger shame. Shame is also often prevalent in the TGD client group due to hearing that their identity is wrong. This shame is a potential target for processing for both groups.

In the author's clinical experience, both ND and gender-diverse clients may have parts that learned to dissociate to protect them. Forced presence through grounding or other meditation may cause distress. In addition, both groups may have experienced traumas related to a lack of bodily autonomy. Younger TGD clients may have had a traumatic experience going through puberty. If providers used ABA with ND clients, they may have repeatedly told them to use their bodies in ways that felt uncomfortable to them. Therapists must seek consent for each

uncomfortable to them. Therapists must seek consent for each intervention and regularly check in to ensure the client is comfortable with the interactions.

Phase 3

ASSESSMENT

When completing the assessment phase, therapists should focus on the issue for which the clients sought therapy, which may not relate to their gender identity or neurodivergence (Hanville, 2024). At the same time, therapists need to be mindful of the level of trauma that these clients will have faced just within and because of their identities.

As the target plan develops, it should be sensitive to not shaming clients who may already be worried about doing something wrong (van Diest et al., 2022). Many of our clients will have the belief that they are not good enough as a result of a lifetime of microaggressions and directly abusive behaviors that they have experienced. If therapists ask them to do things that do not work for their brains, it can trigger shame. Shame is also often prevalent in the TGD client group due to hearing that their identity is wrong. This shame is a potential target for processing for both groups.

Assess whether the client has experienced adverse or stigmatizing reactions from neurotypical individuals related to their behavioral expressions, such as stimming or verbal processing, along with any adverse feedback they may have received about their gender identity, presentation, or choice of pronouns. Additional targets may relate to executive functioning. Clients who struggle to complete tasks and have received negative feedback or been labeled lazy have targets related to those experiences.

Autistic burnout, which Dr. Neff defines as “a state of physical, emotional, and mental exhaustion, can also be a target. Burnout gets triggered by various things, like stress, sensory overload, social isolation, or difficulty navigating social or educational systems” (Neff para 4, 2024). It often happens in multiple incidents, so utilizing a float-back can identify different

traumas around masking (MacInnis, 2022).

Phase 4

DESENSITIZATION

Many ND people have sensory sensitivities, and the eye movement aspect of EMDR may be overwhelming for some. Therapists need to adapt BLS to be sensory-friendly. During the History Taking and Treatment Planning stage, the therapist and client should have already discussed the client's preferred method of BLS. Therapists might try a few different types of BLS with the client to determine what feels right. Some things that the author has used for BLS include music, movement, and fidgets. Therapists can use other adaptations during BLS, such as allowing clients to talk through the entire process if that helps their processing.

Phase 5

INSTALLATION AND PHASE 6 BODY SCAN

Our ND and TGD clients may have past experiences that are also ongoing, such as microaggressions. Installing a positive belief that they are safe will not resonate, may not be factually accurate, and will challenge our concrete-thinking ND clients. If the therapist reframes the language of positive cognition to that of an adaptive belief, it may feel more accessible to a client. For example, the therapist might say, "Let us approach this from a different angle. Instead of focusing on what you 'want' to believe about yourself, how about we explore what might be a helpful way for you to cope with similar situations in the future?" Dr. Chang recommends emphasizing choice and empowerment in the face of their day-to-day challenges (Chang, 2017). Focusing on choice allows clients to shift their minds to developing coping strategies and strengths and creates a space that may feel more accessible and empowering for the client. This approach supports the clients to find a belief that resonates with them and fosters their sense of agency and growth. An example of an adaptive belief is "I can use my strength to navigate challenging times."

This article does not address intersectionality beyond the intersection of ND and gender diversity. People in these communities can have additional intersecting identities, such as race, disability, and socioeconomic challenges. Recognizing these intersections is crucial for providing comprehensive support to ND clients (Hanville et al., 2023).

Continue exploring this topic by getting additional training on the intersection of gender identity and neurodiversity and each topic separately. The best training includes a lived experience component. These communities' voices need to be a part of any discussion on working with them in the therapeutic context.

EMBRACING AN INCLUSIVE AND ADAPTIVE APPROACH

The intersection of gender identity and neurodivergence is essential to therapeutic practice. Therapists should embrace an inclusive and adaptive approach to foster an environment where all clients feel seen and understood. Therapists' ethical codes require that we provide culturally competent care. To ensure that level of care, therapists must challenge their biases and adapt their practices to meet the unique needs of neurodivergent, gender-diverse clients.

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