FROM CONVERSION TO COMPLIANCE

ABA, Conversion Therapy, and the Harm of Normalization

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EXECUTIVE SUMMARY

Pride Month is a celebration, a memory, and a refusal of pathologization and cure. LGBTQ+ people have long been told that their identities, desires, relationships, and gender expressions should be corrected, suppressed, or made acceptable to dominant norms. Autistic people have faced a similar demand to move, communicate, play, relate, and respond in ways that appear more "normal," more compliant, and less visibly deviant.

Applied Behavior Analysis (ABA) and LGBTQ+ conversion therapy are connected through overlapping histories, shared behavior-modification methods, and a common normalizing pressure. The historical record shows their direct connection through colleagues Ole Ivar Lovaas, a central figure in Autism-focused ABA, and George Rekers, a psychologist associated with anti-LGBTQ+ conversion efforts. Their 1974 study used behavioral methods to punish and extinguish "feminine-coded behavior" in a young child, a practice now widely understood as part of the history of gender-expression conversion therapy [1].

This overlap is not only historical. Research consistently finds that Autistic people are more likely than non-autistic people to report LGBTQ+ identities, including diverse sexual orientations and gender identities. Transgender and gender-diverse people are also more likely than cisgender people to be Autistic or report elevated Autistic traits. This means that queer, trans, gender-diverse, Two-Spirit, and Autistic people are not separate populations in this discussion. Many people live at the intersection of both.

The evidence against LGBTQ+ conversion therapy is clear. Conversion therapy is ineffective, unethical, and associated with psychological distress, shame, depression, suicidality, and trauma [2-8]. The evidence around ABA is more contested, largely because many ABA studies measure behavior change rather than wellbeing, autonomy, assent, masking, trauma, or the perspectives of Autistic people themselves. When Autistic (#ActuallyAutistic) people are centered, the ethical problem becomes clear. ABA rewards compliance, punishes refusal, suppresses Autistic traits, and treats Autistic embodiment as a problem to be corrected.

Both conversion therapy and ABA are harmful practices rooted in changing marginalized people to fit dominant expectations rather than transforming environments to support them. This hits especially hard for queer, trans, gender-diverse, Two-Spirit, nonspeaking, multiply disabled, racialized, and otherwise marginalized Autistic people, whose lives sit at the intersection of cure, compliance, and normalization.

The future of care must be survivor-led, neurodiversity-affirming, trauma-informed, consent-based, disability justice-informed, and grounded in self-determination.

FRAMING THE ISSUE

This brief begins during Pride Month, at a moment when LGBTQ+ people, trans and gender-diverse people, disabled people, and Autistic people are facing renewed political and social attack. Gender-affirming care is being restricted and criminalized. LGBTQ+ identities are being framed as threats. Autistic and disabled people continue to be pressured to prove their worth through compliance, productivity, and manageability.

Against this backdrop, Pride cannot be reduced to celebration. Pride is also a refusal. It is a refusal of cure, shame, disappearance, and forced normalcy. At the core of our argument is a simple premise: marginalized people should not have to become less visible, less disruptive, less queer, less trans, less disabled, or less Autistic in order to be treated as fully human.

Conversion therapy and ABA are often discussed as if they are entirely separate issues. However, they share a painful and underrecognized history. Both have been used to correct people whose identities, bodies, communication, movements, desires, or ways of relating were treated as unacceptable. Both have treated difference as something to manage, suppress, redirect, or extinguish.

For LGBTQ+ People, Conversion Therapy Says:

How you love, desire, identify, and express yourself is wrong, and you must change.

For Autistic People, ABA Says:

How you move, communicate, play, resist, and relate is wrong, and you must change.

The central question is not whether professionals can produce behavioral change. Rather, it is whether marginalized people should be changed to make dominant institutions more comfortable. A behavior can be changed and still be harmful. A person can appear more compliant while becoming less safe, less expressive, and less able to advocate for themselves. In this way, both conversion therapy and ABA are disabling forces.

The shared harm is normalization, that is the demand that marginalized people become easier for existing systems to tolerate. Conversion therapy and ABA show how care becomes control when the goal is cure, compliance, and control. A Pride-centered disability justice framework demands a different approach. We argue that LGBTQ+ people and Autistic people do not need conversion, correction, or compliance training. They need safety, access, affirmation, communication rights, bodily autonomy, community, and self-determination.

Pride is the right to exist.

DEFINING THE TERMS

Conversion therapy refers to practices that attempt to change, suppress, or redirect a person's sexual orientation, gender identity, or gender expression. Contemporary scholarship often uses the broader term **SOGIECE**, or sexual orientation, gender identity, and expression change efforts, because these practices do not occur only in formal therapy. They can occur in counseling, religious ministries, family settings, schools, camps, residential programs, peer groups, and informal community environments.

SOGIECE is not limited to attempts to make someone heterosexual. It can also include efforts to suppress gender nonconformity, discourage transition, enforce cisgender identity, or make a young person appear more conventionally masculine or feminine. Survivor-centered research shows that these practices are often embedded in broader systems of shame, isolation, religious coercion, family rejection, and institutional control [9, 10].

Applied Behavior Analysis (ABA) is often described by its defenders as a neutral science of behavior. However, impacted communities rarely encounter ABA as neutral or scientific. They encounter it as an Autism intervention industry whereby adult-directed, data-driven behavior modification is delivered in homes, clinics, schools, and institutions, often for many hours per week.

ABA seeks to increase compliance, reduce Autistic traits, normalize communication, suppress stimming, enforce eye contact, train masking, reduce refusal, or make Autistic people appear more neurotypical. Such practices have been described by Autistic self-advocates as torture. It is important to appreciate that Autistic people are not rejecting communication access, safety, AAC, sensory support, trauma-informed care, or help with distress. The objection is to interventions that treat Autistic ways of being as problems to extinguish.

This brief will use the term **normalization-based intervention** to refer to practices that treat marginalized identity, embodiment, communication, movement, desire, expression, refusal, or distress as problems to be corrected. This term names how such practices have been used to shift responsibility onto the person being targeted rather than requiring environments, systems, services, and communities to become safer, more accessible, and more affirming.

Coercive normalization refers to the process by which therapy, care, education, discipline, or treatment pressures a person to suppress stigmatized parts of themselves in order to satisfy dominant norms. Coercion does not always look like force, violence, or explicit punishment. It can also appear as rewards, praise, access to breaks, approval, affection, safety, family belonging, or institutional acceptance made conditional on compliance. While normalization-based interventions refer to the broader category of practices that seek to correct marginalized people into acceptability, coercive normalization refers to the mechanism by which that correction happens.

SHARED HISTORY

ABA as a formal discipline is usually traced to Donald Baer, Montrose Wolf, and Todd Risley, whose 1968 article "Some Current Dimensions of Applied Behavior Analysis" helped define ABA as a named field [11]. Their article laid out the dimensions of applied behavior analysis and became one of the field's foundational texts.

ABA did not emerge in isolation. It developed from broader behaviorist traditions, including John B. Watson's [100] emphasis on observable behavior, prediction, and control and B. F. Skinner's [101] experimental analysis of behavior shaped by environmental contingencies. Baer et al.'s articulation of ABA built upon these foundations by applying behavior-analytic principles to behaviors deemed "socially significant" [11]. This broader history matters because it situates Autism-focused ABA within a longer intellectual tradition concerned with systematically changing behavior. Behaviorism was not the sole source of conversion therapy, but behavioral principles also became one route through which efforts to suppress gender nonconformity were carried out [13, 17].

Autism-focused ABA, however, is most closely associated with Ole Ivar Lovaas, whose UCLA work helped popularize intensive behavioral intervention for Autistic children. This research framed success in terms of "normal educational and intellectual functioning," a phrase that critics identify as part of ABA's historical investment in normalization [12].

Conversion emerged from several overlapping systems that pathologized homosexuality, gender variance, and gender nonconformity. These included psychoanalysis and psychiatry, religious and moral reform movements, behavioral aversion therapies, and later "reparative therapy" [3].

The direct historical bridge between Autism-focused ABA and LGBTQ+ conversion therapy is Ole Ivar Lovaas. Lovaas was not only a major architect of Autism-focused ABA, but also helped develop a behavior-analytic form of gender-expression conversion therapy. Lovaas co-authored a behavior-modification study designed to suppress feminine-coded behavior in a child. The intervention relied on reinforcement, punishment, parent training, and systematic monitoring [1].

Today, that study is widely discussed as part of the history of gender-expression conversion therapy. The Journal of Applied Behavior Analysis later published an editorial note and expression of concern responding to the Rekers and Lovaas article, acknowledging that the article required ethical and historical contextualization [13]. Behavior-analytic scholars have also called on the field to confront its historical involvement in anti-LGBTQ+ interventions and conversion practices [14-16].

Gibson and Douglas [17] argue that Lovaas's Autism work and the Rekers/Lovaas gender-normalization work should be read together, not treated as unrelated research. Pyne [18] similarly places ABA and conversion therapy in conversation, showing how Autistic and trans children have been treated as incomplete or not-yet-legible persons whose identities must be built, corrected, or stabilized by adults.

This history shows that ABA and conversion therapy are not simply two unrelated practices that happen to resemble each other. They share a documented branch in behavior-modification research aimed at correcting children who were viewed as abnormal or socially deviant.

COERCIVE NORMALIZATION

While conversion therapy and ABA may differ in target population, the behavior-analytic branch of gender-expression conversion therapy and the dominant model of Autism-focused ABA are historically connected through Lovaas. Both normalization-based interventions have been used to make marginalized people appear more acceptable by attempting to change the person rather than changing the conditions around them.

Disability Studies helps us understand this phenomenon. The medical model of disability, originally known as the individual model, locates the problem primarily inside the person: their body, brain, behavior, communication, movement, or capacity. From this perspective, something is wrong with the person and needs to be fixed, cured, corrected, rehabilitated, or eradicated. Within this model, it is believed that doing so will normalize the person so they can be assimilated into society [19-22]. In Autism services, this can mean treating Autistic movement, communication, sensory expression, refusal, distress, or social difference as symptoms to be reduced, rather than as meaningful forms of embodiment, communication, regulation, or resistance [17-19, 23]. In LGBTQ+ conversion therapy, a similar coercive frame treats queer desire, trans identity, gender expansiveness, or nonconforming expression as a problem to be fixed, suppressed, redirected, or made less visible [3, 6, 24].

Disability justice also raises a more fundamental question: who decides which behaviors should be changed in the first place? From its earliest formulations, ABA emphasized changing "socially significant" and "socially important" behaviors [11]. Yet these terms are not neutral. Instead, they reflect judgements about whose ways of moving, communicating, interacting, regulating, or expressing themselves are considered acceptable and whose are treated as problems requiring intervention. Disability-related behaviors such as stimming, reduced eye contact, atypical communication, or refusal may be targeted because they don't fit dominant social expectations [11, 37, 44]. A disability justice lens thus asks not only whether a behavior can be changed, but whose comfort, access, safety, and autonomy are prioritized when intervention goals are defined.

The social model of disability shifts focus from individual deficit to disabling environments. It asks how policies, norms, systems, structures, expectations, and demands disable people [25, 26]. Disability justice shares this rejection of the medical model, but it also challenges the limits of mainstream disability-rights frameworks that have often centered white, physically disabled, legally recognized, and relatively privileged disabled people [27-29]. Disability justice asks how ableism works together with racism, poverty, colonialism, cisheterosexism, medical authority, institutionalization, policing, family regulation, and caregiver control [30-32]. Access is not only a matter of accommodation, but also a question of power, survival, interdependence, consent, and collective liberation [33].

A disability justice lens thus asks not only whether a behavior can be changed, but whose comfort, access, safety, and autonomy are prioritized when intervention goals are defined.

The central problem with normalization-based intervention is that it protects ableist systems from having to change, instead treating marginalized persons as the variable that needs to be changed. ABA, when organized around compliance and normalization, teaches Autistic people to survive hostile environments by masking, suppressing distress, tolerating harm, and obeying authority. Conversion therapy teaches LGBTQ+ people to survive cisheteronormative environments by suppressing identity, desire, expression, and self-knowledge. In both cases, the person is trained to absorb the violence of the environment rather than the environment being required to become less violent. Normalization turns oppression into an individual treatment goal. This is coercive normalization.

Disability justice challenges the power relations underlying such practices. ABA often occurs in contexts where Autistic children do not have meaningful power to refuse within service systems controlled by adults, including homes, schools, clinics, and other intervention settings [34-36]. Even when interventions

are framed as “positive,” the structure may still be coercive if food, praise, breaks, attention, preferred objects, or access to ordinary life are made conditional on compliance [37-40]. In behavioral interventions, the word “positive” is used to describe something being added or presented, whereas “negative” describes something being removed or taken away. These terms do not mean good or bad in the moral sense [41].

For these reasons, consent and assent are essential. We must ask whether disabled people have a real right to say no, whether their refusal is honored, and whether communication is recognized even when it might not look like speech [34, 35, 42, 43]. Reasonable responses, including crying, shutdown, elopement, aggression, avoidance, silence, dissociation, or refusal, may be criminalized and misconstrued as deviant behaviors that need to be controlled and surveilled instead of supported and accepted [23, 27, 29, 37, 44, 45]. A disability justice approach instead treats distress, refusal, and nonspeech communication as meaningful information about access, pain, fear, overwhelm, trauma, coercion, or loss of control.

The same concerns apply to conversion therapy. LGBTQ+ children and youth are often subjected to coercive normalization by parents, religious leaders, schools, or clinicians while they are dependent on those same adults for housing, care, safety, and belonging [3, 9, 10, 46]. A young person may “agree” to participate in conversion therapy under conditions where refusal risks family rejection, religious punishment, isolation, homelessness, or violence [47, 48]. From a disability justice perspective, this is coerced compliance, not meaningful consent: consent cannot be separated from dependency, power, safety, and the threat of losing care, belonging, or survival resources.

ABA and conversion therapy do not affect all people equally. Racialized and Indigenous Autistic children may be more likely to encounter behavior intervention through surveillance, school discipline, child welfare,

policing, or institutional systems, especially where race and disability are read through punitive school, service, and family-policing structures [49-54]. Queer and trans youth may encounter conversion practices through family rejection, religious authority, anti-trans medical gatekeeping, or residential programs [9, 10, 46, 55]. Queer and trans Autistic people may be targeted by both systems at once: treated as unreliable narrators of their own gender, pressured to mask Autistic traits, denied sexual autonomy, or disciplined for refusal [18, 37, 56-59]. The issue is not whether a particular intervention reduces a behavior, but what kind of person the intervention is trying to produce, for whom, and at what cost [17-19, 38].

Disability justice also reframes the way we think about care. Care is not control. Care is not making someone indistinguishable from the dominant group. Care is not training a person to endure violence silently. Care is collective access, interdependence, communication rights, bodily autonomy, sensory freedom, gender freedom, sexual self-determination, and the right to refuse.

This is why the harm cannot be reduced only to outdated methods or extreme cases. Disability justice does not argue that Autistic people should be denied support, communication tools, safety, education, therapy, or care. It argues that support must not be conditional on becoming less. Care should expand freedom, not shrink personhood.

Normalization-based interventions, such as conversion therapy and ABA, are harmful because they have been used to make marginalized people carry the burden of other people's discomfort. A Pride-centered disability justice framework rejects that burden and insists that queer, trans, disabled, and Autistic people do not need to be corrected into acceptability. They need power, access, affirmation, interdependence, and freedom.

Queer and trans Autistic people may be targeted by both systems at once: treated as unreliable narrators of their own gender, pressured to mask Autistic traits, denied sexual autonomy, or disciplined for refusal.

WHAT RESEARCH SHOWS

Conversion Therapy and SOGIECE

The evidence on conversion therapy is clear and consistent. Efficacy claims are weak. Major professional reviews have found no credible evidence that sexual orientation or gender identity can be changed through therapy, while research links conversion efforts to significant psychological harm. Insufficient evidence has been found that sexual orientation can be changed through therapy. Recommended approaches should help clients integrate identity, values, and faith without treating LGBTQ identity as pathological [3-5, 8].

Research shows an association between exposure to conversion efforts and depression, suicidality, psychological distress, shame, trauma, and family rejection. Parent-initiated conversion efforts are especially harmful because they often occur in the context of dependency, coercion, and rejection [46, 60]. Research with transgender adults links gender identity conversion efforts to psychological distress and suicide attempts [6, 7]. Research with sexual minority adults has also linked sexual orientation change efforts to suicidal ideation and attempts, particularly when connected to adverse childhood experiences [61-63].

> ***If research primarily measures compliance or behavioral conformity while overlooking autonomy, consent, wellbeing, or self-defined quality of life, it provides only a partial account of whether an intervention is truly beneficial.***

Survivor-centered SOGIECE research expands the frame beyond formal therapy. Conversion efforts occur across social contexts, including religious, family, educational, and community settings [9, 10]. Many harmful practices are not labeled “therapy” by the people or institutions carrying them out. They may be framed as guidance, discipline, religious care, family protection, or moral development [60].

The conclusion is clear: LGBTQ+ people do not need to be changed. They need safety, affirmation, access, community, and self-determination [24, 64, 65].

ABA and Autism Intervention

ABA is often described in mainstream clinical literature as evidence-supported, but it is also deeply ethically contested. Mainstream ABA research often claims effectiveness because it measures whether targeted behaviors change. However, behavior change alone is not an indicator of success. Behaviors can be changed in ways that are harmful, especially when the target is compliance, masking, suppression of distress, or reduced visibility of Autistic traits [37, 38, 40]. This distinction is critical because evidence-supported practice should not be understood as evidence of effectiveness for every outcome, but rather evidence for the specific outcomes that are measured.

The strongest critiques come from Autistic adults, disability studies, neurodiversity scholars, and some behavior analysts themselves. They argue that much historical ABA was built around goals like eye contact, indistinguishability from peers, compliance, suppression of harmless stimming, and obedience to adult demands. These goals can promote masking rather than wellbeing. Critics also point to historical use of aversives, power imbalances between therapists and children, insufficient attention to consent or assent, and underreporting of adverse effects [23, 37, 38, 40, 66]. Autistic advocates and scholars have repeatedly challenged ABA for promoting compliance over autonomy, masking over authenticity, normalization over access, control over consent, indistinguishability over self-determination, and behavior reduction over understanding distress [23, 37, 67].

ABA is also not simply a set of techniques. In many Autism service systems, ABA has become an industry: a funded, credentialed, insurance-supported, clinic-based, school-linked, and often for-profit service model that defines what counts as legitimate Autism intervention [68-73]. Families are often told that ABA is the “gold standard,” the only evidence-based

option, or the necessary gateway to support, even when Autistic people themselves have raised serious concerns about harm, coercion, and normalization [37, 40, 66].

Some argue that ABA need only be adapted, modernized, or made more neurodiversity-affirming. This reformist position argues that ABA can move away from normalization, increase attention to assent, avoid targeting harmless Autistic traits, and focus on communication, safety, autonomy, and quality of life [67, 74].

The problem with Autism-focused ABA is deeper than poor implementation. ABA has historically defined Autism care through the modification of Autistic behavior. Even when the goals are described as skill-building, they teach Autistic people that safety, approval, access, and belonging depend on becoming less visibly Autistic [19, 37, 40, 66]. Reform is not enough. A gentler form of coercive normalization is still coercive and normalizing. Better regulation of the ABA industry could potentially reduce some abuses, but it leaves the central problem intact. Autistic children are viewed as a problem to be fixed, while families, schools, clinics, insurers, and institutions are allowed to remain inaccessible, ableist, and controlling. The harms of normalization, masking, coerced compliance, adult control, and loss of self-determination outweigh the supposed gains of behavior change when those gains are defined by adults, insurers, schools, or clinical systems rather than by Autistic people themselves [23, 38, 75].

Recent work asks whether Autistic people themselves find intervention goals acceptable. This research highlights a crucial distinction: Autistic people may support help with communication, autonomy, safety, and distress reduction while rejecting goals that suppress harmless Autistic traits or make Autistic people appear non-Autistic [76-78]. Autistic people need support that expands freedom, access, communication, safety, and self-determination. They do not need an industry built around normalization.

Impacted-Community Knowledge Is Evidence

LGBTQ+ survivors and Autistic people are not merely "stakeholders." They are experts on the harms of cure, compliance, masking, and normalization [9, 23, 37, 40, 60]. To center impacted people means more than quoting them. It means shifting authority: survivors

should define what conversion therapy is, where it happens, and what recovery requires, while Autistic people should define which supports are helpful, which interventions are harmful, and what autonomy means in practice [65, 77, 79-81]. Queer, trans, gender-diverse, Two-Spirit, nonspeaking, multiply disabled, racialized, institutionalized, and otherwise marginalized Autistic people must not be treated as afterthoughts, especially because disability justice and participatory research both show that the people most affected by systems of control are often the least likely to be granted authority within them.

Participatory Autism research is a prime example. When Autistic people help shape research questions, methods, interpretation, and dissemination, the research changes. It becomes more attentive to access, power, communication differences, and the gap between what clinicians measure and what Autistic people experience [80-84]. This is especially important in intervention research, where clinical measures may count behavior change as success even when Autistic people describe the same intervention as masking, coercion, distress, or loss of autonomy [37, 40, 76, 77].

The same is true in conversion-therapy research. Survivor-centered SOGIECE scholarship has changed the field by showing that harm occurs in families, churches, schools, camps, and informal authority relationships, not in clinical offices alone. Impacted people expanded the definition of the problem because they understood where the harm actually happened.

Research and advocacy must move beyond superficial efforts at inclusion, towards actual sharing of power. Impacted people should help shape research questions, definitions of harm, policy recommendations, intervention standards, outcome measures, ethics review, public messaging, and funding priorities.

CENTERING THOSE MOST IMPACTED

The overlap between LGBTQ+ and Autistic communities is not incidental. Research finds that Autistic people are more likely than non-Autistic people to report diverse sexual orientations and gender identities, including bisexual, asexual, gay, lesbian, queer, trans, and nonbinary identities. Studies also find that transgender and gender-diverse people are more likely than cisgender people to be Autistic or report elevated Autistic traits [85-90].

This evidence should lead to more affirming care, not more gatekeeping. Autism does not make someone confused about their gender or sexuality, and being queer, trans, bisexual, asexual, lesbian, gay, nonbinary, or Two-Spirit is not a symptom of Autism [85, 86, 89, 91, 92]. The research shows that many people live at the intersection of neurodivergence and LGBTQ+ identity. That overlap should be treated as a call for better access, better communication support, better clinical humility, and stronger affirmation, not as a reason to delay, doubt, or deny someone's self-knowledge [18, 91-93]. Queer, trans, gender-diverse, Two-Spirit, bisexual, asexual, lesbian, gay, and nonbinary Autistic people are especially vulnerable to systems that treat difference as pathology, confusion, noncompliance, or disorder.

For queer and trans Autistic people, the problem compounds as stigma intersects. Their Autistic traits may be used to question their gender. Their gender expression may be used to question their competence. Their communication differences may be used to deny consent. Their refusal may be treated as behavior to manage rather than self-advocacy to respect.

That need is urgent in a political climate where gender-affirming care is increasingly restricted and, in some jurisdictions, criminalized, and where Autistic people's self-knowledge is too often treated as confusion, rigidity, or incapacity rather than authority [18, 94-98]. Autism should never be used to delay or deny gender-affirming care. It should require clinicians and systems to provide care that is more accessible, more communicative, more patient-led, and more affirming [91, 92, 99].

ABA, conversion therapy, anti-trans gatekeeping, and normalization-based disability services often affect the same people. Pride must include the right to be queer, trans, disabled, Autistic, and unchanged.

RECOMMENDATIONS

The goal is not better normalization. The goal is liberation from normalization.

The evidence and the testimony of impacted communities point in one direction. Systems must stop funding, protecting, and legitimizing interventions that treat marginalized people as problems to correct. Conversion therapy and Autism-focused ABA cannot be addressed only as isolated clinical practices. They are part of broader systems that reward coercive normalization, compliance, and institutional comfort while placing the burden of change on LGBTQ+ people, Autistic people, and queer/trans Autistic people.

The goal is not better normalization. The goal is liberation from normalization. Policy, funding, research, and care systems must move away from correction and toward self-determination, access, consent, communication rights, bodily autonomy, gender freedom, and disability justice.

1. Ban Conversion Therapy & All SOCIEGE Practices

Conversion therapy bans must cover the full range of sexual orientation, gender identity, and gender expression change efforts. This includes formal therapy, religious counseling, pastoral programs, family-based coercion, residential programs, school-based practices, gender-expression change efforts, and informal interventions that pressure LGBTQ+ people to suppress identity, desire, transition, gender expression, or self-knowledge.

A practice should not escape scrutiny because it is called guidance, discipline, prayer, mentoring, family protection, or moral development. The question is whether it attempts to make LGBTQ+ people less LGBTQ+.

2.End ABA as the Default Autism Intervention & Phase Out Normalization-Based Services

Public systems, schools, insurers, and service providers should stop treating ABA as the default, preferred, or required pathway to Autism support. Families should not be told that ABA is the only

legitimate option, the only evidence-based option, or the necessary gateway to services.

Public funding should not support services that aim to make Autistic people appear less Autistic, more compliant, more neurotypical, or easier for adults and institutions to manage. Services should not target forced eye contact, harmless stimming, atypical play, Autistic communication, refusal, distress, or masking simply because they are inconvenient or atypical.

Ending ABA as the default does not mean abandoning Autistic people. It means abandoning a service model built around changing Autistic people to fit inaccessible environments.

3.Redirect Funding Toward Autistic-Led & Affirming Supports

Funding should move toward supports that are Autistic-led, neurodiversity-affirming, trauma-informed, disability justice-informed, culturally responsive, and grounded in consent. These supports include AAC, communication access, sensory access, peer support, family education, inclusive education, occupational supports, trauma-informed therapy, community-based services, supported decision-making, and respite that respects autonomy.

Autistic people do not need an industry built around normalization. They need supports that expand freedom, communication, safety, access, and self-determination.

4. Prohibit Coercive Normalization & Require Meaningful Refusal Rights

Care should never make safety, affection, communication access, family belonging, school participation, housing, spiritual community, or basic needs conditional on suppressing identity, expression, communication, movement, distress, or refusal.

Children, disabled people, nonspeaking people, and people with intellectual disabilities must have meaningful ways to say no. Refusal must be honored, not reframed as noncompliance. Distress, shutdown, withdrawal, elopement, aggression, silence, dissociation, and avoidance should be treated as communication.

Consent is not meaningful when care, safety, housing, belonging, education, or support are made conditional on compliance.

5.Protect Gender-Affirming Care for Autistic People

Autism must never be used as a reason to deny, delay, restrict, or undermine gender-affirming care. Autistic people are capable of knowing their gender identity, communicating their needs, and participating in decisions about their bodies and futures.

When Autistic people need support in gender-related care, the answer is not gatekeeping. The answer is accessible communication, supported decision-making, clinical humility, sensory access, longer appointments when needed, plain-language information, and respect for self-knowledge.

6. Shift Authority to Impacted Communities

Research, policy, service standards, funding priorities, and outcome measures must be shaped by the people most affected. LGBTQ+ survivors, Autistic people, queer and trans Autistic people, nonspeaking Autistic people, multiply disabled people, racialized Autistic people, institutionalized people, and Two-Spirit people must not be treated as symbolic participants after the agenda has already been set.

Impacted people should define harm, determine what counts as meaningful support, shape ethics review, evaluate services, guide public messaging, and decide what futures care systems should make possible.

Across all systems, the standard should be support that expands autonomy, communication, access, safety, connection, and quality of life. Control increases compliance, masking, dependency, fear, and institutional comfort. **Public policy should fund support, not control.**

CONCLUSION: PRIDE MEANS THE RIGHT TO BE UNCHANGED

Pride Month is a celebration, but it is also a warning, a memory, and a demand.

This Pride arrives during a time of social and political upheaval in which LGBTQ+ people, trans and gender-diverse people, disabled people, and Autistic people are being targeted with renewed force. Gender-affirming care is being restricted and criminalized. LGBTQ+ identities are being framed as threats. Disabled people are still pressured to prove worth through productivity, compliance, and manageability. Autistic people are still too often treated as problems to fix rather than people to respect.

These struggles are connected. ABA and conversion therapy share a painful and often hidden history. Both have been shaped by systems that treated difference as deviance, care as correction, and acceptance as something marginalized people could earn only by becoming less visible, less disruptive, less queer, less trans, less disabled, or less Autistic.

That history helps explain how we got here. The same normalizing framework that told LGBTQ+ people to suppress desire, gender, and self-knowledge has told Autistic people to suppress movement, communication, distress, refusal, and self-protection. The same demand appears again and again: change yourself so the world does not have to change.

But LGBTQ+ and Autistic communities do more than share systems of harm. Many people live within both communities. Queer, trans, gender-diverse, Two-Spirit, bisexual, asexual, lesbian, gay, nonbinary, disabled, and Autistic people are not edge cases. They are part of the center of this story. They carry overlapping histories, cultures, survival strategies, grief, creativity, resistance, and knowledge. Their lives show why this issue cannot be reduced to therapy techniques, clinical debates, or professional reform.

The question before us is not whether marginalized people can be trained to appear more acceptable. The question is whether we will keep building systems that require them to do so. A future worthy of Pride cannot be built on conversion, compliance, masking, cure, or coercive normalization. It must be built on self-determination, communication rights, bodily autonomy, sensory freedom, gender freedom, sexual freedom, disability justice, interdependence, and care without control.

LGBTQ+ people do not need to be converted. Autistic people do not need to be normalized. Queer and trans Autistic people do not need to prove that they are competent enough, certain enough, verbal enough, compliant enough, or normal enough to be believed. They need safety. They need access. They need affirmation. They need community. They need futures that do not require self-erasure as the price of survival.

Pride calls us toward those futures. It asks us to remember the harm, name the systems that produced it, and refuse to carry them forward under softer language. It asks us to choose liberation over normalization.

Pride is the right to exist without being cured.

> ***A future worthy of Pride [...] must be built on self-determination, communication rights, bodily autonomy, sensory freedom, gender freedom, sexual freedom, disability justice, interdependence, and care without control.***

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