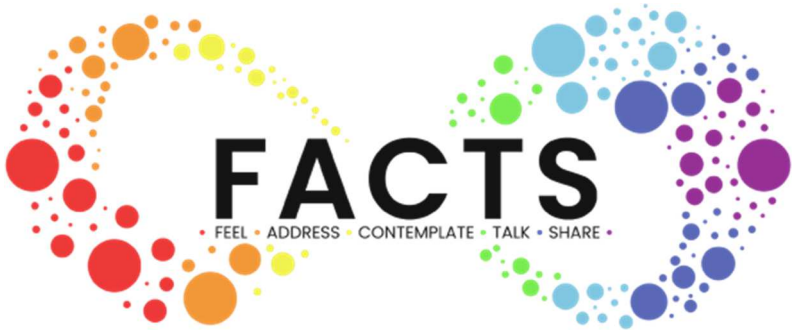


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Feel, Address, Contemplate, Talk & Share

**Work Package 2**

# Literature Review

**Developed by:**

RESEARCH CENTER OF BIOPOLITICS

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# Contents





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# Introduction

## The F.A.C.T.S. Project

This literature review was developed as part of the ERASMUS+ funded project “Feel, Address, Contemplate, Talk, Share (F.A.C.T.S)” (2023-2026).[1] The F.A.C.T.S. project was born from the observation that many autistic individuals express a need to discuss gender and sexuality-related issues. However, professionals often struggle to address these topics due to insufficient knowledge and appropriate training. Research has shown that autistic individuals are more likely to experience diverse sexual orientations and gender identities, and they frequently face challenges such as lower gender self-esteem, gender dysphoria, and increased risks of bullying and harassment.

The F.A.C.T.S. project aims to equip professionals with the tools, knowledge, and skills necessary to support autistic individuals in navigating these issues, fostering a deeper understanding of sexuality, including sexual and gender diversity. By updating practices in vocational education centres, the project seeks to enhance the well-being and quality of life of autistic beneficiaries by addressing sexuality, gender identity, and relationships in a more holistic, informed, and supportive way. The F.A.C.T.S project also emphasises the importance of understanding the influence of parents' and caregivers' beliefs and biases in the development of an autistic person's sexual identity.

The primary expected outcomes of the project include:

a) The development of an innovative training program for professionals working with autistic adults, focusing on enhancing their understanding of sexual orientation, gender identity and gender expression issues among autistic people.
b) The creation of guidelines for professionals, administration, and autistic peer mentors to support and guide autistic people in addressing and

[1] Funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Education and Culture Executive Agency (EACEA). Neither the European Union nor EACEA can be held responsible for them.



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navigating issues related to their sexuality, including sexual and gender identity and expression.

c) The development of an online platform and educational videos accessible to trainees, staff from other organisations, and interested individuals, serving as a knowledge base for ongoing learning and support.

The F.A.C.T.S. project is designed for two key target groups:

- Direct Target Group: Professionals working with autistic individuals, particularly in vocational education centres, mental health services, and care facilities. Professionals will receive training to incorporate gender-informed practices into their daily work with autistic beneficiaries.
- Indirect Target Group: Autistic individuals who will benefit from the enhanced knowledge and support trained professionals provide. These individuals will also play a significant role in the research and development of the training, providing insights into their experiences of gender identity, sexual orientation, and expression.

**Aim & Methods of the Literature review**

The primary aim of the current literature review was to establish a foundation for the educational training program and accompanying guidelines for professionals and administrative staff working with autistic beneficiaries and their families on sexuality-related issues. The review ensures that participants receive scientifically sound and up-to-date knowledge to better support autistic individuals in enjoying healthy sexuality.

The key objectives of the literature review were to:

a) Identify 10 global best practices for professional training.

b) Define the thematic units to be included in the project curriculum, ensuring alignment with the priorities and expectations of stakeholders.

This study employed a state-of-the-art research methodology based on the six-step approach outlined by Barry, Merkebu and Varpio (2022). The authors suggest that through a “chronologically rooted narrative synthesis”, this approach is used to review large bodies of literature, enabling the



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identification of historical trends, current perspectives, and future directions in the field through a “chronologically rooted narrative synthesis” (Barry, Merkebu and Varpio, 2022)

A systematic and collaborative process within the project consortium was key to developing the literature review across many stages (protocol design, data collection, feedback and consolidation). The F.A.C.T.S. project consortium includes service providers for autistic and neurodiverse beneficiaries and advocacy organisations for the rights of autistic people across many European countries (Bulgaria, Finland, France, Greece, Italy and Malta), with valuable theoretical expertise and practical experience in the field, as well as direct access to feedback by autistic self-advocates, families and professionals.

By the end of the process, the finalised deliverable served as a solid foundation for developing the training program and supporting materials for professionals and service providers of autistic beneficiaries, effectively addressing stakeholders’ sexuality-related needs and priorities.

The *Research Center of Biopolitics (RECEBI)* at Panteion University of Social and Political Sciences was responsible for the conduction of this literature review. In close collaboration with the project coordinator (Ploes), RECEBI was responsible for the preparation, coordination, and execution of the leading research activities. The researchers involved are *Anna Daskalaki, Sociologist, MSc Public Health & Health Policy* and *Dimitris Tourlidas, Sociologist, MSc in Philosophy*.



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# 1. Key Concepts in Autism and Sexuality

## 1.1. Understanding Autism

"Autism", as we know it today, is a relatively recent construct, even though individuals who displayed behaviours associated with it have probably existed throughout history. This dynamic concept includes a wide range (or a "spectrum") of individual experiences, each linked to a specific definition of what autism is, what it means for the person experiencing it and its identity, how others address it, and who gets to decide the above (Waltz, 2023).

### 1.1.1. The Medical Model of Disability

One of the most influential definitions of autism to date stems from the medical model of disability. According to this framework, "Autism Spectrum Disorders" (ASD) is a diverse group of neurodevelopmental conditions, causally linked to a variety of factors, including genetic and environmental ones (WHO, 2019; 2023). It is a lifelong disability whose basic symptoms firstly manifest during early childhood and involve some degree of persistent difficulties/deficits in social communication and interaction, as well as restricted or repetitive behaviours, activities or interests (CDC, 2024)[2].

Regarding ASD prevalence, a recent study by Yang et al. (2023) based on data from the 2019 "Global Burden of Disease", concluded that the overall age-standardised incidence rate (ASIR) for ASDs was 9.3 per 100,000 people globally, showing a slow-increasing trend which might indicate a steady increase in diagnosis. Two other systematic reviews and meta-analyses reported a 0.6% (Salari *et al.*, 2022) and 1% (Zeidan *et al.*, 2022) global prevalence of autism in 2021. Inequalities in diagnosis were prevalent both between countries and between female and male autistics, with high-income countries and male populations reporting higher ASD incidence, a fact most

[2] "Deficits" in social communication and interaction include a) social-emotional reciprocity, b) nonverbal communicative behaviours, and c) developing, maintaining and understanding relationships. The group of deficits in restricted, repetitive behaviours consists of a) stereotyped or repetitive motor movements, b) insistence on sameness, inflexible adherence to routines, or ritualised patterns of verbal or non-verbal behaviour, c) highly restricted, fixated interests, and d) hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment. A person must display difficulties in each of three areas of deficits in social communication and interaction, while at least two of four types of restricted, repetitive behaviours (CDC, 2024).



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probably related to the diagnostic procedures (Zeidan *et al.*, 2022; Yang *et al.*, 2023).

Additionally, specific co-occurring mental and neurological conditions are more prevalent in ASD populations than in the general population (Lai *et al.*, 2019). According to the systematic review and meta-analysis of (Micai & colleagues (2023), studies on the issue show substantial heterogeneity, but among the most prevalent conditions are developmental coordination disorder, attention deficit hyperactivity disorder (ADHD), anxiety disorder, intellectual disabilities, disruptive behaviour, somatic symptom and related disorders, sleep-wake disorder, and motor problem.

ASD symptoms manifest and develop in numerous ways in each case. Based on the “severity” of the symptomatology, and mostly the level of intellectual functioning, autistic individuals are often distinguished within a spectrum of “low- to high-functionality”, requiring an equivalent level of support (Kenny *et al.*, 2016). In reality, many autistics get diagnosed much later in life as social demands become increasingly challenging. Additionally, late diagnosis of autism is related to tensions between diagnostic criteria and definitions of what constitutes autistic behaviour (Pearson and Rose, 2021).

The extent to which ASD diagnosis is beneficial varies among individual experiences. Although this is not always the case (Thompson-Hodgetts *et al.*, 2020), ASD diagnosis is the entrance point for tailored services and entitlements, while it can remove the blame and alleviate frustration caused by confusion and uncertainty from undiagnosed autistics and their families (Chiri, Bergey and Mackie, 2022). Early identification of ASD and early intervention services are increasingly being promoted, especially in cases with increased support needs, potentially leading to more positive developmental outcomes and enhancing the quality of life to some extent (Daniolou, Pandis and Znoj, 2022).



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### 1.1.2. The Neurodiversity Paradigm and the Social Models of Disability

Despite the benefits of framing autism under this medical model, scholars and activists since the ’90s have critically addressed some of its negative connotations and several of its implications. The “pathology paradigm”, upon which the medical model is constructed, perpetuates the idea that there is one “normal” or “healthy” mind, while significantly diverging from this phenotype is “internally pathological” and a cause of distress both for the divergent people and their families. While the difficulties individuals face can have varying degrees, scholars argue that this perspective can facilitate stigmatising stereotypes, discrimination, and/or oppression against autistic people while narrowing the variety of their experiences (Chapman, 2020; Chapman & Bovell, 2022).

Under the influence of the social models of disability, the neurodiversity paradigm rejects this idea of the “right” human brain, which idealises “neurotypical” people falling within the dominant/superior societal standards of normality. According to Chapman (2023) these notions of neuro-normativity are influenced by historical material conditions and provide the ideological background to various forms of discrimination, suppression, marginalisation and exclusion against neurodivergent people, including autistics. He proposes that, based on the neurodiversity paradigm, it is best to conceptualise cognitive functioning similarly to biodiversity. Thus, diversity in cognitive functioning, as all forms of human diversity (e.g., sexual and gender), is a natural, integral and valuable element of our biocultural reality, providing alternative ways “of thinking, communicating, and interacting in the world” (Jack, 2012).

Thus, it is more suitable to adopt a positive and affirmative language when addressing autism and autistics (Davidson & Henderson, 2010; Vivanti, 2020). Debates exist on whether person-first language (e.g., “person with autism”) or identity-first language (e.g., “autistic person”) best serves this goal and the meaning of its choice changes under broader social influences. Currently, person-first language tends to mean that autism should be viewed as only a part of the individual identity. In contrast, identity-first language



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places autism at the core of identity, eliminating the distance created by the above interpretation of person-first language. This research uses identity-first language, because of its increasing support and compelling arguments (Dwyer, 2022).

### 1.2. Understanding Sexuality

Like autism, sexuality has been variously understood and conceptualised across historical and cultural contexts, shaped by evolving social, scientific and political discourses (Cocks, 2013). A working definition of the World Health Organization (WHO, 2024a) on sexuality emphasises the importance, multidimensionality and complexity encompassed in this term:

> "…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors."

This definition underscores that sexuality extends beyond sexual acts or reproductive functions. It is an integral and multifaceted part of human life, and as such it is central to individual prosperity, human connection, and collective well-being. Another definition adopted by WHO (2024a) highlighting this link between sexuality and human prosperity is that of sexual health:

> "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."

Sexual health, as health overall, is not merely the absence of a disease or prevention from harm but is also inseparable from sexual pleasure (Gruskin et al., 2019). The Global Advisory Board for Sexual Health and Wellbeing



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(GAB, 2024) similarly proposes a working definition of sexual pleasure, in line with the WHO working definitions of sexual health and rights:

> "Sexual pleasure is the physical and/or psychological satisfaction and enjoyment derived from solitary or shared erotic experiences, including thoughts, dreams and autoeroticism. Self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations are key enabling factors for pleasure to contribute to sexual health and wellbeing. Sexual pleasure should be exercised within the context of sexual rights, particularly the rights to equality and non-discrimination, autonomy and bodily integrity, the right to the highest attainable standard of health and freedom of expression. The experiences of human sexual pleasure are diverse, and sexual rights ensure that pleasure is a positive experience for all concerned and not obtained by violating other people's human rights and wellbeing."

### 1.2.1. Key Terms and Theoretical Considerations

Scholars have suggested several competing theories to explain the process and underlying causes of sexuality-related phenomena, reflecting different disciplinary perspectives on the issue that range from biological determinism to social constructionism. Increasingly, as our understanding of human development evolves in most scientific disciplines, scholars highlight the complex interplay between individual agency and biological, psychological, social, and environmental factors that determine the maturity and manifestation of human sexuality. In the meantime, rather than searching for a single cause of gender and sexual orientations, many have shifted towards recognising and embracing the variability, diversity, and fluidity of human sexuality as a biocultural reality (Fuentes, 2012, 2025; Cocks, 2013; Bailey et al., 2016; Diamond & Rosky, 2016; Ganna et al., 2019; Diamond, 2020).

Given the purpose and scope of this literature review, a thorough investigation of the multi-dimensional and complicated phenomenon of human sexuality is beyond its limits, even more so under a sophisticated and comprehensive theoretical framework. However, it is essential to clarify some fundamental concepts to minimise theoretical ambiguities and ensure a shared understanding of key terms and considerations as a required initial



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step before delving into the issues on the sexuality of autistic people. In the *Good Practices* chapter of this literature review, additional resources are provided tailored to educating health and care professionals on more sexuality-related issues (e.g., sexual maturation, sexual function and satisfaction) (for example Brick Exchange, 2025a; b).

A critical distinction in discussions of sexuality is that between *sex* and *gender*. According to the American Psychological Association (APA, 2024), *sex* refers to "the biological status of being male, female, or intersex," determined by anatomical, hormonal, and chromosomal characteristics. *Gender*, by contrast, refers to "the psychological, behavioural, social, and cultural aspects of gender (i.e., masculinity, femininity, nonbinary, nonconforming, or other gender)", since each given society assumes some "socially constructed roles, behaviours, activities, and attributes" appropriate for different genders (APA, 2024).

While this distinction is widely adopted, scholars have questioned whether it addresses current findings and critical theoretical frameworks on what sex and gender constitute. For many centuries, societies have operated under the assumption that gender naturally follows sex. This view, known as *gender essentialism*, provides that men and women have inherent, fixed, biologically determined traits that shape their cognition, behaviours, abilities, and societal roles (Morgenroth & Ryan, 2018).

Under the same historical context, other predominant assumptions justified in gender essentialism and embedded in societal structures, institutions, and language, are *heteronormativity* and *cisnormativity*, meaning the beliefs that heterosexuality (i.e., attraction to people of a particular different gender) and cisgender identity (i.e., people whose gender identity aligns with their sex assigned at birth) accordingly are the natural, default, or superior cultural norms, while enforcing a binary understanding of relationships under a monogamous and in some cases only reproductive framework (Ashley, 2023). This perspective justified also rigid gender roles and social hierarchal structures, as seen, for example, in historical discourses that women are naturally/biologically inferior to men and created disparities



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between men and women evident in various spheres of public and private life (Janega, 2023). In recent history, shaping cultural practices through disciplinary discourses about the human body has also been illustrated as a mechanism of the capitalist system to regulate and exploit workers' bodies (*biopolitics*) and thus control the forces of social production and reproduction at the populations level (*biopower*) (Foucault, 1978).

Essentialist arguments have often been more reflective of social biases than scientific facts. The idea that sexuality is purely biological has been challenged by scholars such as Simone de Beauvoir (1949), who argued that while bodies have biological characteristics, male-dominated societies create gendered expectations that shape how individuals experience and express their gender through the process of "naturalisation", i.e., making something appear natural, even though it is not. Similar ideas have been applied to sexual orientation, highlighting how cultural norms influence not only how people define their sexuality but also how they experience desire itself (Diamond & Rosky, 2016).

The notion of a strict sex-gender division, where sex is a biological reality, and gender is merely a social overlay, has also been questioned by Judith Butler (1990), who argue that cultural discourse shape even the way we talk about sex. One cannot escape talking about sex without referring to a binary notion of *femininity* and *masculinity*, shaped by historical and political forces. Current scientific evidence has questioned sex as a (binary) biological category, much like biological race (Fuentes, 2012; Snorton, 2017). This perspective does not deny biological differences but suggests that what we consider "biological" or link to this so-called biological reality is already mediated through social meaning (Haslanger, 2012). Butler (1990, p.114) have claimed that sex and gender cannot be separated, since everything is basically gender:

> "Physical features" appear to be in some sense *there* on the far side of language, unmarked by a social system. It is unclear, however, that these features could be named in a way that would not reproduce the reductive operation of the categories of sex. These numerous features gain social meaning and unification through their articulation within the category of sex. In other words, "sex" imposes an artificial unity



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on an otherwise discontinuous set of attributes. As both *discursive* and perceptual, "sex" denotes an historically contingent epistemic regime, a language that forms perception by forcibly shaping the interrelationships through which physical bodies are perceived".

Butler (1990) argue that gender is not something we "are" or that we "have" but something we "do" through a set of repeated stylised actions that are socially meaningful (i.e., recognised by others as meaningful) and create the illusion of a stable and gendered self. In their other words, gender is *performative*, meaning that by saying it, you do it. We enact gender through language, gestures, and various kinds of enactments and behaviours, and in doing so, we reinforce (or challenge) existing norms.

For example, consider a young boy, who when he falls, hurts his knee and begins to cry, which is a normal reaction to pain, is told "Boys don't cry". He might still cry the first time, but after repeated corrections from parents, teachers, or peers, he learns to hold back tears. Over time, this behaviour, meaning restraining this emotion and reaction, becomes an expected part of his identity as a "real man". Suppose he continues to cry openly or express vulnerability. In that case, he may not only be scolded but also ridiculed with labels with negative social symbolic meanings like "cry-baby", "femboy," or even "gay", associating emotional expression with femininity (thus probably with weakness and inferiority) and, by extension, non-heteronormative identities. In this way, gender performance is regulated in a way that reinforces both traditional masculinity and heteronormativity (Pascoe, 2012).

Gender is inseparable from the gender norms that shape gendered behaviours through socialisation and reinforcement. As an embodied event (Budgeon, 2003), gender is one of the ways that human subjects publicly come into existence (*subjectification*). However, it creates the illusion of a private, authentic self that exists before this public process takes place throughout an individual's life (Butler, 1990).

Usually, the term *gender identity* refers to a person's deeply felt sense of their gender, which may or may not align with their assigned sex at birth. *Gender expression* relates to how people outwardly communicate their



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gender identity or role through, for example, names, clothing, behaviour, speech, and mannerisms (APA, 2024). Ashley (2023) describes gender identity as "how we make sense of our gender subjectivity—the totality of our gendered experiences of ourselves." Integrating social messages, bodily experiences, language, and cultural norms into a coherent self-concept. As Butler argue (1990), although individuals can make choices about their body and gender, the meanings of what "body", "gender" or even the "self" mean are out of individual control and depend on the symbolic meanings of the social world.

As mentioned before, people whose gender identity aligns with their sex assigned at birth are referred to as *cisgender*, whereas those whose gender identity and roles differ from those usually associated with their sex assigned at birth fall under the umbrella term *transgender*. People who decide to affirm their gender identity undergo some *gender-affirming* processes. *Transition* is another word to describe the process that some transgender people go through to align their lived experiences with their gender identity through different pathways, including social transition (e.g., using new names, pronouns, clothing, having their gender legally recognised) and medical transition (e.g., hormone therapy and surgery) (APA, 2024).

In addition to transgender identities, gender diversity includes gender nonconforming identities and expressions that differ from the norms associated with one's sex assigned at birth, as well as *non-binary, genderqueer, and genderfluid* identities or expressions, which challenge the strict male-female binary understanding of gender (Diamond, 2020), "including people who identify as both male and female, neither, moving between genders, a third gender or outside of gender altogether" (APA, 2024). *Gender dysphoria*, a diagnosis recognised in the Diagnostic and Statistical Manual (DSM-5), refers to the distress experienced due to incongruence between a person's gender identity and their assigned sex (APA, 2024). However, not all transgender or gender-diverse individuals experience gender dysphoria, as many thrive in trans-affirmative



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environments that recognise, respect and support their needs, as well as those of gender nonconforming people (Ashley, 2023; APA, 2024).

*Sexual orientation* is a multi-dimensional category closely related to gender, which incorporates sexual attractions, fantasies, arousal, and identity (Diamond & Rosky, 2016). Sexual orientation is usually categorised based on the gender that generally attracts a person. Common categories of sexual orientation include *heterosexuality* (attraction to people of a different gender), *homosexuality* (attraction to people of the same gender), *bisexuality* (attraction to people of more than one gender), *asexuality* (experiencing little or no sexual attraction), and *pansexuality* (attraction to people regardless of gender). The term *LGBTQIA+* stands for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual + (and/or other sexual orientation, gender identity or forms of expression).

While these labels can be helpful, they are not fixed, exhaustive, or universal as is usually assumed. As is the case of defining womanhood (Butler, 1991), the process of setting an exact definition of gender-related categories under patriarchal systems is always going to be an exclusionary process against individuals whose narrative does not fit these definitions, in contrast to a certain amount of grey area (Kristeva, 1980). Current research indicates that sexual attraction and identity are more fluid and evolving (Bailey *et al.*, 2016). Additionally, the components of what constitutes a sexual orientation might not coincide. For instance, a person might have sexual fantasies or experience sexual arousal for a person of the same sex yet not identify as gay, lesbian, bisexual or other sexual identities. Many individuals experience shifts in their attractions and identities over time, influenced by relationships, social environments, personal reflection and other factors (Diamond & Rosky, 2016). Thus, trying to make everyone fit the complexity of their inner experiences into fixed categories contradicts the biocultural reality of the fluidity of sex/gender (Fuentes, 2025).

It is important to remember that before the 19th century, individuals were not categorised based on sexual orientation, but rather, societies judged sexual behaviours primarily based on moral or religious frameworks. The



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emergence of medical and psychiatric classifications in the 19th and 20th centuries led to the creation of “homosexual”, “heterosexual” and others as distinct categories (Cocks, 2013). Notably, homosexuality and transgender identities were classified as mental disorders in medical manuals for much of the 20th century, reflecting how scientific discourse policed sexual and gender diversity (Denton, 2016).

### 1.2.2. The Social and Political Dimensions of Sexuality

WHO (2024a) recognises that sexual health should be viewed within specific social, economic and political contexts. Health status in general, as well as the distribution of health and disease within a population, is continuously determined by the “conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life”, including, among others, economic, political and environmental systems, policies and social norms (WHO, 2024b). In other words, socio-economic and job status, education, housing conditions, early childhood development, access to care, social inclusion, and various other factors -all influenced by broader systems and forces themselves- continuously determinate who will be more likely to remain healthy, live longer and enjoy a higher quality of life, and who is at risk to experience poorer health outcomes, reduced life expectancy, and poorer overall well-being facing systemic disadvantages (WHO, 2024b).

Similarly, sexuality and sexual health are not merely about individual attraction, sexual functions or behaviour. They are about who has the right to exist freely, to pleasure, to love, to express desire, and to access legal and social protections, and who does not. Societies define norms and deviance, deciding who is recognized as “normal”, “natural”, or “righteous” and who is labelled as “abnormal”, “unnatural”, or “sinful”, and, as a result, who is granted rights and protections and who faces stigma, marginalisation, criminalisation, and punishment. These norms are not neutral but have been historically constructed and enforced through religious doctrine, state laws, and violent repression, causing harm to some while benefiting others (Butler, 2024).



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Despite the progress made in many parts of the world, women, LGBTQIA+ individuals, and other groups systematically face intersecting forms of oppression based on class, disability, race, caste, ethnicity, religion and age, and are denied rights even today. Systemic inequalities are unravelled in uneven possibilities to enjoy a healthy sexuality and overall well-being freely. Beyond exclusion from education, work, housing and many other spheres of social life, women and LGBTQIA+ people face additional forms of discrimination and violence, such as bullying, harassment and gender-based violence, causing various physical and mental health disparities (UNFPA, 2024).

Although this is not a new phenomenon, during the last few years public beliefs and attitudes towards sexuality and gender issues are becoming increasingly polarising under a turbulent political climate. The rise of the anti-gender movement, backed by political and religious groups, has sought to roll back womens' and LGBTQIA+ rights, significantly limiting access to safe abortion, criminalising gender-affirming care, and cutting funds for essential health and care services, by claiming to defend "traditional values". Without drawing an ideological and moral equivalence between all parties and individuals involved in these movements, the movements in practice seek to reinforce power structures at the expense of personal freedoms and human rights, by enforcing the unsubstantiated and misleading perception that women and LGBTQIA+ people are the real threat and cause of widespread distress (Graff & Korolczuk, 2022; Butler, 2024). Despite these barriers and forces, marginalised communities are not just victims but also agents of resistance and change. Women, LGBTQIA+ activists, and disability rights advocates have fought for decades to dismantle oppressive structures and push for legal and social progress (Ashley, 2023; Čierna and Bianchi, 2024).

### 1.2.3. Legal Framework on Sexual and Reproductive Rights

Sexual and reproductive health rights (SRHR) are core to the health and well-being of people and communities. During the last decades, a series of human rights standards related to sexuality and sexual health have been



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developed and operationalised through national laws and policies. Nonetheless, in many settings, laws continue to single out or discriminate against women and LGBTQIA+ people, as well as other groups with stigmatised sexualities, in violation of human rights standards (e.g., restricted access to abortion services, criminalisation of sex work, requiring third-party authorisation for health and care services for women and adolescents, criminalisation of consensual same-sex behaviours, banning gender-affirming care), alongside other discriminatory policies (WHO, 2015; ilga, 2020).

Addressing and fulfilling sexual rights is pivotal to improving the sexual health of all humans. Following the HIV/AIDS movement and its effect in enforcing social coalitions and shifting the focus to key populations, WHO and agencies of the United Nations (UN) adopted a growing understanding of sexual rights as human rights related to sexual health and sexuality, albeit with a focus on challenges rather than including sexual pleasure as well (Gruskin et al., 2019).

On the contrary, significant attention to pleasure is embedded in the Declaration of Sexual Rights (WAS, 2014), which was developed by a global professional association under a series of revisions to acknowledge and promote sexual rights, including the dimension of sexuality as a source of pleasure, well-being, fulfilment and satisfaction. The declaration recognises that “sexual rights are grounded in universal human rights that international and regional human rights documents already recognise, in national constitutions and laws, human rights standards and principles, and in scientific knowledge related to human sexuality and sexual health”. These include the rights to:

- Equality and non-discrimination,
- Life, liberty, and security,
- Autonomy and bodily integrity,
- Be free from torture and cruel, inhuman, or degrading treatment or punishment,
- Be free from all forms of violence and coercion,
- Privacy,



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- The highest attainable standard of health, including sexual health; with the possibility of pleasurable, satisfying, and safe sexual experiences,
- Enjoy the benefits of scientific progress and its application,
- Information, education and the right to comprehensive sexuality education,
- Enter, form, and dissolve marriage and other similar types of relationships based on equality and full and free consent,
- Decide whether to have children, the number and spacing of children, and to have the information and the means to do so,
- Freedom of thought, opinion, and expression,
- Freedom of association and peaceful assembly,
- Participation in public and political life,
- Access to justice, remedies, and redress.

Most of these rights are also embedded in international, European and national legal frameworks on the rights of people with disabilities and other socially marginalised groups who face intersectional discrimination (Botsou *et al.*, 2023). Among these instruments is the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2008), which has been ratified by all European Union (EU) member states.

As per Article 25, people with disabilities have the right to access gender-sensitive healthcare services, "including in the area of sexual and reproductive health and population-based public health programmes", without discrimination and concerning their dignity and needs. Moreover, under Article 23 of the CRPD, state parties are mandated to "take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others", recognizing their right to marry, create families, decide if they want to have children, as well as when and how many, "have access to age-appropriate information, reproductive and family planning education" and retain their fertility. Additionally, Article 16 calls for the implementation of a variety of age- and gender-responsive measures protecting the right of people with disabilities to live free "from all forms of



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exploitation, violence and abuse", thus including sexual exploitation. Finally, other articles related to sexuality are those on the right to dignity, autonomy and independence (Article 3), equality and non-discrimination (Article 5), freedom of expression and opinion, and access to information (Article 21), respect for privacy (Article 22), and education (Article 24).

**Table 1: National Legal Frameworks Protecting the Sexual Rights of Autistic Individuals in Selected EU Member States**

| Country | Legal instrument | Content |
|---|---|---|
| **Bulgaria** | National Assembly of the Republic of Bulgaria (SG 56/13 JUL 1991) Constitution of the Republic of Bulgaria. Art. 6. | (1) All persons are born free and equal in dignity and rights.<br>(2) All citizens* shall be equal before the law. There shall be no privileges or restriction of rights on the grounds of race, national or social origin, ethnic self-identity, sex, religion, education, opinion, political affiliation, personal or social status or property status. |
| **Finland** | Republic of Finland (731/1999) The Constitution of Finland. Sections 1, 6, 7, 10, 11 & 12. | • Human Dignity and Personal Integrity (Section 1 and Section 7): The dignity of every person is inviolable, which includes respect for individual autonomy and the right to self-determination, such as sexual self-determination. Section 7 protects the right to life, personal liberty, and physical integrity, prohibiting any violations of personal or sexual integrity.<br>• Equality and Non-Discrimination (Section 6): "Everyone is equal before the law". This provision prohibits discrimination based on gender, gender identity, sexual orientation, or any other personal characteristic. The Constitution specifically requires promoting gender equality in all areas of |



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| | | society: “Equality between women and men shall be promoted in social activity and working life”.<br>• Right to Privacy (Section 10): “Everyone's private life, honour, and home are protected.” This guarantees the protection of a person's sexual orientation, sexual identity, and decisions related to their private life.<br>• Freedom of Religion and Conscience (Section 11): Individuals have the right to freedom of conscience and religion, including personal decisions related to sexuality and gender identity.<br>• Freedom of Expression and Access to Information (Section 12): This right ensures that individuals have the freedom to receive and share information, which is essential for sexual education and awareness of rights related to sexuality and gender. |
| **Finland** | The Non-Discrimination Act (1325/2014). Sections 5, 8, 9 & 15. | • Promotion of Equality (Section 5): Authorities, employers, and education providers are obligated to promote equality and take active measures to prevent discrimination based on sexual orientation or gender identity.<br>• Prohibition of Discrimination (Section 8): Discrimination based on sexual orientation, gender identity, or gender expression is explicitly prohibited in all areas of life, including employment, education, access to services, and public spaces.<br>• Multiple Discrimination (Section 9): The law acknowledges that individuals can face multiple forms of discrimination, such as on the grounds of |



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| | | both gender and sexual orientation and seeks to address such situations comprehensively.<br>• Reasonable Accommodations (Section 15): To ensure equality, reasonable adjustments must be made for individuals, including those whose needs may relate to their gender identity or expression. |
| **France** | République française (2003) Charte des droits et libertés de la personne accueillie. Article 12. | Respect for the dignity and integrity of the person are guaranteed. Apart from the exclusive and objective necessity of carrying out the treatment or support, the right to privacy must be preserved. |
| **France** | Secrétaire d'Etat chargée des personnes handicapées (2021) Circulaire DGCS/SD3B/2021/147. | Announces 3 measures to be implemented in the whole of France by medico-social services: training for professionals on the topic of sexuality and relationships, resource centres with documentation in ETR on these topics, and a reminder sent out to all executive directors to respect the right to intimacy and sexuality of those supported. |
| **Greece** | Greek Government (2019) Constitution of Greece. Article 21, paragraph 6. | People with disabilities have the right to enjoy measures ensuring their autonomy, their professional integration, and their participation in the social, economic, and political life of the country. |
| **Greece** | Greek Government (2024) Penal Code. Article 338, Law 5108/2024. | Abuse of the incapable of resistance:<br>(1) Whoever, by abusing the mental or physical disability of another person or his/her inability to resist any cause, performs a sexual act with him/her shall be punished by imprisonment for a term of up to ten years.<br>(2) If the act of the preceding paragraph was committed or enacted by two or more persons acting |



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| | | in concert shall be punishable by imprisonment of up to fifteen years. |
| **Italy** | Italian Republic (2023) Constitution of the Italian Republic. Articles 2, 3 & 32. | • Article 2: The Republic acknowledges and guarantees the inviolable rights of man, both as an individual and within the social groups in which one's personality is expressed. The Republic requires that the fundamental duties of political, economic and social solidarity be fulfilled.<br>• Article 3: All citizens possess equal social dignity and are equal before the law, without distinction of sex, race, language, religion and political orientation, personal and social conditions. It is the duty of the Republic to remove economic and social obstacles which, by limiting the freedom and equality of citizens, prevent the full development of the natural person and the actual participation of all workers in the political, economic and social organisation of the country.<br>• Article 32: The Republic shall safeguard health as a fundamental right of the individual and as a social interest and shall guarantee free medical care to the indigent. No one shall be forced to undergo medical treatment unless provided for by law. In no case shall the law violate the limits imposed by respect for the natural person. |



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| **Malta** | Equality for Men and Women Act (Cap. 456) | The Equality for Men and Women Act (Cap. 456) and its amendments explicitly prohibit discrimination based on sexual orientation, gender identity, gender expression, or sex characteristics. This includes protection for autistic individuals under the broader framework of anti-discrimination laws. |
| **Malta** | Republic of Malta (2000) Equal Opportunities (Persons with Disabilities) Act (Cap. 413). | Malta's Constitution and the Equal Opportunities (Persons with Disabilities) Act (Cap. 413) prohibit discrimination against persons with disabilities, ensuring their access to rights in all domains of life, including sexual and reproductive rights. |
| **Malta** | Ministry of Justice and Home Affairs (Act No. XXVI 2016) Persons within the Autism Spectrum (Empowerment) Act. | The Persons within the Autism Spectrum (Empowerment) Act (Act No. XXVI of 2016) focuses on improving the well-being, inclusion, and autonomy of autistic individuals. It aligns with the UN Convention on the Rights of Persons with Disabilities (CRPD), which Malta has ratified. The CRPD guarantees sexual and reproductive rights for people with disabilities, emphasising autonomy and consent. |
| **Malta** | Ministry for Health, the Elderly and Community Care (2010) National sexual health policy for the Maltese Islands. | The National Sexual Health Policy for the Maltese Islands (2010) underscores the importance of inclusivity in sexual health services and education, aiming to cater to all individuals, including those with disabilities. The policy emphasises that sexual health is a vital component of overall well-being and should be accessible to everyone, regardless of their abilities.<br><br>While the policy advocates for the inclusion of people with disabilities in sexual health programs and campaigns, it does not explicitly address the unique needs of autistic individuals. This absence highlights a |



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gap in the policy concerning tailored approaches for the autism community.



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## 2. Autism and Sexuality: Evolving Themes and Core Insights

The sexuality of autistic people has gained a progressively growing interest among the scientific community during the last decades. From a quantitative perspective, a recent bibliometric study on the evolution of scientific production on the sexuality and affectivity of autistic individuals between 2000-2023 (Torralbas-Ortega *et al.*, 2024), revealed that from a total of 314 articles, most studies have been published during the last 10 years, peaking between 2020-2022. Additionally, high-income Western countries, especially the USA, the UK, other European countries, and Australia, prevailed in collaboration and publishing on the topic, raising concerns on global health equity. In terms of study subjects, children and adolescent autistic populations were the primary ones. Another recent study on the methods used in studies about the intersection of autism and gender diversity conducted between 2018-2023, identified common concerns related to the validity and generalisability of the studies. These concerns were due to differences in the conceptualisation of the research topics (e.g., gender dysphoria and gender diversity), weak and diverse sampling, as well as usage of non-validated measures (Mittertreiner *et al.*, 2024).

Regarding the qualitative characteristics of the literature on the sexuality of autistics, researchers initially shifted from ignoring the topic to documenting and tackling problematic outcomes, based on the perspectives of the caregivers and service providers of autistic people (Sala *et al.*, 2020). More recently, research is adopting a more de-stigmatising, gender-informed and holistic approach to the sexual development of autistic people (Dewinter, van der Miesen & Holmes, 2020), which, as will be discussed, shares both similarities and differences with the sexual development of neurotypical people (Dewinter et al., 2013; May, Pang & Williams, 2017; Dekker, 2019; Corbett et al., 2020), and should be viewed as part of the broader human sexuality (Bertilsdotter Rosqvist & Jackson-Perry, 2021). Primarily through qualitative studies where self-report and self-advocacy prevail, the previously unheard voices of autistic people elaborate on how they perceive and prioritise issues related to their sexuality, setting the agenda both for future



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studies and clinical practice (George & Stokes, 2018; Sala et al., 2020; Dewinter et al., 2024).

### 2.1. Inappropriate Sexual Behaviours

Several studies on the sexuality of autistic people in previous years focused on sexual behaviours that were considered inappropriate, offensive, or in other ways problematic by caregivers and service providers. These behaviours mainly were related to autistics with co-occurring intellectual disabilities, in contrast to “high-functioning” autistics (Realmuto and Ruble, 1999; Hellemans et al., 2007; Dewinter et al., 2013; Fernandes et al., 2016; Pecora, Mesibov & Stokes, 2016). Public or excessive masturbation was among the most prevalent inappropriate behaviours, continuing with sexual offences (e.g., assault, stalking, and rape) and paraphilic behaviours (e.g., fetishism, voyeurism, paedophilia) (Dewinter et al., 2013; Fernandes et al., 2016; Schöttle, Tüscher & Turner, 2017; Postorino et al., 2018; Hartmann et al., 2019; Pecora et al., 2020; Maggio et al., 2022).

A number of factors were associated with these behaviours, including limited peer-learning during adolescence, leading to poor knowledge and awareness of societal norms regarding appropriate sexual behaviour (e.g., awareness on privacy rules and knowledge on masturbation techniques) (MacKenzie, 2018; Postorino *et al.*, 2018). In addition to these social learning difficulties, other contributing factors, often considered “autistic traits”, included difficulties with empathy and inhibition, repetitive and restricted interests, and sensory sensitivities (Hellemans et al., 2007; Nichols & Blakeley-Smith, 2009; Gougeon, 2010; Postorino et al., 2018).

However, the actual prevalence of these sexually deviant behaviours among autistics is unknown (Crehan & Sperry, 2021), while it remains unclear whether they are indeed more prevalent among autistics than in neurotypical populations, as suggested in previous findings which consisted mainly of case studies, thus results are not applicable to the broader and diverse autistic population (Postorino *et al.*, 2018). Counterfeit deviance should be taken into consideration in such cases, meaning that behaviours of some autistics, e.g.,



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with restricted and repetitive behaviours and interests, that appear to have sexual drives behind them, may, in fact, be solely the result of behaviours associated with autism (e.g., restricted and repetitive behaviours) (Crehan & Sperry, 2021).

## 2.2. Sexual Victimisation

Beyond concerns about acting sexually inappropriately, recent findings suggest that autistics, especially women and LGBTQIA+ autistics, are more likely to be sexually victimised in comparison with non-autistic people, especially by someone they know, like parents, caregivers and peers (Dike *et al.*, 2023). Social isolation and exclusion, and thus lack of strong supportive networks, can further increase vulnerability to sexual victimisation and adverse health outcomes after an abusive incident (Cheak-Zamora *et al.*, 2019; Pecora, Hooley, *et al.*, 2020).

Studies propose that increased susceptibility to sexual violence might also originate from limited or invalid knowledge and awareness on manipulative and abusive behaviours on behalf of autistic people, making it difficult to identify, interpret and report them as such (Bush, 2016; Pecora, Mesibov & Stokes, 2016; Sedgewick et al., 2019). The same goes for risk factors associated with violence, the awareness of which could help early detection and prevention of potential sexual violence against autistic people (Hellemans et al., 2007; Sevlever, Roth & Gillis, 2013; Brown-Lavoie, Viecili & Weiss, 2014; Postorino et al., 2018; Joyal et al., 2021; Gibbs & Pellicano, 2023).

Yet even when identified as violative acts against them, some autistics might not know how to respond to these incidents due to challenges in communication and conflict management (Bush, 2016; Sedgewick *et al.*, 2019). In other cases, they may avoid reacting and/or disclosing later such events in fear of social exclusion and secondary victimisation by relatives and formal institutions (e.g., criminal justice and healthcare systems) (Joyal *et al.*, 2021; Kerns *et al.*, 2022).



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## 2.3. Sexual Experiences

Even though all the above adverse experiences may constitute a significant part of many autistics' sexual lives, these lives extend beyond the dichotomy of sexual misconduct and victimisation. A common stereotype about autistics' sexuality is that they are disinterested or incapable of engaging in sexual activities, as well as creating and maintaining intimate relationships and families (Koegel et al., 2014; Hannah & Stagg, 2016; MacKenzie, 2018; André et al., 2020; Frawley, 2023). Nonetheless, a growing number of studies has revealed that many autistics express interest in sexuality and intimate relationships and engage in solo and partnered sexual activities from adolescence (Mehzabin & Stokes, 2011; Byers, Nichols & Voyer, 2013; Dewinter et al., 2015; Pecora, Mesibov & Stokes, 2016; Pecora et al., 2020; Weir, Allison & Baron-Cohen, 2021) and throughout adult life (Stokes, Newton & Kaur, 2007; Byers et al., 2013; Pecora, Mesibov & Stokes, 2016; Sala et al., 2020; Joyal et al., 2021; Maggio et al., 2022) as neurotypical people.

A commonly debated issue among researchers and autistic communities is the level of intensity that autistic people show in sexual activity and sexual desire, ranging from asexuality to an intensive interest (Bertilsdotter Rosqvist & Jackson-Perry, 2021). Although studies do not agree on whether autistics report similar or lower levels of sexual interest and experiences to neurotypical participants, it is clear that a significant number of autistics, mostly not "high functioning", have delayed sexual experiences or fewer than expected by them (Gilmour, Schalomon & Smith, 2012; Bejerot & Eriksson, 2014; Bush, 2016; Pecora et al., 2020). Moreover, even though results again vary (Byers et al., 2013; Byers, Nichols & Voyer, 2013), most findings show that autistic women engage more in sexual activities and intimate relationships compared to autistic men (Pecora, Mesibov & Stokes, 2016; Schöttle, Tüscher and Turner, 2017; Strunz et al., 2017; Pecora et al., 2019; Joyal et al., 2021). Some authors interpret these results under the



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"female autism phenotype"[3] framework which, among else, provides that autistic women show better outcomes in communication and social interaction compared to autistic men (Lai et al., 2015; Turner, Briken & Schöttle, 2017; Hull et al., 2020).

However, Sedgewick et al. (2019) concluded that autistic women had less, and more challenging intimate relationships compared to non-autistic women. At the same time, literature findings reveal that, compared to autistic men or non-autistic women, autistic women have lower levels of sexual self-awareness, interest, desire and satisfaction, and usually experience increased sexual anxiety, adverse and/or abusing events (Byers et al., 2013; Bush, 2019; Pecora et al., 2019; Pecora et al., 2020; Sala et al., 2020). Additionally, autistic men report lower levels of sexual satisfaction and greater levels of confusion, anxiety and frustration compared to autistic women, given that their sexual desires and interest to engage with others are less likely to get actualised (Byers et al., 2013; Pecora, Mesibov & Stokes, 2016; Strunz et al., 2017).

Another interesting research finding is that sexual interest and pleasure, as well as certain sexual activities, can be conceptualised in several ways by autistics. Specifically, participants from the qualitative study of Beato, Sarmento & Correia (2024) revealed that they struggled to associate specific feelings and sensations with the notions of "sexual interest, excitation and desire". Ultimately, they correlate them with physical reactions or emotional state/mood. In another example from the same study, participants described masturbation either as relevant to pleasure/orgasm, physical relief, and emotional regulation or as associated with negative feelings, such as shame, discomfort and dissatisfaction.

Given the importance of physical intimacy in intimate relationships, atypical sensory processing appears to play a significant role in the sexual, affective and reproductive experiences of autistic people (Cheak-Zamora et al., 2019; Gray, Kirby & Graham Holmes, 2021; Dewinter et al., 2024). Hypo-

[3] Further details about the autism female phenotype are discussed in Section 4.1 of this literature review.



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or hyper-sensitivity to certain sensory stimuli can influence how autistic individuals perceive pleasure and eroticism of tactile and other sensations, which then impacts both their sexual experiences as well as creating and maintaining intimate relationships (Sala *et al.*, 2023).

On the one hand, having adverse reactions towards certain stimuli can hamper both solo and partnered sexual activities since sensory dysregulation experiences can be particularly emotionally unpleasant and physically painful (Barnett & Maticka-Tyndale, 2015; Schöttle, Tüscher & Turner, 2017; Postorino et al., 2018). For example, some interviewees in the research of (Beato, Sarmento & Correia (2024) described some diverse struggles autistics can face during partnered sexual activities, in part associated with hyposensitivity to stimuli, such as “decreased or absent sexual desire, decreased ability to reach an orgasm, persistent pain in the genital or pelvic area during sexual intercourse, difficulty tolerating the penetration, insufficient vaginal lubrication, low vaginal relaxation, difficulty achieving and maintaining erections”. Moreover, delays in becoming aware of their sensations or in communicating them to sexual partners can further impede managing relevant situations (Barnett & Maticka-Tyndale, 2015). Furthermore, Postorino et al. (2018) observed that hyposensitive types needed intense stimulation for sexual arousal and faced difficulties in reaching orgasm. On the other hand, autistic people who experience atypical sensory processing may find comfort, pleasure and reassurance in several types and specific amounts of physical intimacy beyond just sexual intercourse, including hugging, touching, having physical proximity, and sitting or sleeping next to their partners (Sala *et al.*, 2023). In another case, for sensation-seeking autistics or those who have incorporated their sensory needs into their sexual lives, sensory sensitivity can amplify their sexual experiences and sexual pleasure (Bush, 2016).

### 2.4. Intimate Relationships

As mentioned previously, studies have revealed that many autistics express interest in intimate relationships (Stokes, Newton & Kaur, 2007; Gilmour, Schalomon & Smith, 2012; Dewinter et al., 2015; Strunz et al., 2017;



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Hancock, Stokes & Mesibov, 2020), have a strong desire for love and commitment in various levels and types of physical and emotional intimacy (MacKenzie, 2018), create multiform (Bush, 2016) and long-lasting relationships, get married, and have children (Smith *et al.*, 2021) as any other human. Others are disinterested in intimate relationships (Bush, 2016) or find creating and maintaining them particularly exhausting (Strunz *et al.*, 2017). Additionally, previous negative experiences, like sexual harassment and abuse, unhealthy relationships and bullying, can further foster negative feelings around dating and relationships (Sala *et al.*, 2020).

Furthermore, many autistics share similar perspectives on intimate relationships with non-autistic individuals, such as their beneficial role in reinforcing their self-esteem, stability, and companionship (Beato, Sarmento & Correia, 2024). They might also value trust, openness and honesty, clear communication, emotional proximity and romance, acceptance, care, and support, as well as self-awareness, safety, and respecting personal boundaries and needs as core features of a healthy relationship (Cheak-Zamora et al., 2019; Sala, Hooley & Stokes, 2020; Joyal et al., 2021).

Contrarily, the literature indicates various difficulties autistics face in establishing and maintaining intimate relationships (Sala, Hooley & Stokes, 2020). Dating, in particular, was an issue for which autistics highlighted their need to obtain more knowledge and skill-building, including topics like initiating contact, expressing attraction and (dis)interest in general and/or in an appropriate manner, understanding others' expectations and learning how to adjust to them (Cheak-Zamora et al., 2019; Dewinter, van der Miesen & Holmes, 2020; Beato, Sarmento & Correia, 2024). Indeed, studies reveal that many autistics view dating as a complex game of neurotypical individuals (MacKenzie, 2018) and a source of anxiety (Beato, Sarmento & Correia, 2024), given that it requires, among other things, understanding and responding to subtle cues of interest or discomfort, and various social norms (Barnett & Maticka-Tyndale, 2015; Beato, Sarmento & Correia, 2024). Other challenges related to autism have been identified to interfere with initiating relationships, such as lacking specific, pragmatic language skills, repeated and narrow interests, strict routines and rituals, atypical sensory processing,



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and poor flexibility (Strunz et al., 2017; Turner, Briken & Schöttle, 2017; Postorino et al., 2018; Hancock, Stokes & Mesibov, 2020; Pecora, Hooley, et al., 2020; Sala, Hooley & Stokes, 2020; Kohn et al., 2023; Beato, Sarmento & Correia, 2024).

Studies have also shown that, when it comes to online dating apps and websites, autistics have raised concerns about safety and uncertainty, like being misled or victimised, dealing with online dating norms, stigmatisation and rejection, balancing between curating and preserving their true identity in their online profiles, and transitioning from an online to a face-to-face interaction (Roth & Gillis, 2015; Gavin, Rees-Evans & Brosnan, 2019; Brosnan & Gavin, 2021; Choi et al., 2023). However, online dating also has several advantages since, for example, it can provide the ability to control self-presentation, alleviate stress from face-to-face communication, and adequate time to process information, evaluate the circumstances and respond (Roth & Gillis, 2015).

Regarding challenges during intimate relationships, the most reported issues were related to communication and social interaction, as well as confusion and uncertainty on or disagreement with social norms around relationships and gender roles. Fear of not being able to understand and fulfil their partners' needs and wishes was also a difficulty reported by autistic people, as well as fear of rejection, anxiety, poor confidence and self-esteem and avoidance behaviours (Barnett & Maticka-Tyndale, 2015; Cheak-Zamora et al., 2019; Hancock, Stokes & Mesibov, 2020; Alonzo, 2023; Torralbas-Ortega et al., 2023; Beato, Sarmento & Correia, 2024).

These findings appear to be more prevalent in couples consisting of one autistic and one non-autistic partner, especially in the early stages of the relationship (Strunz et al., 2017; Dewinter, van der Miesen & Holmes, 2020; Smith et al., 2021). Specifically, in many studies, communication issues (e.g., lack of clarity and directness) were described as a core problem and source of tension in neurodiverse couples, often diminishing self-esteem and intensifying feelings of isolation within the relationship (Goldstein Hode, 2014; Dewinter, van der Miesen & Holmes, 2020; Sala, Hooley & Stokes, 2020;



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Smith et al., 2021). Moreover, in the study of Smith et al. (2021) autistics in relevant couples raised concerns about how to identify and convey their emotions, a worry that their non-autistic partners seem to share, expressing their impression that their autistic partner may have empathy towards them. On the contrary, participants in the research of Beato, Sarmento and Correia (2024) felt more attracted to neurodivergent individuals, highlighting their preference for people who are flexible, adaptable, and share common interests.

### 2.5. Reproductive Health and Parenthood

Another critical issue is the experiences, needs and challenges related to the reproductive life and parenthood of autistic people. To begin with, the research of Ames et al. (2024) showed that adolescents with autism and other developmental disabilities who participated in the study had a higher likelihood of being diagnosed with menstrual disorders, polycystic ovary syndrome, and premenstrual syndrome compared to their typically developing peers. Yet, at the same time, they were less likely to visit an obstetrician-gynaecologist.

In a study on the post-menarche experiences of autistic and non-autistic women (Steward *et al.*, 2018), although individual experiences varied and at times overlapped between the two groups, some autistic participants reported that periods exacerbated autism-related challenges, like sensory overload (e.g., “being sensitive to the smell of the blood”) and emotional and behavioural self-regulation (e.g., “understanding my own emotions has always been difficult for me so any mood swings made life even more difficult”), as confirmed by other studies as well (Grove *et al.*, 2023). Additionally, respondents declared that menstruation needs to be de-associated from dirt, fear and shame and that further practical information (e.g., managing available products, strategies to relieve pain and other emotional or physical symptoms) and preparation for potential outcomes (e.g., “skin changes” and “tender breasts”) or events (e.g., action plans for setbacks, identifying reliable sources of information and support in times of need) were essential for them.



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For the same reasons, pregnancy (Hampton *et al.*, 2022) and menopausal transition (Groenman *et al.*, 2022) can be particularly challenging for autistic women. For instance, in the qualitative studies of Moseley, Druce & Turner-Cobb (2020, 2021) autistic female respondents noted that menopausal symptoms, such as hot flushes, heightened their sensory sensitivity or generated new types of sensory triggers. Menopause impacted their ability as well to regulate and control social circumstances and emotions, describing this as if their "autism broke" (Moseley, Druce & Turner-Cobb, 2020) and lost its beneficial effects. Furthermore, some added that these issues negatively influenced communication and relationships with others, including marital and sexual relationships ("sensory pain makes you think it's a relationship thing – like, why don't I want to be touched there? Maybe I don't love him?") (Moseley, Druce & Turner-Cobb, 2020). They also mentioned that their mental and emotional well-being deteriorated, experiencing increased anxiety and depression, or even suicidal ideation, as well as sleep problems and deterioration in cognitive function ("brain fog", "crushing tiredness and executive function") (Moseley, Druce & Turner-Cobb, 2021) and ability to cope with everyday living. Finally, menopause was presented as part of a broader midlife transitional period, incorporating internal and external changes, either positive or negative, and related to stereotypes on the ageing female identity, fertility, and sexual desirability. Participants considered enhancing professional knowledge, understanding, and support through bidirectional communication and practical guidance critical, stressing that menopause should not continue to be taboo.

A systematic review of the experiences and results of pregnancy and parenthood of autistics (McDonnell & Delucia, 2021) revealed similar findings to menstruation and menopause. Beginning with pregnancy, per recent findings (Hampton *et al.*, 2022; Grove *et al.*, 2023), autistic women have reported receiving inadequate perinatal and postpartum care, given that limited information on pregnancy and childbirth was provided to them. Further reasonable accommodations were also needed to alleviate sensory discomfort and to facilitate communication. It also appeared that sensory processing was impacted mostly negatively during all stages of pregnancy



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(e.g., during checkups, delivery, and breastfeeding) and that autistic women were at increased risk of medically indicated preterm birth and other adverse pregnancy outcomes, as well as of ante- and postnatal depression and significantly elevated prenatal stress.

As for parenthood, the systematic review (McDonnell & Delucia, 2021) featured the same challenges when interacting with healthcare professionals, to the point that some concealed their autism diagnosis to avoid stigmatisation or potential involvement of child protective services. Additionally, studies showed that parenting could be isolating for autistic parents, at times accompanied by feelings of stress, guilt and incompetence and that they are more likely to struggle with multitasking and managing household responsibilities, especially if family members unequally distribute these responsibilities.

Furthermore, a subsequent qualitative study on the experiences of autistic mothers (Dugdale *et al.*, 2021) reflected on how having a shared diagnosis with their children was depicted both positively and negatively. On the one hand, autistic mothers described this experience as the foundation for sharing a special bond and understanding with their children. On the other hand, the sharing diagnosis brought the extra responsibility of having to mediate autism-related difficulties and conflicts with others or constituted a source of guilt for passing genes related to autism to their children. Based on the same findings, some described parenthood as a rewarding and joyful experience, a component or promoter of self-growth and adaptation. At the same time, autism-related characteristics, such as analytical thinking and a need for routine, were presented as positive tools when managed appropriately.



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# 3. Gender Identity, Sexual Orientation and Autism

## 3.1. Autism as a Gendered Concept

As Moore et al. (2022) argue, the theory and diagnosis of autism has been intensely gendered throughout the years through pathways cultivated by normative gender expectations, traditional gender roles and ableist hegemonic discourses. Heterosexual cis-gender male autistics have constituted the predominant autistic subject from the foundational studies of autism until the beginning of the 21st century (Haney, 2016), in a way that autism was associated with what was back then believed to be a typical/hegemonic masculine cognition and behaviour, such as being adept at systematic/rigid thinking and being less empathetic (Baron-Cohen, 2002). Until today, males are over-represented among autistic populations, as evident by the fact that autistic females are 3-4 times less likely to be diagnosed with ASD or are more likely to get their diagnosis much later in life (Rutherford *et al.*, 2016) compared to autistic males.

While scholars have argued that this diagnostic imbalance might stem from biological “protective” factors that prevent autism development in women, many authors gradually support the idea that autism conceptualisation and diagnostic criteria have a high degree of gender bias and fail to capture the varying ways that autism manifests and in particular how it unfolds among female autistics (Hull, Petrides & Mandy, 2020) unless it severely impacts them (Saure *et al.*, 2023). Based on a recent systematic review and meta-analysis of differences in autism phenotype between males and females (Cruz *et al.*, 2024), the latter show fewer difficulties with social interaction and more motivation to be socially engaged but face more cognitive and behavioural challenges (e.g., externalising problems) challenges. The same study also suggests that, potentially, autistic females - as well as gender non-conforming autistics- camouflage autism and use masking (e.g., mimicking facial expressions, maintaining eye contact, and suppressing repetitive movements) and compensating (e.g., using more nonverbal or reciprocal communication, appearing more attentive to others’ facial expressions and emotions) strategies more frequently than cis-gender autistic males.



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However, both gendered autism discourses, meaning those arguing for a male and a female autism phenotype, reproduce essentialist accounts of gender and autism. Thus, they may conceal the constructional "nature" of these categories and the wide actual variations in expressing gender and autism both distinctly and intersectionally (Hull, Petrides & Mandy, 2020; Pearson & Rose, 2021; Moore et al., 2022).

### 3.2. Prevalence of Sexual and Gender Diversity among Autistic People

Scientists have been documenting an overlap between autism and sexual and gender diversity since the 90s, when a few studies described cross-gender behaviours in autistic children, mainly boys, like cross-dressing, adopting cross-sex roles and interests, preferring friends of the opposite sex, or clearly stating disappointment with their sex assigned at birth (Mukaddes, 2002; Silberman, 2015, pp. 319-320). In the meanwhile, many gender-diverse people started to get an ASD diagnosis (Sala *et al.*, 2020). Yet the issue remained somehow neglected until recently (Hillier *et al.*, 2020).

Emerging evidence reveals that autistic people are more likely to identify as non-heterosexual, lesbian, gay, bisexual, or pansexual than their non-autistic counterparts (Dewinter, De Graaf & Begeer, 2017; Postorino et al., 2018; Bush, 2019; Hillier et al., 2020; Pecora, Hooley, et al., 2020; Sala et al., 2020; Joyal et al., 2021; Maggio et al., 2022; García et al., 2023). To a similar extent, gender diversity outside the gender binary model is widespread among autistic populations from childhood and throughout life, probably more prevalent than in neurotypical populations (Strang, Janssen, et al., 2018; Stagg & Vincent, 2019; Sala et al., 2020; Corbett et al., 2023; García et al., 2023; Dewinter et al., 2024) while, in reverse, autism seems to be prevalent among gender non-conforming populations (Warrier *et al.*, 2020). Moreover, contrary to the first observations on cross-gender autistic boys in the '90s, autistic girls seem more likely to express opposite-sex "preferences, mannerisms, and appearances that fall outside of traditional gender norms" (Brunissen *et al.*, 2021). Similarly, a recent systematic review of how studies measure gender dysphoria/incongruence in autistic groups revealed that most



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findings reported a higher prevalence of relevant characteristics in this group compared to non-autistic control groups across all ages. However, the link may not be as strong as suggested due to weak validity and reliability of the majority of studies (Mears *et al.*, 2024). Nonetheless, a particular correlation between the two exists and needs further investigation (Sala et al., 2020).

In addition, several studies revealed that a small but significant group of autistic people, particularly assigned at birth females, was more likely to identify in the asexual spectrum in comparison with non-autistic control groups, reporting lower levels of sexual desire and lifetime sexual behaviours (Gilmour, Schalomon & Smith, 2012; George & Stokes, 2018; Bush, 2019; Hillier et al., 2020). Nonetheless, asexuality has substantial divergence and is not solely associated with a lack of sexual desire for others. For instance, some people may not be interested in developing sexual relationships with others but desire to have solo sex only or create intimate relationships, at times experiencing higher sexual satisfaction than non-asexual individuals (Bush, Williams & Mendes, 2021). However, scholars have highlighted that a decreased sexual desire might stem from previous overwhelming or adverse sexual experiences in some cases, as well as feelings of incompetence and low self-esteem (Gray, Kirby & Graham Holmes, 2021; Ronis et al., 2021). Additionally, other authors suggest that interpersonal and social challenges which are typical in autism may also be a contributing factor to asexuality, along with difficulties in defining their sexual identity (Attanasio *et al.*, 2022).

In general, autistic people often express uncertainty about their gender identity and sexual orientation, dissatisfaction with traditional gender roles and reduced motivation to comply with gender expectations. Some autistics repeatedly stated that “doing gender” was confusing and emotionally exhausting (Davidson & Tamas, 2016). Some found it difficult to fit their experiences into fixed labels on gender identity and sexual orientation identities (Griffin, Lombardo & Auyeung, 2016; Strang et al., 2018; Bush, 2019; Hillier et al., 2020; Lewis et al., 2021; Maggio et al., 2022). Additionally, in the study of Cooper, Smith & Russell (2018), autistic participants scored higher rates of gender incongruence but lower levels of gender identification



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(i.e., an individual's level of affiliation with and positive effect from a gender group) and gender self-esteem (i.e., whether a person views their gender group in a positive or negative way) compared to neurotypical participants. Similarly, in a qualitative study of how autistic adults experience gender dysphoria, participants reported significant feelings of distress since their bodies did not align with their gender identity, as well as due to limited social acceptance towards gender- and neurodiversity. Some reported difficulties, such as facing a dilemma between their need for medical transition and their need for consistency and routine. They also highlighted that they need further understanding of and strategies to manage complex intersectional identities and needs, in addition to improved healthcare access (Cooper *et al.*, 2022).

### 3.3. Explanatory Frameworks for Gender Diversity and Sexual Orientation in Autism

Overall, the underlying reasons why and how autistics display more commonly non-heteronormative sexual orientations and non-cisgender identities are still unclarified and debated, as is the case of explanatory frameworks of sexual and gender development across all human beings (Bailey *et al.*, 2016). Nonetheless, scholars have suggested some hypotheses. Although further research is necessary to understand the mechanisms behind gender and sexual diversity among autistics, current models advocate for a multivariate approach, considering a combination of factors to comprehend relevant research findings (van der Miesen *et al.*, 2018) and use a biopsychosocial and developmental framework to formulate issues of sexuality, gender and relationships (Sala *et al.*, 2020).

Biological theories have proposed that prenatal androgen exposure may influence the development of autistic traits and sexual orientation, meaning that higher levels of foetal testosterone could contribute to the expression of autistic traits, as well as an increased likelihood of developing same-sex attraction later in life (Sala *et al.*, 2020). This hypothesis is often linked to the "extreme male brain" (EMB) theory of autism, which posits that autism is associated with a hyper-masculinised cognitive and neural profile (Baron-Cohen, 2002). However, the evidence for this theory is mixed and



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debated in terms of its correlation with autism, with some studies supporting correlations between prenatal androgen exposure and autistic traits (Auyeung *et al.*, 2009), while others the complexity of neurodevelopmental pathways and the limitations of reducing autism to a single biological factor, the inconclusiveness of the available scientific results, as well as epistemological gender bias (i.e., the existence of gendered cognitive traits) and methodological limitations (Fine, 2013; Teatero & Netley, 2013; Ferri, Abel & Brodkin, 2018).

The concept of neural masculinisation has also been invoked to explain the higher rates of gender dysphoria observed among autistic individuals, particularly women. According to this model, increased prenatal androgen exposure may lead to the development of more “male-typical” neural and behavioural traits, which could contribute to a greater likelihood of identifying as male or experiencing gender dysphoria (Grimbos *et al.*, 2010). However, this theory has significant limitations. For instance, it does not adequately account for the high rates of gender dysphoria observed among autistic males (Sala *et al.*, 2020). Furthermore, the neural masculinisation model predicts that autistic men, due to their hypothesised hyper-masculinised brains, should exhibit lower rates of same-sex attraction. Contrary to this prediction, studies have found that autistic men report higher rates of homosexual or bisexual orientation compared to neurotypical men (Turner, Briken & Schöttle, 2017), challenging the assumption that prenatal androgen exposure uniformly influences sexual orientation in autistic individuals.

Gilmour, Schalomon & Smith (2012) have attempted to reconcile these findings by suggesting that prenatal testosterone may play a more significant role in the development of autism and same-sex attraction in females than in males. They speculate that while lower prenatal androgen levels in males are associated with higher rates of same-gender attraction, excessive prenatal testosterone in males may not necessarily correlate with reduced same-sex attraction. Additionally, they propose that same-gender attraction in both males and females might be associated with a hyper-masculinised brain. However, this hypothesis remains speculative and requires further empirical



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investigation, thus highlighting the complexity of the relationship between prenatal hormones, neurodevelopment, and sexual orientation and suggesting that different mechanisms may be at play in males and females (Gilmour, Schalomon & Smith, 2012).

From a psychological perspective, some suggest that core features of autism, such as stereotyped interests and cognitive rigidity, might lead to inflexible interpretations of gender roles (Jacobs *et al.*, 2014; van der Miesen *et al.*, 2018). Consequently, autistics might lack the cognitive flexibility needed to understand that gender roles can vary, potentially leading them to develop a transgender identity if their traits do not align with these stereotypes (Pecora, Hooley, *et al.*, 2020). Additionally, autistics might consider an individual's sex or gender identity less critical in choosing an intimate or sexual partner than non-autistics do (Turner, Briken, & Schöttle, 2017).

Psychosocial theories propose that difficulties in implicit social learning might explain greater gender diversity among autistics (Sala *et al.*, 2020), meaning that gender diversity is expected in autistics because social information influences less identity development (van Schalkwyk, 2018). Similarly, for the broader range of intimate and sexual orientations, it is hypothesised that autistics may act more independently from social norms and respond less in socially desirable ways in research settings (Strunz et al., 2017; Turner, Briken & Schöttle, 2017). In contrast, non-autistics, more concerned with social norms, might conform to societal expectations and suppress any non-heterosexual attraction, responding in more socially desirable ways in research settings (Gilmour, Schalomon & Smith, 2012). The study of Meston et al. (1998) partially supports this hypothesis, showing a significant negative correlation between self-reported same-sex sexual fantasies and social desirability among men, but not women.

From a distinct perspective, instead of focusing on autism's interference with gender identification from a deficiency perspective, their intersection could provide novel insights into what it means to be both autistic and gender non-conforming (Garcia, 2021, p. 167). Indeed, autistic individuals tend to be less susceptible to social conditioning and do not instinctively



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absorb social norms. As a result, they may feel less pressure to conform to societal expectations, allowing them to explore gender identities more freely than neurotypical individuals (Ehrensaft, 2018; Cooper *et al.*, 2023). However, instead of questioning the autistic individual concerned about their gender identity, there is an opportunity to reflect on what gender really is. Jack (2012) stated that "due both to their ability to denaturalise social norms and to their neurological differences, autistic individuals can offer novel insights into gender as a social process. Examining gender from an autistic perspective highlights some elements as socially constructed that may otherwise seem natural and supports an understanding of gender as fluid and multidimensional".

### 3.4. Intersectional Minority Status

An essential factor to consider when addressing LGBTQIA+ autistics is the potential impact of their intersectional minority status (Maggio *et al.*, 2022). Many autistics that are not cisgender or heterosexual have been variously prevented from living a life with authenticity and dignity, face multiple societal barriers (ASAN, NCTE & LGBTQ Task Force, 2016) and increased unmet care needs. Being autistic and being LGBTQIA+ certainly each has their challenges, yet people belonging to these groups share a great deal of stigmatisation, invalidation, discrimination and systematic exclusion (e.g., in employment, housing, education, and healthcare), grounded, among others, on stereotypes about what it means to be autistic and/or sexually and gender diverse (Brooks, 2015).

They also have a similar "therapeutic" history, given that both some autistic and LGBTQIA+ individuals have been subjected to normalising interventions that aimed at eliminating their "undesirable" traits, such as Applied Behavioural Analysis (ABA) and conversion therapy, respectively. Both "therapeutic" frameworks have been criticised or questioned the least by autistic self-advocates and queer disability theorists for being ineffective and unaligned with clinical ethical duties since they suppress or disregard individual needs, desires, and inner experiences, further causing harm to the



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individuals (Glaves & Kolman, 2023). At the same time, both groups, in many cases, are denied access to transition-related and gender-affirming healthcare services (Garcia, 2021; Grove et al., 2023), or face restrictions in their decision-making power over their bodies through mechanisms such as institutionalisation or legal guardianship (ASAN, NCTE & LGBTQ Task Force, 2016).

Many autistic LGBTQIA+ individuals struggle to find acceptance within either neurotypical LGBTQIA+ spaces or mainstream autistic communities, along with other social spaces, both of which may not fully understand their unique understandings, experiences, and needs. Not only autistic LGBTQIA+ people often have to face a particularly challenging dual coming out process (Dewinter, De Graaf & Begeer, 2017; Dewinter, van der Miesen & Holmes, 2020), but as Hillier et al. (2020) indicate, there are instances when professionals, family members or even members of autistic and LGBTQ+ communities invalidate their self-identification and inner experiences. They explain that this invalidation might stem from misconceptions related to the relationship between autism and sexual and gender diversity, as well as to stereotypes and misconceptions on what autism, gender and sexuality stand for separately.

For instance, scholars and clinicians often assume that gender diversity and gender dysphoria/incongruence among autistic people is a rare phenomenon or question its genuineness by perceiving it as a temporary special interest or obsession or an experience of identity confusion related to social struggles. Thus, they assume that when autistics express concerns about their gender, these concerns result from autistic traits or co-occurring mental health disorders, such as Obsessive Compulsive Disorder (OCD) (Glaves and Kolman, 2023). The perceived “severity” of autism or the intellectual disability can further exacerbate this issue while triggering over-protective attitudes (Rushbrooke, Murray & Townsend, 2014; Dewinter et al., 2016; Hillier et al., 2020).

However, in a recent qualitative study, autistic gender-diverse participants highlighted the importance of accessing communities relevant to



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their identities to increase their self-understanding and self-acceptance (McAuliffe, Walsh & Cage, 2023). Challenging false assumptions is also critical for choosing the most effective clinical pathway for autistic gender-diverse people. For instance, treating gender dysphoria as a symptom of OCD and thus focusing on treating OCD causes and symptoms seems to be insufficient in reducing concerns and needs related to gender identity (Glaves & Kolman, 2023).

This dual minority position may further negatively affect autistics' mental and physical health through various pathways, including by facing increased levels of minority stress. Minority stress refers to chronic stress that minority populations experience due to environments that perpetuate observable, expected or internalised stressors such as stigma, prejudice, social disadvantage, harassment, discrimination and victimisation (Meyer, 2003; Botha and Frost, 2020; Kung, 2024). Under the same context, both LBGTQIA+ and autistic people from childhood are more frequently exposed to traumatic (i.e., stressful, frightening or dangerous) events, which results in adverse and persisting physical and emotional responses, internalising issues, impaired cognitive functioning and polyvictimisation (Torralbas-Ortega et al., 2023; Cooke et al., 2024; Di Marco et al., 2025).

For example, in the study of (George & Stokes, 2018) autistic individuals belonging to sexual and gender minorities exhibited poorer mental health outcomes (depression, anxiety and stress) compared to heterosexual autistics and non-autistic participants. Furthermore, as minority group membership became increasingly restrictive, mental health levels deteriorated further. Likewise, Pecora, Hooley, et al. (2020) corroborated these findings, showing that sexually and gender-diverse autistics experienced higher rates of internalising conditions, such as isolation, anxiety, and depression, compared to heterosexual autistics and neurotypicals, similar to other research findings (Sumia & Kaltiala, 2021). Moreover, Sumia & Kaltiala (2021), as well as Strauss and colleagues (2021), concluded that gender-diverse autistic adolescents and youth were more prone to self-harm, suicidality, psychotic episodes or receiving other psychiatric diagnoses than



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non-autistic adolescents with gender dysphoria. It also highlighted that masking strategies, used as coping mechanisms against stigma and other adverse behaviours by both many autistic people and LGBTQIA+ individuals, can trigger adverse health effects, such as burn-out and Prolonged Adaptation Stress Syndrome (Pearson & Rose, 2021).

## 4. Good Practices

As understanding of autism, sexual orientation, and gender identity continues to evolve, mental health professionals must adopt informed, supportive and inclusive practices that respect the diverse experiences of all autistic individuals. Autistic people with diverse sexual orientations and gender identities often face unique experiences, both in navigating their identities and seeking acceptance in society. However, they also share many of the exact needs and aspirations as other autistics, such as desires for intimate relationships, parenthood, fulfilment in social and intimate interactions. The literature search and findings, reveal several good practices for mental health professionals seeking to offer comprehensive support.

### Providing Gender-sensitive, Comprehensive and Adaptable Sexual Education

Autistic people have the same need for sex education to develop healthy sexuality throughout their life course as any other human being. However, many of them may have fewer opportunities to explore their gender identity and sexuality (van Schalkwyk, Klingensmith & Volkmar, 2015), experience social barriers that prevent them from receiving adequate sex education and developing knowledge and skills vital for their psychosexual functioning and sexual well-being (Hellemans et al., 2007; Dewinter et al., 2013; Hannah & Stagg, 2016), and may rely solely on online and media sources of questionable credibility and reliability to learn about sexuality (Brown-Lavoie, Viecili & Weiss, 2014).



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In the meantime, both professionals and caregivers of autistics, especially of autistic children and adolescents, have reported several challenges in providing sexual education and support (Holmes, Himle & Strassberg, 2016; Hancock, Stokes & Mesibov, 2017). While there is stronger awareness of sexuality and gender diversity among these populations, many counsellors and service providers remain at a loss regarding appropriate advice, guidance, and interventions (Hillier *et al.*, 2020).

Under the influence of their formal education, socio-political viewpoints, religious and moral beliefs on both autism and sexuality (Deffew *et al.*, 2022; Torralbas-Ortega *et al.*, 2023), caregivers and service providers might avoid getting involved in issues that are confusing or tabooed (Schaafsma *et al.*, 2017; Deffew *et al.*, 2022; Torralbas-Ortega *et al.*, 2023). Over-protective and restrictive attitudes and behaviours that can emerge due to similar reasons or in fear of legal and ethical considerations can further limit autistics' opportunities to explore independently or with others their sexuality and gender identity (McGuire & Bayley, 2011; van Schalkwyk, Klingensmith & Volkmar, 2015). A systematic review on the communication of sexuality between parents and autistic adolescents (André *et al.*, 2020), revealed that parents tend to over-emphasise issues of sexual abuse and hygiene and least communicate topics such as masturbation, sexual intercourse, use of condoms, pregnancy and menstruation, and sexually transmitted diseases (STDs). Many of them believe that their children, especially if they display "low intellectual functioning", are unlikely to have sexual and affective experiences, and even more to create their own families (André *et al.*, 2020).

A comprehensive sexual education for autistics needs to cover a wide range of topics and follow a pleasure-based approach to sexual education (Ford *et al.*, 2021), which includes not only sexual mechanics, function, and safety from unwanted outcomes, but also ways to navigate sexual and intimate relationships in all stages (e.g., socio-emotional skills, flirting, dating, breakup, and marriage) and circumstances (e.g., public-private, and physical-online). Following this process, autistic people should receive support to explore, identify and express their own and their partners' sexual needs,



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preferences and boundaries, as well as their sexual and gender identity, to communicate and manage relevant difficulties, and to critically engage with socio-cultural norms (Beato, Sarmento & Correia, 2024).

Autism-adapted sex education should deal with challenges in communication and social thinking, complex information processing and understanding, or sensory experiences during physical touch (Torralbas-Ortega *et al.*, 2024). Professionals should tailor sexual education to meet the communication needs and learning styles of their autistic beneficiaries, ensuring that they present the material in straightforward, structured ways that allow for deeper understanding (Hartmann *et al.*, 2019). It is essential to provide multiple sessions and follow-ups to reinforce learning and help autistics apply what they have learned in their own lives while providing support throughout the process (Schaafsma *et al.*, 2017; Grove *et al.*, 2023). Finally, it can be beneficial to involve autistics as trainers in the sexual education programmes, or include parents and caregivers of autistics, especially children and adolescents, as trainees (in separate sessions) and allies.

**Table 2: Good practices and useful resources on sexual education for autistic communities**

| Type | Source | Content |
|---|---|---|
| **Scientific article** | Ragaglia, Caputi & Bulgarelli (2023) Psychosexual Education Interventions for Autistic Youth and Adults—A Systematic Review | Systematic review on the psycho-educational interventions on sexuality for autistic people. Core characteristics of these programs are discussed. Good practices were applied in the studies, but no intervention had proven effectiveness in increasing both psychosexual knowledge and appropriate sexual behaviours. |
| **Guideline** | WHO & BZgA (2017) Training matters: A framework for core | Competencies framework developed to support the development and implementation of educational programs for sexuality trainers. It covers areas such |



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| | competencies of sexuality educators | as attitudes, skills and knowledge, and entails good practices from other countries of the WHO European Region. |
| **Guideline** | UNESCO (2018) International technical guidance on sexuality education: An evidence-informed approach | Technical guidance on comprehensive sexuality education (CSE) for education, health and other authorities and stakeholders, targeting children and adolescents inside and outside of school environments. |
| **Guideline & other resources** | WHO (2019) QualityRights materials for training, guidance and transformation | Package of training and guidance materials, developed to build capacity among mental health practitioners, people with psychosocial, intellectual and cognitive disabilities, families and other stakeholders. It covers topics such as human rights, legal capacity and decision-making, recovery, freedom from coercion, violence and abuse, peer support, transforming services and others. |
| **Guideline & other resources** | National Autistic Society (2024) Sex education - a guide for parents | Sex education guide for parents of autistic children. It provides recommendations on potential issues to be covered and useful resources. |
| **Guideline & other resources** | CAST (2024) The UDL Guidelines | Tool for educators, curriculum developers, parents and others to implement the “Universal Design for Learning” framework through a set of concrete suggestions. This framework aims to ensure that all learners, with or without disabilities, enjoy access and participation in quality and meaningful education. |
| **Image Bank** | Santé BD (2024) La Banque d’images | Image bank for health professionals and others to communicate health issues, including emotional and sexual life. |



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| **Scientific article** | Dubreucq & Dubreucq (2021) Toward a Gender-Sensitive Approach of Psychiatric Rehabilitation in Autism Spectrum Disorder (ASD): A Systematic Review of Women Needs in the Domains of Intimate Relationships and Reproductive Health | Systematic review on the needs of autistic women in romantic relationships and reproductive health. It includes a table of interventions on sexuality and romantic relationships. |
| **Tips** | Galindo (2022) Circles of Sexuality: Creating Inclusive, Comprehensive Sex Education for Autistic Students | Framework for developing or choosing sex education curricula for neurotypical and autistic students. It identifies six topic areas to be included in a relevant curriculum, including sexual health and reproduction, sexual identity, intimacy, sensuality, sexualisation and values. |
| **Guideline** | Poulin (2021) Éducation à la sexualité: prendre en considération certaines caractéristiques des jeunes autistes | Reflection guide for professionals who accompany or undertake sexuality education interventions that include the needs of autistic youth. It covers various cases that might emerge during relevant interventions, in each of which professionals are invited to reflect on their level of comfort in these situations and advice is provide. |
| **Thesis** | Ballor (2021) Teaching Individuals with Autism to Identify Dangerous Online Dating Behaviors | Study assessing the effectiveness of video modeling as a method to identify warning behaviours and remediate risk factors in online dating for autistic adults. |



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| **Guideline** | CEREBRA (2022) Learning Disabilities, Autism and Internet Safety: A guide for parents | Guide for parents and carers of autistic children and children with learning disabilities, aiming at limiting risks on adverse online experience and making the use of the internet more beneficial. It includes suggestions and case studies. |
| **Multiple resources** | Seattle Children's (2024) Puberty and Sexuality Education Resources for Youth with Autism | Resources related to the sexuality of autistic adolescents. It includes books, school curricula, toolkits and websites, as well as videos. |
| **Tips** | irl (2023) Let's Talk About Consent: Sex Ed for Teens and Young Adults | Article that provides tips to parents of autistic adolescents related to asking and providing sexual consent. |
| **Tips** | irl (2023) Top 10 Dating Tips for Autistic Teens and Young Adults | Article that provides dating tips for parents of autistic children, autistic adolescents, young adults, and adults taking their first dating steps. It aims to make dating more pleasant, successful and safe for autistic people. |
| **Videos & other resources** | OAR (2024) Sex Ed for Self-Advocates | Sexuality education guide for autistic people aged 15 and over. It consists of 9 modules, each consisting of subtopics and relevant articles and audio-visual material. Additional resources are provided as well. The modules cover the themes: public vs private, puberty and the body, healthy relationships, consent, dating, sexual orientation and gender identity, values and sex for the first time, sexual activity, online relationships and safety. |
| **Videos & other resources** | Advocates for Youth, Answer & Youth Tech Health (2024) amaze | Educational videos and other useful materials for children, young adults, parents and educators that provide positive, comprehensive, accurate and engaging information about sexuality. |



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| **Image bank** | Rinnekoti (2017a; b; c; d) TYÖKALUJA SELKEÄÄN SEKSUAALITERVEYSKASVATUKSEEN | Image bank for professionals and carers of people with disabilities covering sexuality topics. |
| **Webpage** | Yle (2019) Pikku Kakkosessa annetaan kaikille kehon osille nimi ja opetellaan uimapukusääntö | Guide for children's body language education. It covers practicing common behaviours and learning rights and supports positive body image. It includes videos and other materials. |
| **Guideline** | Ilmonen et al. (2024) Seksuaalioikeudet | Guidance which provides a comprehensive picture on sexual rights for professionals and others. |
| **Training toolkit** | GAB (2018) Sexual Pleasure: The Forgotten Link in Sexual and Reproductive Health and Rights | Toolkit designed for health professionals, including social workers, psychologists, and other service providers working in sexual and reproductive health. It is also intended for trainers and facilitators who conduct workshops or training sessions. It is particularly useful for those who want to adopt a sex-positive approach in their practice, focusing on the positive aspects of sexuality and pleasure, rather than solely on the risks and negative outcomes of sexual behavior.<br><br>Key findings include:<br>• shift from risk to pleasure approach (shift towards a pleasure-based approach, which acknowledges that people engage in sexual activity for reasons such as intimacy, love, and pleasure, not just reproduction or risk, which can improve sexual health outcomes by promoting open communication, consent, and safer sex practices),<br>• sexual pleasure as a human right (exercised within the framework of sexual rights, including equality, |



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non-discrimination, autonomy, and bodily integrity, professionals are encouraged to help clients explore their sexual desires and pleasures in a safe, consensual, and non-judgmental environment),

- practical tools for professionals (practical modules for training, including exercises, case studies, and tools like the Pleasuremeter, which helps professionals assess the links between sexual health, rights, and pleasure during sexual history taking, while offering guidance on how to discuss sensitive topics like sexual pleasure, consent, and sexual diversity with clients, even in conservative or faith-based contexts),
- addressing stigma and taboos (professionals are encouraged to create a safe and non-judgmental space for clients to discuss their sexual concerns and experiences),
- cultural and religious sensitivity (strategies for professionals to navigate these sensitivities while still promoting sexual health and rights, emphasising also the importance of respecting clients' values and beliefs while also providing accurate, non-judgmental information,
- empowering clients (by incorporating discussions of sexual pleasure, professionals can empower clients to make informed, autonomous decisions about their sexual health and relationships, while helping clients explore their bodies, communicate with partners, and negotiate safer sex practices, all of which contribute to improved sexual wellbeing).



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| **Training program** | Brick Exchange (2025b) Sexual and Reproductive Health and Rights | Online training for health and care professionals on sexual and reproductive health and rights. The training structure consists of:<br>• introduction, sexual orientation, gender expression and gender identity,<br>• sexual function and satisfaction,<br>• taking a sexual history,<br>• family planning, infertility and preconception,<br>• safe abortion<br>• gender-based violence<br>bodies, communicate with partners, and negotiate safer sex practices, all of which contribute to improved sexual wellbeing). |
| **Training program** | Brick Exchange (2025a) Reproductive | Online training for health and care professionals on the reproductive system. The training structure consists of:<br>• normal reproductive system (structure and function of the female and male reproductive systems, physiology of sexuality, including sexual maturation)<br>• disorders of the reproductive systems<br>• pregnancy, growth and development |

**Fostering an Affirming and Inclusive Environment**

One of the foundational practices for health and care professionals working with autistic LGBTQIA+ beneficiaries is creating an affirming, respecting, validating and inclusive environment. Many individuals who are both autistic and LGBTQIA+ experience intersectional discrimination, as societal norms often invalidate their gender and sexual identities or attribute



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their experiences of gender and sexuality to their autism. Studies show that such individuals frequently face isolation, not only from neurotypical LGBTQ+ communities but also from autism communities, because of misunderstandings or rejection of their non-normative or typical identities (Hillier *et al.*, 2020).

Sexual and gender diverse autistic beneficiaries should feel safe to explore and express their whole selves without judgement by recognising and affirming their sexual and gender identities without treating autism as a factor that diminishes their capacity to understand or express these identities. As discussed by Hillier et al. (2020), rejecting the notion that autism inherently impairs (normative) gender identification and sexual understanding is essential in avoiding the common pitfall of invalidating their experiences. Autistics must be treated as complete individuals whose identities are integral to their self-perception (Garcia, 2021), and care should be tailored to their experiences and needs. However, a recent scoping review of clinical guidelines for the care of autistic gender-diverse people (Bo et al., 2024) concluded that among the guidance found, there are no available detailed and practical recommendations for clinical practice targeting specifically this group, possibly lacking further evidence-base in the field and gender care more broadly.

**Table 3: Good practices and useful resources on fostering an affirming and inclusive environment for LGBTQIA+ autistic communities**

| Type | Source | Content |
|---|---|---|
| **Scientific article & Guideline** | Strang et al. (2021) A Clinical Program for Transgender and Gender-Diverse Neurodiverse/Autistic Adolescents Developed through Community- | Article that describes the process of developing a clinical support program (Strang, Meagher, *et al.*, 2018; Strang *et al.*, 2020) for therapists, clinicians, and support providers working with autistic and gender-diverse youth using community-based participatory design. This structured group-based support program is the most comprehensive clinical |



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| Based Participatory Design | guidance for gender-diverse autistics to date (Bo et al., 2024) and contains recommended reasonable accommodations and adapted therapeutic strategies and methods for safe gender exploration.<br><br>11 clinical techniques resulted from a needs assessment, including:<br><br>• providing opportunities to practice gender expression skills and style (e.g., choose voice tone, make-up and clothing),<br>• providing a safe group environment for exploring gender styles (e.g., try new pronouns if they want),<br>• inviting gender- and neuro-diverse social role models displaying different stories and possibilities,<br>• clearly embrace all gender identities, including fluid identities,<br>• adopting a flexible mindset about gender,<br>• individualising consultations on medical gender treatments,<br>• providing training on social and executive function skills, such as flexibility, organization, and social interactions,<br>• investing in future planning and independent living skills to prepare for adulthood,<br>• exploring the strengths and challenges of being both gender- and neuro-diverse,<br>• providing safety strategies and advocacy skills (e.g., awareness of unsafe situations, gender expression in public spaces, identifying trustworthy people),<br>• providing opportunities for peer socialisation through structured and informal opportunities. |



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| | | The importance of providing separate and parallel parent support groups is highlighted as well of promoting a shared understanding, reduce conflicts and improve family support. |
| **Guideline** | National LGBT Health Education Center (2020) Neurodiversity & gender diverse youth: an affirming approach to care | It extends the recommendations developed by Strang, Meagher, and colleagues (2018) by providing a more practical steps and principles to guide clinicians in their conversations with gender diverse autistic individuals (Bo et al., 2024). |
| **Checklist & other resources** | I can network (2021) Checklist of good practices for service providers working with autistic LGBTIQA+ young people | Checklist of signals for fostering the inclusiveness of support services for autistic LGBTQIA+ youth. It includes general recommendations related to services' staff, including administrative staff, procedures and physical environment. Additional resources are provided. |
| **Guideline** | Coleman et al. (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 | Comprehensive guideline for overall gender-related care for health and care professionals developed by the World Professional Association for Transgender Health (WPATH). Topics related to autism and gender diversity intersection prevail in the sections pertaining to children and adolescents, and only very briefly in the adults' section (Bo et al., 2024). |
| **Guideline** | The Trevor Project (2024) Supporting LGBTQ+ Young People with Disabilities | General guide for supporting LGBTQIA+ youth with disabilities, including autistic LGBTQIA+ youth. |
| **Guidelines** | LGBT Foundation (2024) Best practice Model for working with | Best practice guide which offers recommendations for organizations and professionals working with autistic and neurodiverse individuals within LGBTQ+ |



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| LGBTQ+ communities who are also autistic and/or neurodiverse | communities. It provides concrete strategies for designing LGBTQ+ and neurodiverse-inclusive services, emphasizing the importance of coproduction, representation, flexibility, and safety in service delivery .<br><br>Key practices include:<br><br>• coproduction (services should be co-designed with the community (lived experiences), rather than imposed on them, and professionals should ensure diverse engagement methods (e.g., focus groups, surveys, one-on-one feedback),<br>• representation and Inclusivity (include autistic and neurodiverse LGBTQ+ individuals in leadership and facilitation roles, and cultural competence training should be prioritized to enhance awareness of intersectional barriers faced by neurodiverse LGBTQ+ individuals),<br>• flexibility and accessibility (offer multiple modes of engagement (in-person, online, hybrid), alternative communication methods (written, verbal, visual aids), adjustments for sensory sensitivities, including quiet spaces and sensory-friendly materials),<br>• consistency and structure (regular schedules, familiar facilitators, and structured sessions that help build trust, clear, advanced communication about session content reduces anxiety for participants, avoid last-minute changes or cancellations, as routine is essential),<br>• safety and trauma-informed practices (safe spaces should be established with clear guidelines on respect and inclusion, staff and volunteers should |



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| | | be trained in safeguarding, mental capacity awareness, and trauma-informed care, sensory-friendly safe spaces should be available for individuals who may need quiet environments),<br>• person-centred and strength-based approaches (recognize individual strengths rather than focusing on deficits, support autonomy and empower individuals in decision-making about their care, avoid one-size-fits-all approaches). |
| **Guideline** | Dartmouth Health Children's (2024) Self-care guide for LGBTQIA2S+ and BIPOC youth | A self-care guide to support LGBTQIA2S+ and BIPOC youth, including self-assessment tips, as well as self-care strategies, activities, support and other relevant resources. |
| **Guideline** | EASPD (2020) I-DECIDE Project Supported Decision Making materials | An ERASMUS+ funded project which developed materials for professionals working with people with intellectual and other disabilities, aiming to support them in free and informed decision-making in finances, consumer rights and healthcare. |

**Providing Culturally Competent and Trauma-Informed Care**

Many autistic people, especially LGBTQIA+ autistics, experience a higher risk of intersectional discrimination and stigmatisation, violence and abuse, resulting in increased levels of trauma, depression, anxiety, and other mental health issues (George & Stokes, 2018; Sumia & Kaltiala, 2021). This dual/multiple minority stress, as well, arising from both their autism and their LGBTQ+ identity at least, often leads to compounded mental health issues. Professionals should adopt a trauma-informed approach, recognising the potential effects of this intersectional marginalisation on the individual's emotional well-being. Many of them also face exclusion from healthcare



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systems or receive inappropriate care that fails to respect both their neurodiversity and their LGBTQ+ identity. As noted in the literature, these individuals often experience negative healthcare interactions, such as being misgendered, subjected to invasive questioning, or overlooked entirely (Torralbas-Ortega *et al.*, 2023).

To mitigate these risks, mental health professionals must provide trauma-informed care that recognises the compounded social marginalisation these individuals face. Trauma-informed care includes acknowledging the unique emotional burdens of living with intersecting minority identities and promoting emotional safety, trust, and empowerment in therapeutic relationships. To this end, they should foster an inclusive and supportive environment by actively working to educate themselves about the unique experiences of autistic LGBTQ+ individuals, implementing affirmative therapy techniques that are both sensitive to neurodivergence and inclusive of gender and sexual diversity, recognising the impact of minority stress and advocating for resources and support systems that address both neurodivergent and LGBTQ+ needs (Strang, Meagher, *et al.*, 2018).

**Table 4: Good practices and resources on culturally competent and trauma-informed care**

| Type | Source | Content |
|---|---|---|
| **Manual** | SAMHSA (2014) SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach | Framework for understanding trauma and guidance on implementing a trauma-informed approach in various service settings. The guide presents strategies to recognize, respond to, and resist re-traumatization in healthcare, social services, education, criminal justice, and other systems. |
| **Scientific article** | Sternberg et al. (2024) Project ATTAIN: Advancing Trauma-Informed Care for Youth | Article on the development of the ATTAIN project, an ongoing initiative targeting at closing the gap in trauma care for youth at the intersection of neurodiversity and gender diversity. Among else, it |



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| | with Intellectual and Developmental Disabilities and/or Gender Diverse Youth | includes training for professionals on trauma-informed, disability-informed, and LGBTQ+-informed practices, as well as screening and assessment tools to identify trauma, PTSD, and quality of life concerns in youth with IDD and/or gender diversity. |
| **Thesis** | McCafferty (2022) A Delphi Survey on the Implementation of Trauma-Informed Care Techniques for Autistic Children | Thesis proposing several new trauma-informed care techniques for therapists specifically designed for autistic children. Some of the key techniques include:<br>• prioritising beneficiary's autonomy and consent through verbal cues as well as by observing the child's mood, behaviour, and willingness to engage,<br>• encouraging self-determination, choice, collaboration, and shared governance in therapy,<br>• avoiding compliance-based interventions that force autistic children to conform to neurotypical behaviours,<br>• providing culturally sensitive alternatives (e.g., alternative communication techniques),<br>• reducing trauma triggers (e.g., unnecessary restriction of movement),<br>• using Enhanced Milieu Teaching (EMT) adaptations (e.g., mirroring and expanding on the child's natural expressions, ensuring a safe, play-based learning environment),<br>• incorporating protest as a valid communication skill and goal (e.g., using AAC devices to indicate "no", learning to gesture or verbally refuse activities),<br>• monitoring emotional responses and adjust interventions if distress is detected (e.g., anxiety, avoidance, aggressive behavior), |



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| | | • developing trauma screening strategies, lacking standardized trauma screening tools for autistic children (including, e.g., increased rigidity and avoidance instead of typical PTSD symptoms, sudden loss of previously acquired skills). |
| **Guideline** | NICE (2014) Domestic violence and abuse: multi-agency working | Guideline on planning and providing multi-agency services for identifying, preventing and responding to domestic violence and abuse among women and men in heterosexual or same-sex relationships, and youth. It targets health and social care professionals, providers and other stakeholders, and includes recommendations for ensuring inclusive and accessible services for marginalised groups. |
| **Tip** | Trauma Informed Oregon (2021) Providing Trauma Informed Care to Autistic Adults | Tips for the provision of trauma informed care to autistic adults with intersectional marginalised identities. |

**Promoting Self-Understanding, Self-Acceptance and Autonomy**

Many autistic LGBTQ+ individuals struggle with self-acceptance and confusion about their identities (Davidson & Tamas, 2016). For some, the complex societal constructs around gender and sexuality may feel alienating, further complicated by societal biases and discrimination against autism (Garcia, 2021). Mental health professionals can play a vital role in fostering self-understanding by supporting beneficiaries in exploring their identities at their own pace in a non-judgmental space without imposing rigid labels. Professionals should integrate discussions of neurodiversity with conversations about gender diversity, helping autistics to understand better how autism influences their gender and sexual experiences, and vice-versa.



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Professionals must also promote the autonomy of their clients, encouraging them to define their own identities at their own pace and helping them navigate any external pressure to conform to societal expectations. It is important to support autistic people in living their lives as their true selves (Grove *et al.*, 2023). Supported-decision processes could further promote the autonomy of autistics with more support needs. Furthermore, autistic beneficiaries should be included in all stages of an intervention on their sexuality.

**Encouraging Engagement in LGBTQ+ and Autistic Peer Networks**

Social isolation is a common challenge for autistic individuals, particularly those who identify as LGBTQIA+. Many struggle to find acceptance within either neurotypical LGBTQIA+ spaces or mainstream autistic communities, along with other social spaces, both of which may not fully understand their unique understandings, experiences, and needs (McAuliffe, Walsh & Cage, 2023). Peer support groups, whether online or in-person, can be a powerful tool for fostering connection and belonging since they provide safe spaces where autistics can explore their identities, build relationships, and find emotional support from those with shared experiences (Schaafsma *et al.*, 2017). Peer support networks can also serve as a platform for self-advocacy, empowering individuals to challenge discriminatory practices in both autistic and LGBTQ+ spaces. Additionally, autistic community solidarity can have a positive effect on autistics' perceptions of autism and mental health while decreasing social anxiety (Cooper *et al.*, 2023).

Encouraging beneficiaries to engage with peer support networks explicitly designed for autistic LGBTQIA+ individuals is essential. Connecting beneficiaries with online communities, local support groups, or organisations that embrace neurodiversity and LGBTQ+ inclusion can significantly enhance their sense of belonging and self-acceptance (ASAN, NCTE & LGBTQ Task Force, 2016). In case of limited availability, professionals can support the development of social networks that help autistics engage in intimate and sexual relationships, offering practical guidance for navigating these



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interactions in ways that feel safe and comfortable (Torralbas-Ortega *et al.*, 2023).



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