FACTORS OF IMPACT AND SUGGESTIONS FOR ADAPTATIONS IN PSYCHOTHERAPY WITH AUTISTIC ADULTS

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AN ECIT STUDY

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Introductory framework

Introductory statement

When I settled on the topic of this thesis, it was after a prolonged period of wondering why it seemed as though there was such a widespread and profound hesitation to offer psychotherapy to autistic people with co-occurring mental health issues within the Danish public sector. Both during my internship in one of Region Nordjylland's psychiatric departments, and in my professional life where I work with autistic children, I kept hearing variations on the phrase "People with autism don't profit from psychotherapy enough to warrant offering it" or "They aren't suited for psychotherapy". This seemed, to me, to be a problematic generalization to be basing treatment plans upon. It should be stated that I do not wish to accuse any of the clinicians or social workers I've encountered — and learned so much from — of any ill intent, or clinical misconduct, nor do I consider myself any better qualified to make judgements on treatment plans than they are. I fully acknowledge that my experience in providing mental healthcare is very limited. My impression, however, remains that autistic people presenting with additional mental health concerns that required treatment were often not offered any, and were instead referred on to the primary sector. Within the primary sector, it has been my experience in my time as an aid and respite worker in Aalborg municipality, that in order to be offered treatment, one had to fit into a very narrow margin to be considered a severe enough - but not too severe and complex - case to qualify. However, the fact remains that the responsibility for treatment of autistic adults with comorbid mental health disorders lies with the regions' psychiatric departments, and not with the primary sector (Knüppel et al., 2024). This reluctance to offer treatment in either primary or secondary sector for autistic people's co-occurring mental health issues may be a contributing factor the vast increase in demand and growth for the private sector when it comes to psychiatric care in Denmark, as well as the increase in people paying small fortunes out of pocket to access care (Sørensen et al., 2019). Recent years have also seen a vast increase in Danes changing their public health insurance from group one to group two, in order to have subsidized access to private practitioners (Ejbye Ernst & Raundahl, 2024).

There are doubtless many other factors impacting the decisions being made on whether to offer treatment or not, e.g. underfunding of the public sector, the recent increase in adult patients with developmental disorders in psychiatric treatment (Sundhedsdatastyrelsen, 2024), etc. However, it did appear to me as though one of the reasons behind the profound reluctance to offer treatment beyond making the diagnoses, was a lack of confidence and autism-specific knowledge among clinicians, a problem which has also been commented upon in the research literature (Jubenville-Wood et al., 2023b; Lipinski et al., 2022). Therefore, it is my hope that this thesis might serve to provide some accessible insight into the needs of this patient group, and ways in which we as mental healthcare providers may better fulfill them.

Another important factor behind the decision to pursue this particular topic stems from the scoping review that two of my fellow students and myself conducted as a student project during our ninth semester of study. During our screening process, we were incredibly surprised to find how many studies on recommendations psychotherapeutic for autistic adults did not employ distinct participant groups for autistic adults with and without intellectual disability (Goll Rossau et al., 2024). Mixing these participant groups seemed to us to risk certain inaccuracies in the recommendations reached, based on our assumption that clients in therapy with and without intellectual disability would differ significantly in their needs when it came to individual psychotherapy. This assumption is one I have carried over in the present study, and I have therefore chosen to focus on autistic adults without comorbid intellectual disability.

These reflections lead to the following problem formulation for this thesis:

Which factors and experiences are significant for autistic adults with co-occurring mental health issues, and without comorbid intellectual disability, when undergoing individual psychotherapy?

And

What adaptations to clinical practice do these factors and experiences suggest might be helpful when treating this patient group?

Reading guide

This thesis is written in a format consisting of three sections; an Introductory Framework section, an Article Section, and a Closing Framework section. The purpose of this introductory section is to introduce and describe the context of the problem investigated, the methodology of the research conducted, as well as key concepts and terminology which may be helpful for the understanding of the following article section, and its relation to the closing framework section. The article section however, is meant to initially speak for itself. The Closing Framework section then further explores, comments and expands on the results of the research article.

It bears mentioning that recent studies have suggested a preference among the majority of autistic adults for "identity first language", meaning a preference for being referred to as autistic, rather than "person first language", i.e. using the phrase "person with autism" (Kenny et al., 2016; Taboas et al., 2022). Participants in this study considered their autism to be an integral and inseparable part of their identity, and therefore did not see the point in a discourse that seeks to distinguish the autism from the person. The preference for identity first language was also strongly reiterated by two out of three participants in the present study. Therefore, for the majority of this thesis, "identity first language" is used, in order to respect the wishes of the autistic community, and the present study's participants.

Frequently used terminology

The following two sections briefly introduce and describe terminology considered essential to the understanding of the present thesis.

Psychotherapy definition

"Therapy" and "psychotherapy" are two terms used interchangeably throughout this project. For clarity of concept as to the operationalization of psychotherapy in this study, a definition of psychotherapy has been borrowed from Bruce Wampold and Zac Imel's book titled "*The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work*" (2015). Herein, the following definition is given:

Psychotherapy is a primarily interpersonal treatment that is a) based on psychological principles; b) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint; c) is intended by the therapist to be remedial for the client disorder, problem, or complaint; and d) is adapted or individualized for the particular client and his or her disorder, problem, or complaint (Wampold & Imel, 2015, p. 37)

It is further important to specify, that for the purposes of this study, the term "treatment" does not refer to treatment of the autistic individuals' ASD, but rather to the treatment of their co-occurring mental health issues and/or complaints.

Furthermore, for the purposes of this study, the terms "patient" and "client" are used interchangeably, though in most cases "client" was preferred, as it does not imply that the autistic individual is necessarily ill.

Autism Spectrum Disorder

Autism spectrum disorder (ASD) or as it appears in the ICD-10 "pervasive developmental disorder", is classified by the World Health Organisation as a group of developmental disorders characterized by difficulties with social functioning, communication and restricted and/or repetitive interests and behaviors (World Health Organisation, 2016). These rather broad symptom definitions manifest in diverse ways, and greatly vary in their degree of impact upon the daily life, quality of life, and support needs of the individual autistic person. As an example, some autistic individuals' difficulties with communication are limited to developing speech slightly later than their peers or having slightly unusual speech patterns or echolalia, while other autistic individuals never develop speech at all (Harrison et al., 2018). Other examples of common autism characteristics include difficulties with eye-contact, stereotypical repetitive movements or behaviors (often referred to as "stimming" (Morris et al., 2025)) and difficulties with spontaneous participation in activities (World Health Organisation, 2016). However, many autistic people also experience other related difficulties that are not part of the diagnostic criteria, such as profound sensory sensitivity or hyposensitivity, e.g. difficulties with certain food textures, tight clothing, loud noises, or greater needs for proprioceptive sensory input, etc. (Harrison et al, 2018; Robertson &

Simmons, 2013). Other commonly autism-related issues include difficulties with emotion regulation and executive functions (Demetriou et al., 2018; Mazefsky et al., 2013).

The precise aetiology of ASD is as yet unknown, although it is considered to be the result of genetic variations, with the heritability being around 90%. ASD is a genetically complex disorder, with several genes and variations often being involved in the genetic predisposition. Neuroimaging studies have also indicated that autistic people's neurological development matures on a different trajectory than their neurotypical counterparts, leading to differences in neuroanatomy and neural connections (Harrison et al., 2018).

Introduction to the ECIT methodology

While there is some debate to be had on whether the Enhanced Critical Incident Technique (ECIT) is a method or a methodology (Viergever, 2019), it can be described as a methodology of qualitative research that is a further development on the Critical Incident Technique (CIT). The CIT originated in the United States Army Airforce, and was developed through several studies seeking to improve recruitment and outcomes for military pilots (Flanagan, 1954). It has since been applied to other fields as well, including counselling research (Butterfield et al., 2005; Butterfield et al., 2009). The CIT is an exploratory qualitative research approach, in the form of *"[...] a flexible set of principles that must be modified and adapted to meet the specific situation at hand"* (Flanagan, 1954, p. 335), and as such should not be interpreted as a rigid set of rules for data collection. The CIT and ECIT rely on respondents providing accounts of critical incidents to a selected activity of study (Woolsey, 1986), and are built upon two primary principles; *"(a) reporting of facts regarding behavior is preferable to the collection of interpretations, ratings, and opinions based on general impressions; (b) reporting should be limited to those behaviors which, according to competent observers, made a significant contribution to the activity"* (Flanagan, 1954, p.355). The competent observers referred to can be anyone familiar with the activity, who can provide first-hand observations, and an observer may report about themselves or about others (Woolsey, 1986). Flanagan's original criteria for what incidences could be considered critical was that an incident was critical if it made a significant contribution to the general aim of the activity, which could either be positive or negative. The definition

of "significant" is, according to Flanagan, dependent on the activity (Flanagan, 1954) and the competent observer is considered able to judge whether an observed behavior is successful in contributing to the aims of the activity or not (Viergever, 2019).

The CIT has five overall procedural steps (Butterfield et al., 2005), which will briefly be described below.

Step 1 - Determining the aim of the activity being studied

The first step in a CIT study is to state clearly and simply what the aim of the activity being studied is. The identification of the aims of the activity directs the focus of the study and is used by the respondents (i.e. the competent observers) to select which incidents they choose to report (Woolsey, 1986). In the case of the present study, the activity being studied is individual psychotherapy with autistic adults for their co-ocurring mental health issues. The aim of this activity is facilitating the reduction and/or management of psychological pain and discomfort in the client's life, which may include, but is not limited to, symptom reduction, management of relational issues, and acquisition of psychological "tools" to aid them in their daily life.

Step 2 - Making plans and setting specifications and criteria

Next comes making decisions regarding the observations of the CIT study. In the present study, the observers are autistic adults with personal experience going to therapy. Decisions about the nature of the observations themselves may include setting a certain timeframe in which the critical incidents are to have taken place, specific locations, situations, etc. In the present study, the only such specifications are that participants were asked to recount critical incidents from their own personal experience of individual psychotherapy (Woolsey, 1986).

Step 3 - Data collection

Data collection in CIT studies is usually done by interview, but may also be done in written form. A detailed interview guide is usually written and pilot tested in advance. The interview guide is often used to train interviewers, after which a shortened form is used for the interviews themselves. Interviews should be audio-recorded. While transcription is helpful, it is not strictly required (Woolsey, 1986).

Step 4 - Analyzing the data

The analysis of data within the CIT is mainly descriptive, with the purpose of efficiently summarizing and describing the data in such a way that it can effectively be used to improve upon the practice of the studied activity (Flanagan, 1954). It is considered the most important and difficult step in a CIT study (Butterfield et al., 2005). For the analysis to be useful, a frame of reference is set at this stage, for the purpose of tailoring the analysis to that later purpose (Kain, 2004). In the case of this study, the purpose is to explore ways in which individual therapy may be adapted to better suit a particular patient group, for which reason the frame of reference is impactful factors, actions and practices for individual psychotherapy. Once the frame of reference is set, the inductive process of constructing categories begins. Here, the researcher sorts incidents into groups based upon the frame of reference (Kain, 2004). At this stage, the purpose is to categorize the incidences extracted from the data in as useful a manner as possible, while also preserving their specificity, validity and comprehensiveness as much as possible (Butterfield et al., 2005).

Step 5 - Interpreting and reporting the data

In the final stage, the data is interpreted and reported. The report must be a faithful account of the decisions made in the former four steps, so that the reader may make judgment calls on the generalizability and utility of the study. The report should also include the researcher's judgment on whether the study yielded any results worth knowing (Kain, 2004). Additionally, the researcher is encouraged to review the former four steps and examine and report critically what biases may have been introduced during the process (Flanagan, 1954).

From CIT to ECIT

The enhancements to the CIT that were added to create the ECIT were firstly to add contextual questions to the beginnings of the interviews, in order to provide context for the following data analysis. Secondly, questions regarding so called "wish list items" (WL-items) were added to the interviews, as well as the analysis step. These are questions regarding factors such as people, practices, information, or support that participants wish had been present or available in the situation, and believe would have been helpful (Butterfield et al., 2009). Thirdly, nine credibility checks were added to the procedure. They are listed and explained briefly below (See *Limitations* for discussion of these credibility checks in relation to the present study):

1. Audio recording of interviews

2. Interview fidelity – This check serves to ensure that the CIT method is adhered to, that the interviewer is not asking leading questions or otherwise manipulating the participants, and that the interview guide is being followed. It is usually done by having a researcher who is experienced with CIT studies listen to every fourth interview recording (Butterfield et al., 2009).

3. Independent extraction of critical incidents – A secondary coder to the one who did the initial extraction of CI's and WL items is given approx. 25% of participants' interview transcripts, and performs an independent extraction to ensure that researchers are reliably identifying critical items without bias (McDaniel et al., 2020). A higher accordance rate between extractions is considered indicative of reliability (Butterfield et al., 2009)

4. Calculating exhaustiveness – The suggested method for performing this check is to continually track how many new factors or behaviors emerge. Ideally, researchers would continue processing interviews until a point at which only two or three new critical factors or behaviors are contributed by adding 100 CI's (Butterfield et al., 2005)

5. Calculation of participant rates – The percentage of participants contributing items is calculated for each category to establish the categories' "strength". If less than 25% of participants contributed items to the category, the ECIT framework considers this indicative of a need to reevaluate whether these items might fit into other categories, or whether a new category should be constructed that better accommodates the smaller categories (Butterfield et al., 2009)

6. Placement of critical incidents into categories by an independent judge – This check is performed by having an independent person place a randomly selected sample of 25% of the total CI's and WL items extracted into the categories that the primary coder has constructed. The suggested match rate for validation is 80%.

7. Cross-checking by participants – A follow-up interview is conducted (usually over the phone, and not transcribed) in which participants give feedback on the items extracted and the categories. They are also given the chance to add, remove or amend the items they provided, all to confirm that the analysis resonates with their experience (Butterfield et al., 2005).

8. Expert opinions – Two or more experts in the research field in question are presented with the constructed categories and consulted on whether they find them useful, whether they are surprised by any of them, and whether they find any missing based on their experience (Butterfield et al., 2009).

9. Theoretical agreement – This check has two parts. Firstly, the researcher explicitly states what theoretical assumptions are made in the research. Secondly, the results are compared to exiting research, and contextualized within the field (McDaniel et al., 2020).

Article section

Abstract

Purpose: Autistic adults are at high risk of needing treatment for co-occurring mental health issues and conditions throughout their lifespan. Currently, many autistic individuals find psychotherapy difficult to access and engage in psychotherapy, and do not experience the desired effects of treatment. This study sought to explore what factors and experiences are significant for autistic adults with co-occurring mental health issues - without intellectual disability - when undergoing individual psychotherapy, and what adaptations to clinical practice these factors and experiences suggest might be helpful when treating this patient group.

Methods: The qualitative approach known as the Enhanced Critical Incident Technique (ECIT) was used to design and carry out this study. Three autistic adults participated in semi-structured interviews. Critical incidents and wish list items were extracted from interview transcripts, and categorized thematically.

Results: Participant interviews resulted in the extraction of 109 critical incidents, which were categorized into eight categories: Acceptance and de-pathologization, Communicative approaches, Pragmatic approach, Social skills and needs, Incorporating the body, Sensory accommodations, Continuity and predictability, and Exposure therapy. Each category identifies factors and practices within psychotherapeutic treatment of autistic adults, and presents these under the sub-categorization of either being helpful incidents, hindering incidents or wish list items. The categories identify several impactful factors and practices influencing autistic adults experiences with therapy.

Conclusions: Tentative suggestions for adaptation to practice when treating autistic adults without intellectual disability are given based on the items extracted from interviews. The suggestions made are predominantly in accordance with recommendations in other literature on the topic, and provide insight into the needs, preferences, and experiences of autistic adults in psychotherapy.

Introduction

Autistic adults face a higher risk of suffering from co-occurring mental health issues than neurotypical adults (Lai et al., 2019). Among autistic youths, 70-72% receive a co-occurring psychiatric diagnosis, with depression, anxiety and OCD being the most common (Rosen et al., 2018). Meanwhile, recent years have seen a significant rise in the number of autism diagnoses being made, including increases in the number of late diagnoses (Jensen de López & Thirup Møller, 2024; Schendel & Thorsteinsson, 2018), thus leading to a growing group of individuals at higher risk of needing mental health care in the future, as recent research has shown that later ASD diagnoses are associated with poorer mental health (Jadav & Bal, 2022).

While some studies have been conducted on the fit of various psychotherapeutic modalities for this population, these have predominantly focused on varieties of cognitive behavioral therapy (Flygare et al., 2020; Menezes et al., 2022; Spain et al., 2015; Wichers et al., 2023). Many autistic adults continue to find it difficult engaging in psychotherapy, and do not achieve the desired outcomes of seeking treatment (Camm-Crosbie et al., 2019; Gilmore et al., 2022; Jubenville-Wood et al., 2023a). Most psychotherapeutic interventions adapted specifically to autistic populations also appear to be aimed at children (Goll Rossau et al., 2024), potentially leaving the support needs of many autistic adults unmet.

Beyond CBT based modalities, little other literature is available when it comes to recommendations for adapting psychotherapy to autistic adults without intellectual disability (Goll Rossau et al., 2024). What research does exist in this area however seems to indicate that adaptations such as allowing extra time to establish a therapeutic alliance, setting clear treatment goals, employing interventions that address concrete issues, accommodating sensory sensitivities, and avoiding vague communication may be beneficial. Other recommendations pertained to therapist factors, such as the level of autism-specific training, a non-judgmental stance, and efforts towards de-stigmatizing autistic behaviors in the therapeutic space.

With a sparse amount of available research on this topic, the need for additional exploratory research seems apparent. Therefore, this study aims to examine which factors and experiences are significant for autistic adults who do not have comorbid

intellectual disability, when receiving psychotherapeutic treatment for co-occurring mental health issues, and provide preliminary insight into what adaptations to clinical practice these factors and experiences suggest might be helpful when treating this patient group.

Materials and methods

ECIT approach

The Enhanced Critical Incidents Technique was chosen for this study for several reasons, the first being its utility as an explorative method, which was in accordance with the study's aims (Butterfield et al., 2009). The ECIT approach was also deemed especially fitting for the purpose of exploring autistic adults' experiences in therapy, as it is built partially upon the stance that the participant is capable of judging the effects of their experiences, and primarily seeks to describe these in a manner that helps reach actionable improvements to practice. For this reason, the ECIT does not particularly invite or depend on interpretations from the researcher, as their role is primarily to summarize and faithfully describe the participants' own judgments (Viergever, 2019).

Furthermore, its qualitative approach provided the opportunity to gather this information in the participants' own words, without their responses being confined to strict outcome measures and surveys. This was deemed relevant as it provided thorough descriptions of the impact of the described incidents, and because autistic adults have been shown in recent research to tend to struggle with certain elements of answering survey questions (Stacey & Cage, 2023).

Sampling and recruitment

Three participants were recruited through two different Facebook groups, one being an autism specific online community, the other being a more broadly oriented disability rights advocacy forum. The criteria for participants were the following:

- Participants had to be no younger than 18 years of age
- Participants had to have a formal diagnosis within the autism spectrum

- Participants had to have experience attending psychotherapy
- Participants had to have attended a minimum of six psychotherapy sessions with one therapist
- Participants should not have any intellectual disability

The criterion regarding intellectual disability was omitted from the Facebook post due to experience from previous student projects, where the reasons for certain exclusion criteria were misconstrued and taken offence to. Absence of intellectual disability was instead judged based on level of education and self-reported co-morbidities.

Participants

Nina is a woman in her late thirties. She has an education in the humanities at the graduate level. Nina received her ASD diagnosis in adulthood, after several periods of illness due to stress and anxiety, after which she has been unable to return to the job market. In addition to ASD, Nina also has a formal diagnosis of ADHD. Nina primarily has experience receiving psychotherapy in private practice, but has also received treatment from a psychiatrist.

Emma is a woman in her forties, who received her autism diagnosis two and half years before the time of her interview. Before her ASD diagnosis, her difficulties had been attributed to recurring episodes of depression and anxiety. Emma has several different educations at the undergraduate level within the natural sciences. In addition to ASD, Emma has a formal diagnosis of ADHD, as well as what she referred to as three different anxiety disorders. However, she did not specify which. She was not employed at the time of her interview. Emma's experience with psychotherapy comes from a combination of private practice and psychiatric care in the secondary healthcare sector.

Nora is a woman in her late twenties. She received her autism diagnosis one year before her interview. She had completed vocational education in IT. Nora was diagnosed with schizophrenia, PTSD and ADHD in addition to ASD. Her experience with psychotherapy came exclusively from psychiatric care in the secondary healthcare sector, which she had been referred to because of her schizophrenia diagnosis.

Procedures

All participants gave written consent to the terms of the study prior to their interviews (see Appendix 2 – Consent form). Participants were given the choice of whether their interview took place on a video call, at AAU's campus, or a location of their choosing. One participant chose a video call, and two elected to be interviewed in their own homes. To accommodate potential discomfort from lack of preparation, as some autistic individuals may experience (Jenkinson et al., 2020; Stark et al., 2021), participants were given the option to read the interview questions in advance. Interviews lasted between 50 minutes and 2 hours and 41 minutes. Interviews were conducted in Danish using the interview guide seen in Appendix 3, and were audio recorded and transcribed verbatim, apart from changes made for the purpose of anonymity. Follow up interviews took place over the phone or video call, and were not recorded or transcribed, as is common ECIT practice (Butterfield et al., 2009). All quotes from the interviews are translated into English, directly where possible. However, in some cases, such as certain curse words, direct translation was not possible, and preservation of the apparent intended sentiment was prioritized.

Data analysis

The ECIT extracts experiences from qualitative data that the participants consider to be critical incidents or factors to the studied activity. Thereafter, these critical incidents (CI's) are either classified as helpful or hindering to the activity. Furthermore, factors or practices that they believe would be beneficial to the activity are extracted and referred to as wish list items (WL-items). The CI's and WL-items are then categorized based on common themes and the purpose of the research (Butterfield et al., 2009).

CI's and wish list items were extracted from the transcriptions in order of interview date. A CI or WL-item should be included when the participant is able to provide an example that describes the incident or factor in question, as well as the CI's impact. Incidents that do not have this level of detail are flagged and revisited in the follow-up interview. Three additional items were included after elaboration in the follow-up interviews. After extraction of CI's and WL-items from the individual transcripts, these

are categorized in an inductive manner, one interview at a time. As transcripts are processed, categories are added to, dissolved, combined, etc. in an iterative process (Butterfield et al., 2009).

In a larger scale study, this process would continue until the point of exhaustiveness (Butterfield et al., 2009). However, this study was limited to three participants, and could only continue to a point at which all items were included in a category of at least three items, referenced by at least two participants, in a structure deemed coherent and congruent with the aims of the research. At this point, the results, as well as their respective transcripts were reviewed by the participants as a credibility check measure. Participants then had the option to provide feedback and suggestions for the analysis. This led to the addition of two WL-items, elaboration on a further three items, and two changes in translations.

While the activity being studied here is psychotherapy, which would suggest that the included CI's would have taken place with a psychologist, CI's involving other mental healthcare providers (i.e. psychiatrists and nurses) were also included in cases where the providers were judged to be carrying out psychotherapeutic practice in accordance with the definition provided in the above paragraph titled *Psychotherapy definition*. The terms "therapist", "clinician", "practitioner" and "provider" are used interchangeably.

Table 1. Critical Incidents and wish list categories											
	Helpful CI's n = 50			Hindering CI's n = 27			WL-items n = 32			Total items extracted N = 109		
	Partici-pants (n)	Incidents		Partici-pants (n)	Incidents		Partici-pants (n)	Wish list items				
		(n)	% of cate-gory		(n)	% of cate-gory		(n)	% of category			
Category										Total items in category (n)	Percentage of to-tal items extracted	Relative par-ticipation rate in category (%)
Acceptance and de-pathologiza-tion	2	11	35.5%	2	8	25.8%	2	12	38.7%	31	28.4%	100%
Communica-tive ap-proaches	3	14	46.7%	2	8	26.7%	2	8	26.7%	30	27.5%	100%
Pragmatic ap-proaches	3	10	52.6%	2	3	15.8%	1	6	31.6%	19	17.4%	100%
Social skills and needs	3	5	71.4%	0	0	0%	1	2	28.6%	7	6.4%	100%
Incorporating the body	2	6	85.7%	1	1	14.3%	0	0	0%	7	6.4%	66%
Sensory ac-commoda-tions	0	0	0%	2	3	50%	2	3	50%	6	5.5%	66%
Continuity and predicta-bility	2	3	50%	2	2	33.3%	1	1	16.7%	6	5.5%	66%
Exposure therapy	1	1	33.3%	2	2	66.6%	0	0	0%	3	2.8%	100%

Results

A total of 109 items were identified and extracted. Eight categories emerged and are presented below in order of size. For an overview of the distribution of items across categories, see Table 1.

Acceptance and de-pathologization

The *Acceptance and de-pathologization* category contained 31 items, of which eight were hindering CI's, 11 were helpful CI's, and 12 were WL-items. It was referenced by all participants.

The helpful CI's of this category included experiences of therapists providing informational resources to help clients settle into their autism diagnosis, and see themselves not as defective, but simply different. Receiving the autism diagnosis was in itself a recurring helpful incident. Participants recalled it as a profoundly validating experience that helped them to understand and accept their traits and difficulties, as well as a critical step towards becoming better equipped to advocate for themselves. Emma put it in the following terms:

> *[…] I've lived my whole life amongst horses, and I've tried so hard to be a good horse, but I was a really shitty horse. […] And I didn't understand it. And then, I found out that it was because I was actually a zebra. […] I'm a really shitty horse, but actually a really good zebra. […] So the diagnosis has been a huge relief, and a framework where I can suddenly understand myself.*

Other helpful CI's in this category included experiences with the therapist approaching the client's experiences with curiosity and openness, rather than preconceived perceptions. This was a great relief for Emma, who explained that "*[…] instead of telling me how it is, she asks me what my experience is. […] I haven't been taken seriously in the healthcare system […] so to be taken seriously and being believed is enormously important.*"

Nora also described how her therapist made sure to frequently check in with her regarding her emotional state, and to redirect the conversation before she got

overwhelmed. She explained how this helped *"[…] keep it [her emotional state] at a level where I can keep up"*.

The hindering CI's of this category included examples of participants experiencing misalignment between their own perception of their mental state, and the therapist's perception of the same. This included Nina being told that *"[…] it can be hard to help me, because I'm very critical"*. She described how *"[…] it's definitely hard being told that you're difficult to help"*. However, as she explained, *"[…] what some people perceive as criticism is actually just me asking for precision"*.

Nora described how a psychiatrist's assessment of her level of functioning, support needs and mental state was overly positive compared to her own personal experience at the time. As a result, the assessment was perceived as a complete dismissal of her struggles, and a denial of treatment:

> *It's very nice that she thought that I was functioning well, but I really didn't think I was. […] I was really angry and sad. […] I thought it was because they once again didn't want to give me any treatment. […] I thought it was better to just leave then*

Other examples include participants' recollections of therapists making assumptions about the way they experienced their anxiety and being inflexible when told that this description was not accurate to their experience. Nina recounted one such instance with her former psychiatrist:

> *[…] I was told that I just had anxiety, and that was actually my own fault, because my avoidance behaviors just reinforced the anxiety […] he told me this metaphor […] And I tried to explain to him what it [anxiety] was actually like for me […] And he got irritated at me and said 'No because now you're changing the image! And I was like, 'Yes, I'm changing the image because what you're describing doesn't fit for me' […] And that's what I mean when I say that […] they have ways of understanding […] other kinds of anxiety, but not this autistic type of anxiety that comes from not understanding what's going on or from things being too much.*

Nina also described a situation in which the therapist interpreted her autistic thinking patterns as a pathological degree of overthinking, and need for control: *"I've been*

told 'Now you're overthinking! You need to stop that!', and I'm like, actually I do that to […] be able to even be in this world". Emma described how her a therapist's CBT-oriented approach of focusing on nuancing and altering her thoughts was "*[…] completely useless as hell*", due to her natural way of thinking in black and white patterns, and how it had led her to feel "*[…] very faulty at times, because there sits this clever lady who tells me that this is damn effective, and it's just not […]*". At follow-up, she elaborated further on how being asked to ignore or alter her thoughts in CBT had made her feel like the underlying problem behind the thought was not addressed. Nina also had experiences with clinicians who appeared to have a limited interest in autism, and narrow view of what it is and how it may present differently in different people, leading them to not see the person in treatment clearly. (Nina) "*The entire way of thinking, like the perception and processes. It's like that's not what's interesting. It's only the deficits and the things that can be medicated*".

The WL-items included several suggestions from participants. One was a wish for it to be standard practice when to ask autistic clients whether they prefer person-first or disability-first language, and to respect this preference throughout their treatment, which Emma described the importance of:

> *It means a lot for me that people listen to the way that I identify myself, instead of identifying me based on their own standpoint. And I understand that it's been a trend in the treatment world that it was very important to say that you* have *autism […] but try asking us what actually works for us […] and for me, when someone says that I have autism it sounds like a disease […] I am not sick. I don't need curing. There's nothing wrong with the way that I am human.*

Another WL-item was for therapists to explicitly state that autistic clients are not expected to suppress autism-related behaviors and traits, such as stimming or avoidance of eye-contact, to give clients (Emma) "*[…] that feeling of 'hey, here I am allowed to be as I am, I don't need to spend energy on keeping myself together or […] acting 'normal'*". In addition, having an agreed upon pause-signal available for clients to communicate when their boundaries are being crossed or they are in an unsustainable amount of discomfort during therapy, such as a "safe word" or a non-verbal option - e.g. a stop-lights system - was mentioned by Emma: "*Some of us can become*

nonverbal when we're pressed enough […] So I actually think it would be very bene-ficial to give the autistic person a nonverbal […] emergency brake". Engagement with- and incorporation of clients' special interests and pattern recognition skills into the treatment was also included as a WL-item, because as Nina pointed out;

> *[…] we are usually good at patterns and principles and rules, so being able to say 'it's similar in principle to a different area that you have expe-rience with'- Great to be using the areas of interest that you have, because that's where you have complex knowledge.*

Another WL-item was for therapists not to base their understanding of autism en-tirely on the behaviors and characteristics of autistic people in distress, but to also include characteristics of autistic people who are not in distressed or impaired states in the literature. Emma hoped that this might lead to clinicians having a more nuanced view of autism, and perhaps earlier diagnosis and better quality of care. (Emma) *"There is something wretched and perverse about it when autism doesn't get discov-ered until it becomes a problem for the surroundings […] Because when we're thriving […] we communicate fairly well and we're fairly flexible".* Several WL-items also centered around wishes for more therapists with specialized knowledge of autism. (Emma) *"[…] that would be very useful, so that we as autistics don't have to start out by providing that information. […] Because if we have to start out by putting it into context then all the time will be spent on that".* This also included a wish for more practicing psychotherapists with the lived experience of being neurodivergent them-selves. Additionally, a wish was expressed for more of the autism-specific training of psychotherapists to be based on information from people who are autistic themselves, and for clinicians to be critical of practice based primarily on literature written from a perspective viewing autism as a set of deficits. As Emma described it:

> *It's extremely problematic that autism is viewed through a medical deficit model where you only see the problems and challenges with us not acting normal and convenient. […] I mean, it's bullshit that I am only described through the things that are difficult when I'm under massive pressure.*

The wish for therapists to, as Nina put it, *"[…] put their ego aside"* when it comes to their understanding of their autistic clients' experiences, ways of thinking, reasoning and behaviors was also mentioned, because as Emma described it:

There are many prejudices. [...] when we are used to being misunderstood it's extra vulnerable to sit in a therapeutic space, with a therapist who has certain opinions about us before having begun to talk to us. [...] and you really have to be aware as a therapist, 'is this something I'm assuming or is it something the person has told me?'

Communicative approaches

The *Communicative approaches* category contained 30 items and was referenced by all participants. Eight items were hindering incidents, 14 were helpful incidents, and eight were WL-items.

Many of the helpful incidents in this category revolved around the need for the topics of the conversation to be made tangible for the participants, and included examples of therapists using visual models. Nora described how one model - which resembled diagrams she recognized from school - helped her to understand her emotional states; *"I think it's the visual of it [...] the X and Y diagrams [...] you know, from mathematics. So I think it's familiar as well [...] it's just a new way of thinking about it"*. Therapists using metaphor and imagery familiar to the client, was also mentioned by Emma to have a similar effect for her; *"[...] it's those concretes where she [...] contextualizes my reactions in different situations that's useful. [...] so we use imagery, but it's more like models for explanation"*. Similarly, using concrete and specific observations or situations from the clients' daily lives as the starting point for the conversation was a helping incident. Nina described how this was preferable to general questions such as 'how are you?':

[...] she'll base it on an observation instead and say to me 'Oh, you're wearing makeup today' [...] and then she [...] gives me one possible analysis [...] and I can say yes or no [...] but if she'd just asked me 'how are you?' [...] then I have to sort through what is relevant, and maybe sometimes you can do that, but sometimes you can't.

All participants reported that these points of departure for the conversation helped them to understand and participate on an even footing in the discussion, and to feel that the time spent in therapy targeted the struggles they experienced in daily life in

meaningful ways. Other helpful incidents included therapists providing psychoeducational resources and encouraging the client's curiosity about the methods applied in the treatment. (Nina) *[...] because they [Nina's former therapists] have sensed that 'this one likes doing research' [...] then I've gotten some names or keywords and gone home and researched [...] and then that has generated some questions"*. The therapist being willing and able to explain their point in different ways, often many times, was mentioned by Emma; *"She will keep explaining it in 15 different ways until it clicks in my head [...] and I think that is a really positive experience, that she adapts her communication to what I can internalize"*. Another theme within the helpful incidences of this category was the need for nothing to be left unsaid. Examples included therapists making sure not to assume that an autistic client would know certain things that a different adult client might. In Emma's words; *"Not assuming that I know these things. There's so much [neurotypical communication] that's so fucking bothersome for me [...] when it's only 20% that's actually put into words. The rest is this strange intangible iceberg of body language and stuff [...]"*. Another example was the therapist making sure to state any reactions to the client's utterances out loud - e.g. when reflecting the client's emotional state - instead of exclusively doing so with body language, facial expressions, or tonal inflection. This accommodated the client's difficulties with such communication by significantly reducing the need for these skills, and was (Emma) *"[...] such a relief that it's verbalized so I don't have to spend my energy interpreting it"*. This allowed her to direct her attention and energy towards the treatment itself.

The hindering CI's of this category centered around unclear communication from the therapist. This included incidents in which advice was too generalized for the client to apply it between sessions such as*, (Nina)*"[...] stop overthinking"* , (Nina) *"[...] say nevermind [...]"* or (Emma)*"[...] listen to your gut feeling [...]"*. Emma described her reaction to such advice in the following terms: *"[...] I was like, what the hell kind of thing is that to say? [...] what does it mean?"*. Similar critique was directed at questions that were not specific enough for the participants to determine what a relevant answer might be. (Nina) *"I think it's hard to answer open questions [...] even a question such as 'how is it going?'. [...] even when I've thought about how I am [...] I don't know what answer you're looking for"*. In another incident, Nina expressed how an exercise relying on an open-ended prompt regarding imagining one's future had

been hindering to her due to her difficulties with imagining beyond what she knew and had experiences to support:

> *It could be something like 'where do you want to be in five years?' [...] and it's also because I've been feeling poorly for many years right? So even having to imagine a future has just made me deeply unhappy and afraid. But even if I hadn't, I still think it would have been a bad exercise, again because of lack of imagination*

Nina also mentioned an incident in which her therapist did not adapt their explanation despite Nina expressing that there were logical objections that rendered the chosen phrasing unhelpful to her:

> *Sometimes it's just getting told that something is the same as something else. I often have a problem with when neurotypical people say that something is the same, because for me, I can clearly see the difference. I can clearly see that there are details [...] that aren't the same, and then everything in me screams*

The WL-items in this category primarily consisted of wishes for therapists working with autistic clients to avoid generalizations, exaggeration, and vague communication, and to be aware that their autistic clients may require more details and contextual information because as Nina put it; *"I am not trying to avoid talking about it. It's because I need the details to understand the whole"*. It was stressed by Nina that therapists *"[...] don't need to be afraid of being abstract. You just need to make sure that [...] the experience or explanation that is needed to reach that level of abstraction is present"*. WL-items in this category also included wishing for therapists to not rely on nonverbal communication, because as Emma described *"[...] if we [the autistic clients] are sitting and looking out the window to avoid eye contact, it's not at all certain that we'll register it"*. It was also a recurrent wish for therapists to explicitly address to the client that they might have very different styles of communication, that this difference was not a deficiency on the client's part, and to make sure the client knew that they could ask for clarification whenever necessary, as this according to Nina would help to establish *"[...] equality right? But I think it would be so nice to [...] acknowledge that, well, it's actually a translation problem between two brains that think differently and and communicate differently"*. Lastly, there was a wish for

therapists to frequently check in with their client to ensure mutual understanding of the conversation and to explicitly take on the responsibility for ensuring avoidance of miscommunications in treatment, because as Emma described, *"[...] for many of us late diagnosed women it would be a huge relief to be able to let go of that responsibility"*.

Pragmatic approach

The *Pragmatic approach* category contained 18 items, with nine being helpful CI's, three hindering CI's and six being WL-items. The CI's in this category were mentioned by all three participants.

Most of the helpful CI's in this category were characterized by homework tasks and tools being adapted in cooperation between client and therapist, making them highly specific to the client's daily life. This resulted in participants experiencing these interventions as meaningful, realistic, and logical implementations that provided opportunities for agency in the bettering of their mental health. As described by Emma; *"The autonomy in the fact that it was myself who could change these things in my life [...] That was important"* as well as by Nina; *"If the only things you work on are the ones happening [...] with the therapist, then not much will change in your own life [...] you have to use it, so it's important to make sure that you're able to do it"*. Secondly, the advice, tasks and tools provided were accompanied by precise directions on how and when to enact them, down to step-by-step instructions and backup plans. This was described by Nora to be *"[...] helpful by being very clear that if this thing happens, you do that"*.

The hindering CI's included an incident in which Nina received advice regarding her employment, which did not consider her situation in life during a time in which she described how;

> *Everything inside my head was total chaos, and my whole world had toppled over right? [...] and her solution was [...] 'I work part time. You can easily do that' [...] and I just remember thinking 'well, you're a psychologist, you have a completely different hourly pay than I would if I could even find a position. It's not that easy.*

Nina also described how a therapist had not provided any actionable tools or strategies to help her handle a hard situation. Instead, the therapist only validated that it was hard, which as Nina described was *"[…] not enough […] I can't use that for anything. I mean, I need something I can use, right?"*. The third hindering incident was regarding therapeutic exercises that did not appear to serve a specific purpose, and required imaginary interactions with metaphorical objects, which Emma found to be a nonsensical waste of time. In her own words; *"I mean come on. This is pointless for me. […] I have no mental images […] It makes no sense to me"*.

WL-items in this category mainly centered around providing very clear instructions when recommending exercises, and/or advice, to help break the (Nina) *"[…] huge block between understanding and practice"*. Wishes included a desire for step-by-step instructions and examples. This also included a wish for instructions on when to stop practicing the given tool/strategy, to avoid clients continuing to practice something that is not working or is inducing adverse effects, because as Nina described *"[…] I don't have an intuitive limit for 'that's enough. Now I've spent enough time on this or enough energy' or 'this is something that just frustrates me and I get nothing out of continuing'"*. The wish list for this category also included a wish for therapists not to interpret a client expressing that they cannot practice an exercise or tool as obstinance, and instead using their input to make the given task more useful or realistic for them. Nina explained how *"If I express that I can't, it doesn't mean I don't want to. It means that I can't see how it would be possible"* and described how *"[…] it has to be an interplay […] I have to be a part of modifying it so that it becomes something that fits for me"*.

Social skills and needs

The *Social skills and needs* category contained seven items, of which none were hindering incidents, five were helping incidents, and two were WL-items. All participants contributed to this category.

The helping incidents of this category centered around experiences of having the therapist provide an outside perspective, and help fill in information such as helping to 'decode' recent social situations from the client's life. Nora described how this helped her not to *"[…] get caught in my own head and get stuck in the same track and*

not really get over it". Other helping incidents referenced experiences with receiving help with social boundaries. This included setting one's own, identifying and respecting other people's, and knowing what boundaries are reasonable to set. Emma described how *"[…] it's obvious that my way of navigating friendships isn't the most common, so it's also a matter of what you can expect in a friendship […] and what you give back"*.

The first WL-item in this category was a wish for therapists to guide their autistic clients through social etiquette and skills in concrete terms, such as how to maintain friendships. *(Nina) "[…] like understanding what expectations people have. […] understanding that some people have the expectation that you have regular contact. What does regular contact mean? And how do you do it? Like examples of it."* The other WL-item in this category was for therapists to provide help with understanding feelings, both one's own and the feelings of others. Nina explained how she believed that this might be helpful:

> *[…] both understanding yourself, but also others, because like, I don't have an intuitive way of reacting to the feeling I have. But especially maybe to understand others, and things like why people get angry. […] Like you say something that's true, but then they get mad […] and that can sound banal, but it's something I've been missing*

Incorporating the body

The *Incorporating the body* category contained seven items, six being helpful CI's and one being a hindering CI. There were no WL-items in this category. The CI's in this category were mentioned by two out of three participants.

Two of the four helpful incidents in this category were participants experiencing benefits to using breathing exercises for anxiety management, which Emma described to be helpful because of *"[…] the mastery and the autonomy. This is a tool that I can bring out when I find it necessary and can use it as needed"*. Other helpful CI's in this category included Emma's therapist encouraging physical exercise in a specific way that made the sensory experience of it manageable for her. Emma explained how she was instructed *"[…] when for example I was running to only focus on how it felt in my*

thighs". This helped her to *"[…] even begin to be able to discover that you have a body and feel that it's there and what signals it's sending. […] So it was useful to begin with having to start with the small details"*. Emma also described two CI's in this category regarding experiences of bodily responses in trauma therapy with the guidance of the therapist. She explained how her therapist facilitated her processing of the physiological responses to strong emotions and traumatic memories:

> *[…] she sits me down, […] she makes me feel […] 'What does it feel like in the body?' […] And then I have to really feel, and I'm not very good at that. I don't have the words for it […] And then she says 'Emma, try feeling it also instead of just talking about it' […] because there are some things that are beyond words, and that is damn uncomfortable […] but […] now we're gonna do it and now we're gonna try, and it's okay, it isn't danger-ous. And she talks me through it*

Emma further described the benefits of these experiences:

> *It's been really beneficial that there is this therapeutic space where I can feel this sick, gigantic grief I have […] but where it gets to be in an amount where it doesn't completely topple me over, and where I get to feel that it's not actually dangerous.*

She also described how these experiences had helped her begin to rediscover and read her own body's signals; *"Because it turns out I do actually have a gut feeling! It's actually there and it's telling me relevant information when I can listen to it. But I've needed help to even listen. Because I've trained myself for years not to."*

The hindering incident in this category was also contributed by Emma, who had experienced a mindfulness exercise as profoundly overwhelming, to the point where she found herself in *"[…] a sort of out-of-body dissociation because I couldn't handle all of the signals that came, and it was overwhelming in an extremely gross way"*.

Nina also expressed at follow-up that she wished for therapists to be aware when working with autistic adults that feelings may be experienced very differ-ently in the body, and may not necessarily be easily translatable for the client.

Sensory accommodations

The *Sensory accommodations* category included no helpful CI's, three hindering incidents, and three WL-items, mentioned by two out of three participants.

The hindering incidents centered around the physical surroundings of therapy sessions, both in the waiting room, and within the sessions themselves. For Nora, the waiting rooms often presented a hindering influence for her in her sessions, as the rooms were often crowded, and the alternative quiet waiting rooms provided for patients with a need for sensory sheltering were usually occupied by other patients. She described the crowded waiting room as *"[…] very hard to sit in, because it's noisy, and there's so much visual stimulation, and I can't always just shut it out."* In a similar vein, Emma mentioned that her sensitivity to visual stimuli at times was such a challenge for her that things such as *"[…] pictures with hysterically unpleasant colors on the walls or a messy desk in the room […]"* became a hindrance to her treatment. At follow-up, she added therapists wearing perfume, scented products such as candles, and therapists who smelled of cigarette smoke to this list of hinderances. The final hindering CI in this category was regarding a therapist who declined to shut a window to block out noise, despite Emma's explicit request to do so, because as Emma explained *"[…] she thought that it was summer, and it was important to let in fresh air"*.

Both Nora and Emma stated a wish that it would be standard practice when treating autistic people to have various sensory tools - popularly known as stim-toys or fidgets - on offer for clients' free use, which Emma believed would help to create a space where one could *"Come as you are"*. Nora also explained how these might help because *"[…] sometimes it can get a little […] weird to sit sometimes and […] just stare at another person for an hour and talk."* The remaining WL-item in this category was contributed by Nora, who wished for increased availability of quiet waiting areas *"[…] so that you can shelter yourself without taking that shelter from the others at the same time"*.

Continuity and predictability

The *Continuity and predictability* category included two hindering CI's, two helpful CI's, and one WL-item. It was referenced by all participants.

The first hindering CI of this category was concerning a time in which circumstances in a therapist's private life abruptly rendered her unable to continue sessions, during which time Emma was also in deep crisis due to extremely difficult life circumstances. Emma explained the experience as follows:

I wrote to ask if I could get an appointment, and she said 'I'll get back to you in a few days'. And then I didn't hear from her for six weeks. [...] That's of course always extremely inappropriate, but as a neurodivergent person who was that vulnerable, I mean, it was extra bad. Because I take things literally, so when she says she'll get back to me in a few days I just sit and wait for her to get back to me. [...] I was walking around thinking that it was probably me who had done something wrong

She further explained the effect of this period: *"It was motherfucking problematic that she just disappeared like that. I was really knocked on my ass over it. [...] It was several years ago, and it lingers in me that [...] she just disappeared"*

The second hindering CI was frequent changes in mental healthcare providers within the public psychiatric care system, which was challenging for Nora due to her difficulties communicating with new people, and the adjustment period required for the providers to learn her communicative patterns. As she put it:

The feeling that I don't understand what you mean, you probably don't understand what I mean [...] It's just that the starting phase with a new person is hard. [...] I mean, new face, new voice, new ways of phrasing things. All of it. It's hard.

Helpful incidents in this category centered around therapists consistently following up on the topics discussed in the previous session, and ending sessions with suggestions for what topics to discuss during the next appointment. Participants described how this gave them the opportunity to mentally prepare for the next week, and gave them the opportunity to use the time between sessions productively to process and reflect, as this was not always easy for them to do while in session. As Nina described it;

It's not certain that you can answer it right then and there, it may be something you need to think on till next time, and then you can come and

say 'I've thought about what you asked me last time, and now I'm ready
to discuss' because you've had time to do that processing.

The WL-item in this category was Emma's wish for therapy providers to be as transparent and clear as possible when communicating what neurodivergent clients can expect from them as pertains to their availability, and for therapists to, when possible, provide resources for any periods of unavailability (e.g. recommendations for an interim therapist). She explained how *"[...] it's so important when you're working with neurodivergent people who are often more vulnerable [...] and very literal [...] how we talk about- When we're making our next appointment"*.

Exposure therapy

The exposure therapy category contained three CI's, two of which were hindering CI's and one was a helpful CI.

Nora had found exposure therapy "*In the beginning really really unpleasant*" but also expressed that *"I think that it works [...] like, it's not as bad anymore to go out [...] when I know I'm going out alone"*. The other two participants had experienced exposure therapy as being harmful to them. Nina described how *"[...] the idea that you just have to expose yourself to the things you're uncomfortable with"* had been hindering for her, and how *"[...] every time I kind of expressed that 'it isn't working' or 'it's not working in the right way'"* she was told *"[...] that's not true"*. In her follow-up interview, Nina also explained how she felt that the logic behind applying exposure therapy to her anxiety was flawed, as her anxiety stemmed from what she referred to as autistic overload, and was worsened by exposing her further instead of first regulating arousal. Emma explained how she felt the method was inappropriately applied to her social anxiety:

> *[...] my social [...] anxiety is not anxiety. [...] It's a long life's worth of*
> *bad experiences with having a hard time engaging in social situations qua*
> *my neurotype. [...] I have social fear [...] And fear is based in something*
> *real. It's not just thoughts you have to challenge, it's fucking experience*
> *that sits in the body and nervous system, that the more you poke it, the*
> *worse you feel.*

Emma explained how *"It's been 10-15 years since I started it [exposure therapy] and I'm still paying the price for it now"*.

Discussion

Suggested adaptations

The objective for this study was to explore what factors and incidents autistic adults experienced as significant for their psychotherapeutic treatment, and how these factors and experiences may suggest possible adaptations to better accommodate the needs of this patient group. The suggested adaptations are briefly summarized below.

Therapists should be aware when working with late-diagnosed autistic adults that they may need support settling into the diagnosis and understanding its implications. Such support might for example be given in psychoeducational resources. Therapists should also be sensitive to the fact that the diagnosis may shed new light on years of difficulties, and that clients may need help processing this. Therapists should also approach their autistic clients with curiosity, and willingness to put aside preconceived notions on autism, and the autistic clients' experiences of their co-occurring issues. Frequently checking in with clients on their emotional state and wellbeing, and accepting their judgment is encouraged. Therapists are also encouraged not to interpret their autistic client's need for details and clarification as resistance. Approaches such as certain aspects of CBT may not be applicable to this population without adaptation, as asking autistic people to change their thinking when they are not doing well may not be a meaningful approach to the client. Clients may also benefit from providers shifting their understanding of autism away from perspectives that regard it as inherently pathological. Suggestions on how to signal acceptance to clients were given, and included, but were not limited to, adhering to clients' preferences for disability-first vs. person-first language, explicitly stating that they are not expected to suppress autism-related behaviors, and seeking training and knowledge on autism based on autistic people's own perspectives.

Regarding communication with the client, outcomes may benefit from using concrete experiences or observations from the clients' lives as points of departure for the conversation. Diversifying pathways of communication may likewise be beneficial, e.g. by using visual models, or imagery that falls within the client's frame of

reference. Avoiding vague speech and generalizations is also suggested, as well as avoiding relying too much on non-verbal communication. Results also indicated that counting on autistic clients "reading between the lines" would be counterproductive, and that assumptions on what constitutes common knowledge should be put aside. It was also suggested that therapists should explicitly acknowledge differences between the respective communication styles of therapist and client, and that they should assume primary responsibility for mutual understanding.

Ensuring that interventions target specific, concrete issues in the client's life in ways that are tailored to the individual is recommended, as this was reported to help clients put them into practice and gain agency over their mental health. Thorough instructions and backup plans should be provided. Clients should be involved in adapting tools and homework tasks to fit their needs and capabilities.

Regarding helping autistic clients with their social skills and needs, cooperative decoding of clients' experiences is recommended, as autistic clients may need help filling in missed social cues or contextualizing other people's reactions. Helping them navigate social etiquette such as expectations and boundary setting may also be helpful.

Incorporation of emotion regulation techniques such as breathing exercises may be helpful. Therapist-guided approaches to managing bodily sensations and physiological response to strong emotions may also be beneficial, and help autistic clients better connect these to emotional and cognitive states.

With regard to sensory accommodations, therapists working with autistic clients should aim to avoid an overstimulating environment, by e.g. minimizing noise, providing sheltered waiting areas, or simplifying décor. Providing stim-toys can also be recommended.

While disruptions to therapist availability are sometimes unavoidable, therapists working with autistic clients might ameliorate the effects of such disruptions by communicating clearly when they will be available again when possible, and in case of prolonged unavailability providing recommendations for interim providers. Frequent changes in providers should be avoided where possible. It may also be beneficial to consistently follow up on discussions from the previous session, and to prepare clients for the proposed topics for the next session in advance.

While findings regarding the application of exposure therapy were divided, therapists should carefully consider individual client characteristics such as stress-sensitivity and source of anxiety when judging whether exposure therapy is a good fit for their client. Close monitoring of the impact of exposure should be done continually to avoid adverse effects.

Perhaps the most important suggestion that can be made based on this study, however, is for therapists working with autistic clients to adapt their practices to the individual, using the client as an expert witness to their own capability and experience. These findings clearly suggest that there is no one-size-fits-all approach for treating autistic adults for their co-occurring mental health concerns. This theme is discussed in more detail in the Closing framework.

Alignment with existing literature

The findings described above are predominantly congruent with other literature investigating psychotherapeutic treatment of autistic people for co-occurring mental health concerns. This includes findings regarding the importance of therapists taking an accepting stance to their autistic clients' traits and experience (Camm-Crosbie, 2019; Gilmore et al., 2022; Mazurek et al., 2023). The recommendation for interventions to target specific goals identified in collaboration between client and therapist were likewise aligned with other studies of this specific patient group (e.g. Gilmore et al., 2022; Jubenville-Wood et al., 2023a). The findings regarding the negative impact of uncertainty and unpredictability stemming from changes in providers or unavailability are also consistent with research regarding autistic people's tendency to struggle tolerating uncertainty (Jenkinson et al., 2020). Findings regarding communication between client and therapist also concur with other studies in this field in several respects, such as the difficulties described by participants regarding open-ended or vague questions and non-verbal communication (Bradshaw, 2024; Jubenville-Wood et al., 2023a, 2023b). Results suggesting that offering several pathways of communication (e.g. visual models or concrete observations) may help to bridge the communicative gap between differently functioning minds closely mirror findings on autistic adults' experiences in somatic healthcare (Bradshaw, 2024). Accommodations for sensory sensitivities identified here are also consistent with existing research (Goll Rossau et al., 2024).

Similarly, when comparing the results of this study to models of psychotherapy regarding common factors, several factors align. The most referenced category in this study was *Acceptance and de-pathologization*, in which the effects of factors such as being believed by your therapist and not being expected to suppress traits and behaviors in therapy were emphasized. These factors align closely with the common factor of the therapeutic relationship as described in the Contextual Model (Messer & Wampold, 2002; Wampold, 2015; Wampold & Imel, 2015), which posits that one of the three major pathways of change in psychotherapy is the genuine, empathetic and non-judgmental relationship with the therapist. This being the most referenced category of the study appears concurrent with the Contextual Model's claim that the relationship is as impactful as any specific elements of treatment modalities, and is worth putting a specific and intentional effort in to establish (Wampold & Imel, 2015). Another identified factor in this study was the importance of interventions making sense to the client and aligning with their personal understanding of the problem at hand. This resembles the description given in the Contextual Model of the second pathway of change, which is the expectations of the client (Wampold, 2015). These commonalities with common factors-based theory would seem to suggest that the needs of autistic clients bear significant resemblance to the therapeutic needs of the general population.

Some discrepancies between the present results and existing research do appear, however, when comparing them to studies investigating approaches to management of the ASD itself, rather than of the co-occurring issues. One such case is Nina and Emma's reported negative experiences with CBT-based approaches. CBT is widely recommended for treatment of anxiety disorders and depression in autistic people (Rosen et al., 2018; Wichers et al., 2022) and has been posited to be an ideal choice of intervention for autistic adults, partially due to the highly structured approach (Ozsahin et al., 2021; Spain & Happé, 2020). However, both in the case of Ozsahin et al. (2021) and Spain & Happé (2020), the goal of applying CBT or similarly behaviorally oriented approaches such as Applied Behavioral Analysis was the management of ASD. The idea that autistic traits and behaviors were something to be treated was explicitly rejected and reported as a hindering factor by both Emma and Nina. As such, the difference in recommendations may be a question of vastly different views on autism as a disorder.

The participants presented divided experiences with exposure therapy. Despite exposure therapy being regarded by some as the gold standard treatment for pathological anxiety (Hamlett et al., 2023), both Nina and Emma described how it had been applied in their treatment to their detriment. Contrarily, Nora reported benefits from exposure therapy. In Nora's case, exposure therapy was directed at more concrete tasks such as leaving her home alone, while in Emma's case it had been applied to her social anxiety, which may present one potential explanation for their vastly different experiences. However, it is also likely that autistic individuals' higher sensitivity to environmental stressors and heightened emotional responses (Bradshaw, 2024; Rosen et al., 2018) play a significant role in increasing the likelihood of unsuccessful application of exposure therapy.

The findings of this study identified potentially helpful adaptations to practice that were not encountered in the readings that preceded this study. For one, descriptions of the benefits of therapists explicitly taking responsibility for ensuring good communication was not widely represented in the literature. This might suggest that the social workload of attending individual psychotherapy is a factor that is not yet sufficiently understood when it comes to autistic adults who do not at surface level exhibit difficulties with social communication, due to learned masking behaviors, and that clinicians may be liable to taking the effort behind those capabilities for granted. Findings concerning the benefits of incorporating the body beyond the use of breathings exercises and relaxation techniques were likewise not encountered in the readings that preceded this study, possibly indicating an overlooked area of potential. However, it is also likely that such literature has been missed, as the search has primarily been conducted in psychologically and medically oriented journals, and may not have identified relevant literature from other areas of practice (e.g. physical or occupational therapy).

Limitations

There are several limitations to this study, one of which being the number and relatively homogenous characteristics of the participants (e.g. shared sex, comorbid ADHD, and late diagnosis). Such factors may have led the results of this study to reflect a set of challenges and experiences that are not necessarily representative of the broader autistic population and limit the degree to which the results can be generalized. In addition to this, all participants were recruited through Facebook groups where the

discourse is often not overly positive, which may have led to negative bias in the participants' recollections of their experiences in therapy. However, as 46% of the CI's extracted were helping incidents, this seems unlikely.

As for the sample size, it was not possible to include enough participants in this study to achieve data saturation. However, within the ECIT framework, the sample size is not considered to be determined by the number of participants, but by the amount of CI's (Butterfield et al., 2005). When comparing this study to other ECIT studies however, (e.g. Jubenville-Wood et al., 2023a), the sample size is not markedly smaller, despite having less than half as many participants, which would appear to indicate that the present data set is of sufficient size to achieve a rich analysis.

Of the nine credibility checks of the ECIT (see *From CIT to ECIT)*, only some could be met in the present study. The second check referred to as "interview fidelity" could not be met according to standard ECIT practice, as no expert on CIT studies was available. The third credibility check of independent extraction of CI's by another person was not possible. In place of independent extraction, the categories, CI's and WL items within them were presented post-anonymization to an external psychologist (i.e. a former fellow student), as well as the transcripts. The fourth check of calculating exhaustiveness did not make sense in the context of the present study and was not completed. The sixth check of having an independent judge categorize the extracted CI's and WL items could not be met. It was instead sought partially adhered to by the aforementioned discussion with an independent psychologist. The eighth check of submitting the results to two or more experts in the field has not been done as of yet. However the submission of this thesis, and the subsequent defense may serve this purpose.

Due to these limitations, this may be regarded as a partially successful ECIT study, in which adherence to ECIT credibility checks was attempted to the extent that was possible within the practical circumstances of the project.

Future directions

Future research in this area might include further exploration of this same topic, though on a larger scale both in terms of participant number and amount of researchers involved, to better meet the credibility checks of the ECIT and achieve data saturation. Beyond that, comparative research to explore whether providers' and clients'

experiences are mismatched is needed. Additionally, further research on some of the underlying mechanisms of issues related to autism, such as the relationship between interoception, alexithymia and anxiety may provide significant insights into how practitioners may better understand and help their autistic clients. Increased involvement of the autistic therapy recipients themselves in all stages of the research process may also give deeper insight and help elucidate overlooked factors for treatment. This may be especially pertinent in research regarding the needs and experiences of autistic people who do not at surface level present as stereotypically autistic, and exhibit significant masking behaviors.

Conclusion

This study sought to explore what factors and experiences autistic adults without intellectual disability regarded as significant to their psychotherapeutic treatment for co-occurring mental health issues, and what suggestions for adaptations to practice might be made based upon those findings. Due to the limitations of this study, all recommendations for adaptations to practice are tentative, and any practitioners reading them should assess critically whether they are a fit for their practice and clients. Nonetheless, the findings of this study do provide insight into the needs and preferences of autistic adults in therapy, as well as recommendations that in most cases are feasible, and generally uncontroversial when compared to existing literature in this area. This research furthermore indicates that there is room for improvement in several aspects of psychotherapeutic treatment of this population, and highlights the importance of including autistic adults in adapting their own care to their needs.

Closing framework

Due to space restrictions in the article-based thesis format, as well as the ECIT approach being primarily descriptive, further discussion and contextualization of the overarching themes between categories is needed. Therefore, the following section elaborates on two of the emerging themes across categories, and perspectives relating more broadly to mental healthcare services.

Power dynamics in psychotherapy

A prominent theme across several of the categories presented in the results is the power dynamics present in any therapeutic relationship, and how this may be an especially important factor to pay attention to when treating autistic people.

In any treatment context in which a person seeks the advice and perspective of an expert in the field, there is an inherent asymmetry to the relationship, and psychotherapy is no exception (Lindhardt, 2013). While this is not necessarily a disadvantage to the treatment, it is a factor which demands deliberate and thorough consideration on the therapist's part.

The results above would seem to indicate that when treating autistic adults, even further consideration of these power dynamics may be needed. One example of heightened risk of power imbalances becoming a hindering influence when working with autistic clients can be found in the participants' descriptions of how it could at times be hard for them to know how they felt, or how to put their cognitive or emotional state into words. Such difficulties bring with them a heightened risk of practitioners crossing clients' boundaries or encouraging practices with adverse effects without necessarily knowing it. Depending on the autistic client's traits and state, they may not be able to continually assess the effect of any given intervention in the moment, and as such may have a very hard time knowing when to withdraw consent. One such example came from Emma, who explained how she, out of faith in her therapist as an expert, continued to practice mindfulness exercises and CBT approaches, in spite of these having either no effect or adverse effects. She described her thinking at the time in the following terms:

> *[…] there sits this clever lady who tells me that this is damn effective,*
> *and it's just not damn effective […] and then I start thinking it's because*

I'm doing something wrong or it's because something is wrong with me
[...] That narrative, that it's because I'm not trying hard enough, that
turned into 'I [...] goddamn have to mindfulness so hard now [...] and
it just got worse and worse. And the same for the cognitive.

This exemplifies how, when working with people who have a hard time monitoring their state, and tend to think literally, therapists should be especially aware of their position of power as an expert "consultant" in that person's life.

Another theme within the results relating to the power dynamics of treatment is the question of whether to view autism as a disorder in the first place. Both Nina and Emma's expressed discontent at being viewed, as autistic people, through a medical deficit lens. As Emma expressed it, "[…] *I am not sick. I don't need curing. There's nothing wrong with the way that I am human".* To Emma, as she repeatedly expressed in her interview, the preference for being referred to as 'being autistic' rather than 'having autism' seemed indeed not to simply be a preference, but a basic requirement for any sort of trustful alliance to be built between her and her provider. While this could easily be interpreted by providers as resistance, autistic rigidity, and impaired insight regarding her ASD diagnosis, there is another plausible explanation; that the strong reaction is a very logical response to accumulated experiences throughout life of being misunderstood, discounted, and condescended to. In fact, autistic people experiencing similar dynamics with their healthcare providers has been described in the literature (Bradshaw, 2024), indicating that this is a problem on a larger scale. Autistic people are, by nature of the diagnostic criteria of the ICD-10 as well as the DSM-IV (American Psychiatric Association, 2013; World Health Organisation, 2016), described as showing impaired communication. However, this past decade has seen the emergence of several alternate ways of viewing such communicative issues, with The Double Empathy Problem (DEP) being one of the more prominent. The DEP as described by Milton (2012) provides an alternative way of approaching the communicative divide between neurodivergent and neurotypical individual, in which difficulties with understanding and communication between neurotypical and autistic people are not viewed as a deficit on the neurodivergent party's side, but as a mutual divide between differently disposed individuals. The DEP has gained considerable popularity among academics, practitioners, and in popular terminology (Livingston et al., 2024). While the results of this study cannot – nor does it aim to - provide definitive answers

on the utility of the DEP, it is evident that in several incidents, the participants' perspectives and meanings were not understood or considered, such as the incident described above in which Nina's psychiatrist insisted on one particular explanation of her anxiety, rather than listening to hers. Furthermore, when approached with curiosity, participants reported beneficial effect which would seem to indicate that approaches - such as the DEP - in which autistic clients are not by default considered the cause of any miscommunication are viable strategies for building trustful therapeutic alliances. Such approaches may also be helpful to avoid ruptures due to misalignment in understanding of whether autism is in and of itself a problem for the client. Regardless of whether one subscribes to the DEP conceptualization or similar frameworks within neuro-affirming care approaches, there is research to support that professional self-doubt as a therapist is predictive of better outcomes (Nissen-Lie et al., 2017). These factors highlight the importance of the willingness among providers to confront their own biases or pre-existing ideas and conceptualizations of autism, as well as the notion that passing for being neurotypical is not necessarily an indicator of improvement, and may incur great costs down the line such as burnout, anxiety, and suicidal ideation (Lofthouse, 2024; Morris et al., 2025).

Individualized psychotherapy

Across categories, all participants described how they had in particular been helped when their therapists had based treatment on their individual needs, communicative style, and day to day experiences. It may seem banal and commonplace to do so as a psychotherapist, regardless of what diagnoses the client may have. However, the fact that all participants described hindering incidents in which their needs, preferences, and experiences were disregarded due to practitioners' preconceived notions of them suggests that there is room for improvement. It bears mentioning that several of these experiences stemmed from treatment in psychiatric care. This is, naturally, in itself not sufficient background to direct any widespread criticism towards the psychiatric care provided in Denmark's public healthcare sector. It does spark questions as to whether one of the great strongholds of evidence-based practice and biomedical models that is the secondary healthcare sector is necessarily the best place to direct the primary responsibility for treating the co-occurring mental health concerns of autistic adults.

These three participants are far from alone in criticizing certain aspects of psychiatric care in Denmark. The lack of alternatives to the psychiatric system in Denmark has recently been commented on in popular media (Lund & Bruun Pedersen, 2025; Svanborg, 2022), with emphasis being put in particular on problems stemming from disproportionate attention being paid to diagnoses, rather than to the person in treatment. Such considerations may be especially relevant for the treatment of the Danish autistic population, seeing as much of the psychiatric treatment offered in the public healthcare sector consists of so-called "care packages" (i.e. "pakkeforløb"). The package structure was introduced with the explicit purpose of making patient care follow more uniform trajectories for different patients (Danske Regioner, n.d.). While the idea behind this is, according to Danske Regioner (n.d.), to ensure that all patient care conforms to the same quality standard, it may not be the best fit for a patient group that by the very nature of their ASD do not think and process information, sensory input and emotions quite like the average patient, and may as indicated by the findings of this study have a greater need for individually tailored care. Furthermore, autistic individuals often have a more tenuous connection to the job market, and lower likelihood of completing secondary education compared to their neurotypical counterparts (Toft et al., 2021), and may therefore not have the means to seek such individualized care in the private sector.

The theme of not receiving individualized treatment ties into a greater ongoing debate about the development of what has by some been dubbed an emerging monoculture of medicalizing counselling services (Strong, 2017). The Danish Psychological Association has written into their statement of principles that their members should conduct evidence-based practice (EBP) based on the best possible quality of research. While they do not give any strict limitations for what universally constitutes the best possible evidence (Dansk Psykolog Forening, n.d.), the ideal of EBP in general has been criticized by several scholars, for reasons such as lack of accounting for therapist variability, being steered excessively by neoliberal administrative agendas, and adopting the idea of "gold-standard treatments" rather than aiming for diversity among empirically supported treatments (Leichsenring et al., 2018; Strong, 2017; Wampold & Bahti, 2004).

CBT is widely considered one such gold standard treatment (Leichsenring et al., 2018). However, a closer look at some of literature describing the use of CBT

specifically for treating autistic people's co-occurring mental health concerns shows that studies frequently report several adaptations to CBT protocol being needed to accommodate the individual needs of autistic clients (Flygare et al., 2020; Gilmore et al., 2022; Jubenville-Wood et al., 2023a; Wichers et al., 2022). As for the present study's results, participants mentioned, as stated in the article section, that CBT-based approaches were not helpful for them, as it went against their natural way of thinking. When considering these results as well as the aforementioned literature on using CBT with autistic clients, CBT can be regarded as one example of how even the most popular and empirically supported treatment approaches need to be augmented to fit the individual, and how aiming for more uniform treatment packages may be counterproductive, especially for autistic individuals. What's more, potential fallacies in evaluating the evidence base should be considered, as studies of CBT-based approaches tend to receive quite a lot more funding than other approaches. In the UK, variants of CBT received 40.6% of research funding in psychotherapy according to Leichsenring et al. (2018), and volume of research should not uncritically be equated to quality and strength of evidence.

As mentioned, these considerations may put into question whether the psychiatric sector is necessarily the best place to direct the task of treating autistic adults' co-occurring mental health concerns. One possible avenue to explore with regards to equipping therapists within psychiatric practice to identify and meet the individual needs of patients is for researchers growing the evidence base for different treatment approaches adapted to this population to include the people in question in all stages of research. Integrating lived experience, and synthesizing it with the existing body of research likely bears significant potential for improving services for stigmatized groups (Speyer et al., 2025), and with the frequent communicative barriers present between autistic people and their providers (see *Power dynamics in psychotherapy*), autistic adults are likely no exception. Integration of peer counsellors or peer support workers in a similar fashion to how this is done in the FACT teams of Region Nordjylland (Lerbæk et al., 2024) may also present new and improved opportunities to better treatment and mutual understanding between providers in the secondary sector and their patients.

Concluding statement

As mentioned in the Introductory statement, a large part of my motivation for writing a thesis on this particular topic was the impression that there was an idea circulating among practitioners that autistic people rarely benefitted from psychotherapy. This was, as stated, an exploratory study, and not meant to confirm or deny any specific hypotheses, nor are the experiences of three people sufficient to do so. However, the fact that 50 of 109 items extracted in this study were helping incidents hardly supports the claim that autistic people are not suited to psychotherapy. Another part of the motivation behind this study was the impression that few autistic adults were offered psychotherapeutic treatment within the public sector, partly due to lack of confidence among practitioners in their ability to take on the task. As results indicated, however, simply meeting clients with openness, curiosity, and acceptance went a long way towards treatment being helpful to them. Nonetheless, results would seem to suggest that there are several other factors for treatment of this population that warrant additional and deliberate attention.

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