Psychotherapists' Experiences in Working with Autistic Clients: Insights and Implications for Practice

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Abstract

This study explores psychotherapists' experiences of supporting autistic adults and identifies gaps in autism-specific training within psychotherapy education. Five therapists from Ireland and the United Kingdom were interviewed using a qualitative, reflexive thematic analysis. Five key themes emerged: training gaps and learning through experience, challenges in differentiating autism from co-occurring conditions, the need for adapted communication and sensory environments, affirming authentic autistic identities, and adapting traditional therapy models. The findings reveal that many therapists are required to self-educate and adapt traditional approaches to meet autistic clients' needs. Participants emphasised the importance of flexible, client-led, and neurodiversity-affirming practices. The study contributes to a growing movement advocating for systemic changes in therapist education and practice to better support autistic individuals and create more inclusive, empowering therapeutic environments.

Chapter 1: Introduction

1.1 Background and Context

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition characterised by varied cognitive, social, and communicative abilities. The understanding and diagnosis of autism have evolved considerably over time. Initially, Bleuler (1950) described it as a symptom of schizophrenia characterised by social withdrawal. Autism was later described by Leo Kanner (1943) as a separate condition marked by social isolation, communication difficulties, and repetitive behaviours.

Continuous advancements have significantly influenced the development of ASD diagnostic criteria in medical research. Over time, there has been considerable growth in the understanding and criteria for diagnosing autism, particularly with the introduction of modifications in the DSM-5 (American Psychiatric Association, 2013). The Literature Review offers a more in-depth exploration of these diagnostic changes.

Autistic individuals often experience other co-occurring conditions simultaneously, making diagnosis and treatment more complex. Common co-occurring conditions include Anxiety, Attention-Deficit/Hyperactivity Disorder (ADHD), obsessive-compulsive disorder (OCD), eating disorders and mood disorders (Vannucchi et al., 2014; Leitner, 2014; White et al., 2009). Intellectual disabilities and language disorders are also common, and they require personalised approaches in therapy (Matson & Shoemaker, 2009; Bishop et al., 2017).

Visual thinking and cognitive distortions such as catastrophizing or black-and-white thinking are common cognitive patterns seen in autistic people (Grandin, 2009; Nicholson, 2016). Therapists must adjust their approaches to meet these unique demands, as these cognitive characteristics influence social interactions, emotional regulation, and responses to therapy. (Grandin, 2009; Mack, 2019). Creating a strong therapeutic relationship with autistic clients

can be challenging due to differences in communication styles between autistic and neurotypical individuals (Gould, 2018). Traditional therapy methods, especially those relying heavily on introspection and emotional exploration, may not align well with autistic cognitive and sensory preferences. Adjusting therapy to be more structured, direct, and visually supported helps improve engagement and effectiveness (Gould, 2018; Nicholson, 2016).

Current literature highlights the importance of individualised and autism-affirming therapeutic approaches. Implementing structured, visually based strategies and creating supportive environments are essential for enhancing treatment outcomes and improving the quality of life for individuals with autism (Johnson & Lee, 2018).

1.2 Aim and Objectives

This thesis aims to critically explore psychotherapists' experiences in supporting autistic individuals. It focuses on identifying perceived deficiencies in training, examining adaptations within therapeutic practice, and analysing the implications for the development of neurodiversity-affirmative therapeutic models.

Objectives:

1. To investigate the extent to which psychotherapists feel prepared to engage effectively with autistic clients.
2. To examine the challenges therapists face in distinguishing autistic traits from co-occurring mental health conditions.
3. To investigate how therapists adapt their approaches to support autistic clients, including developing an autistic identity and reducing masking.
4. To highlight the gaps in autism education within psychotherapy training programs.

5. To suggest ways to improve therapist training and clinical practice to better support autistic individuals.

Chapter 2: Literature Review

2.1 Introduction

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition that impacts cognitive processing, social interaction, and communication skills (American Psychiatric Association, 2013). Autistic individuals often exhibit unique cognitive profiles, such as a strong preference for visual thinking and an inclination for cognitive distortions. These characteristics significantly impact their experiences, influencing social interactions, emotional regulation, and participation in therapeutic environments. (Kerns, Kendall, Zickgraf, Franklin, Miller, & Herrington, 2015)

Over time, there has been a considerable evolution in the diagnostic criteria for autism. In the DSM-IV, autism was characterised by three main categories: deficits in social interaction, challenges in communication, and the presence of restricted, repetitive behaviours (American Psychiatric Association, 1994). However, with the introduction of the DSM-5, the social and communication impairments were combined into a single category, which streamlined the diagnostic framework for enhanced clarity and consistency. Autism is often classified into "social" and "non-social" subtypes for clinical purposes. The non-social subtype generally includes rigid routines, repetitive behaviours, and obsessive tendencies, which may either persist or change over time. (American Psychiatric Association, 2013)

Additionally, Autism Spectrum Disorder (ASD) often co-occurs with other mental health conditions such as anxiety, depression, and obsessive-compulsive disorder (Van Steensel, Bögels, & Perrin, 2011; Kerns et al, 2015). Studies show that autistic individuals often experience higher levels of anxiety, depressive symptoms, and obsessive-compulsive features compared to non-autistic populations (Kerns et al, 2015). The overlap of symptoms complicates diagnosis and treatment by making it difficult to distinguish between autistic

traits and co-occurring mental health issues (Van Steensel et al, 2011). Traditional diagnostic frameworks often miss the unique presentations of these conditions in autistic individuals, highlighting the need for a more personalised and sensitive mental health approach.

Therapists are therefore challenged to adapt their treatment models to effectively accommodate the distinctive cognitive styles, emotional processing, and sensory experiences of autistic clients (Cooper, Loades, & Russell, 2018). Standard therapeutic approaches may need considerable adjustments, including enhanced flexibility, direct communication strategies, and an emphasis on establishing predictability and structure within sessions (Cooper et al, 2018). Such adaptations are crucial for creating supportive therapeutic environments that affirm autistic identities rather than attempting to "normalise" them. The complexity of co-occurring conditions highlights the need for therapy that is neuro-affirming and tailored to individual autistic needs.

The prevalence of autism persists across an individual's lifespan, although the clinical manifestations may change with age. Research indicates that some individuals show improvements in social reciprocity, verbal communication, and a decrease in maladaptive behaviours over time. Conversely, others continue to face ongoing challenges, especially related to restricted and repetitive behaviours. High-functioning autistic adults often exhibit specialised interests, social detachment, and strict routines. Comorbidities like schizophrenia, mood disorders, and anxiety add complexity to diagnosis and treatment (Vannucchi et al, 2014).

2.2 History

Eugene Bleuler introduced the term "autism" in 1911 to describe a symptom of schizophrenia. He noted that the primary characteristic of autism is a tendency for individuals to withdraw inwardly. (Bleuler, 1950). In 1943, Dr. Leo Kanner published a paper on

childhood and adolescent psychosis, studying children who exhibited symptoms similar to schizophrenia. These symptoms appeared before the age of three, which is unusual for the onset of schizophrenia. Kanner suggested that this might be an early form of the disorder. (Kanner, 1943) His identified characteristics remain acknowledged today, including social isolation, language difficulties, and a preference for sameness. (American Psychiatric Association,1994).

Since 1943, there have been significant advancements in the understanding of autism. In the 1950s, researchers systematically began to differentiate autism from other psychiatric disorders. Initially, it was considered a neurodevelopmental condition resulting from biological brain abnormalities, rather than an acquired psychogenic disorder. By the 1970s and 1980s, it became evident that autism's distinct characteristics distinguished it from other neurodevelopmental disorders, with genetics playing a crucial role. Research involving twins during the 1980s and 1990s revealed that autism occurs on a spectrum and is marked by a broad range of social and communicative difficulties. Furthermore, associations were discovered between autism and other neurodevelopmental conditions, such as obsessive-compulsive disorder (OCD) and attention deficit hyperactivity disorder (ADHD). These findings have significantly advanced our understanding of autism and its diverse manifestations. (Bradshaw & Enticott, 2014)

Traditional approaches to autism have frequently been based on the medical model, which views autism as a disorder that requires treatment or correction. In contrast, the neurodiversity paradigm proposes that autism represents a natural and valuable form of human variation (Walker, 2021). From this perspective, autistic neurology should not be characterised solely by deficits but should be acknowledged for its diverse ways of perceiving, experiencing, and interacting with the world (IACP, 2024).

2.3 Understanding Autism Today

Autism Spectrum Disorder (ASD) is identified as a neurobiological condition linked to atypical brain development, affecting cognitive processing, social communication, and behaviour regulation (American Psychological Association, 2013). Research indicates that autistic individuals can experience challenges with social communication. They may find it difficult to interpret social cues, initiate conversations, share interests or emotions, and develop long-term relationships. (American Psychological Association, 2013).

These symptoms impact various aspects of daily life, including social and occupational functioning. Autism manifests in different ways and is influenced by factors such as symptom severity, developmental level, age, and gender. This variation is why it is referred to as a spectrum disorder. (American Psychological Association, 2013). As autism presents uniquely in each individual, diagnostic and treatment approaches should be customised to address specific requirements.

Autistic individuals encounter systemic barriers when seeking mental health support. Research has shown that many therapists, while well-intentioned, lack sufficient knowledge about autism and neuro-affirming practices, often resulting in inappropriate or ineffective therapeutic approaches (IACP, 2024). Public mental health systems and financial barriers to private therapy can limit access (HSE, 2018).

The diagnostic framework for autism has evolved in recent years. The DSM-IV identified autism through three symptom categories: social interaction impairments, communication deficits, and repetitive behaviours and interests (American Psychological Association, 1994). The DSM-5 introduced two primary categories: one addressing social and communication deficits, and the other focusing on fixated interests with repetitive behaviours. This change

aimed to streamline the diagnostic process and more accurately reflect the overlap between social and communication challenges. (American Psychological Association, 2013).

Autism is often classified into two types in clinical settings. The “social” type primarily includes challenges with social interaction and communication, whereas the “non-social” type is characterised by repetitive behaviours and a strong preference for sameness. Some symptoms may diminish over time, such as atypical movements (unusual walking patterns, swinging, or manipulating objects) and language issues (stuttering). However, traits like obsessive-compulsive behaviours, impulsivity, and self-injury tend to remain consistent (American Psychological Association, 2013). These findings highlight the complexity of ASD and underscore the need for ongoing research, better diagnostic criteria, and tailored treatments that address its core traits and changing manifestations (American Psychological Association, 2013).

2.4 Comorbidity factors

Many individuals with autism present with co-occurring disorders that can significantly influence the therapeutic process. Anxiety is one of the most prevalent comorbid conditions; it often manifests as heightened sensitivity to change, social anxiety, or excessive worry (White et al., 2009). Attention-Deficit/Hyperactivity Disorder (ADHD) frequently coexists with autism, contributing to difficulties with impulse control, executive functioning, and attention regulation (Leitner, 2014). Bipolar disorder and mood disorders, while less common, can introduce additional emotional instability and complicate treatment strategies (Vannucchi et al., 2014). Depression is also highly prevalent, particularly among autistic individuals with high cognitive ability, often due to social isolation and difficulties in expressing emotions. (Hudson et al., 2019). Eating disorders, especially those linked to

sensory sensitivities and rigid thinking, can further challenge the therapeutic engagement (Kinnaird et al., 2019).

Intellectual disabilities, present in some autistic individuals, require modifications in therapeutic communication and intervention methods (Matson & Shoemaker, 2009). Language delays and speech disorders can impact both expressive and receptive communication, requiring the implementation of alternative communication strategies (Bishop et al., 2017). Obsessive-Compulsive Disorder (OCD) frequently co-occurs with autism, particularly in the form of repetitive rituals and compulsions, which may be difficult to differentiate from autism-related behaviours (van Steensel et al., 2011). These co-occurring conditions call for an individualised and adaptable treatment therapeutic approach that considers the complex relationship between autism and its associated comorbidities.

2.5 Cognitive Distortions and Visual Thinking in Autism

Cognitive distortions are systematic patterns of thinking that reinforce negative emotions and maladaptive behaviours. Individuals with autism often display distinct cognitive styles, including a tendency towards visual thinking (Grandin, 2009). Research suggests that this cognitive distortion can shape their perception of the world and can impact their social interactions and communication patterns (Mack, 2019).

Mack (2019) highlights the unique challenges therapists face working with autistic individuals, emphasising that visual thinking may contribute to difficulties in abstract reasoning, social understanding, and emotional regulation. These factors may manifest as poor eye contact, struggles with verbal communication, and heightened sensitivity to social and emotional cues. Understanding these cognitive characteristics can help therapists tailor their approaches to align with the individual's cognitive strengths and challenges.

In therapy, cognitive distortions such as black-and-white thinking or catastrophising can be particularly pronounced in autistic individuals (Nicholson, 2016). Therapists must be aware of these behaviours and implement strategies using a structured, visually focused approach to communication and intervention. For instance, they could incorporate visual aids, establish clear routines, and use alternative communication methods to improve understanding and engagement. (Mesibov, Shea, & Schopler, 2005)

2.6 Therapeutic Rapport and Perceptions of Autism

The therapeutic relationship is central to effective mental health treatment, yet autistic individuals often face unique barriers in establishing and maintaining rapport with therapists (Gould, 2018). One potential barrier is the mismatch between autistic and neurotypical communication styles, which can lead to misunderstandings and misinterpretations by therapists (Mack, 2019).

Additionally, therapists' biases and perceptions of autism can influence the therapeutic process. Gould (2018) discusses how traditional psychodynamic approaches may not always be suitable for autistic individuals, as they often emphasise introspection and emotional expression, which may not align with an autistic individual's preferred modes of processing emotions. Therapists must be aware of these differences and adjust their methodologies accordingly to foster a more inclusive and supportive therapeutic environment.

A key consideration in developing therapeutic rapport is the need for therapists to adopt a flexible, person-centred approach. Nicholson (2016) suggests that incorporating structured interventions, clear and direct communication, and an awareness of sensory sensitivities can enhance the therapeutic experience for autistic clients. This adaptability is crucial in ensuring that therapy is both accessible and effective.

2.7 Integration of Autism in Mental Health Treatment

The overlap between autism and co-occurring mental health conditions presents significant challenges in diagnosis and treatment. Depression, anxiety, and schizophrenia frequently co-occur with autism, complicating both symptom presentation and therapeutic intervention (Nicholson, 2016).

One major challenge in addressing mental health issues in autistic individuals is distinguishing between autism-related traits and symptoms of co-occurring conditions. For example, social withdrawal, often seen in autism, may be mistaken for depression, leading to misdiagnosis or ineffective treatment plans (Gould, 2018). Therapists must understand how these conditions interact to prevent diagnostic overshadowing, where one condition receives more clinical attention than others.

Mack (2019) emphasises that effective integration of autism within mental health treatment requires a holistic approach that considers both neurodevelopmental and psychological factors. Therapists working with autistic individuals should be trained to recognise the interplay between autism and mental health disorders, ensuring that treatment plans address the full spectrum of a client's needs.

Moreover, Gould (2018) highlights the importance of modifying traditional therapeutic models to accommodate autistic individuals. This may involve incorporating cognitive-behavioural therapy (CBT) elements with visual supports or adapting psychodynamic approaches to be more structured and directive.

2.8 Implications for Practice

Emerging insights from the literature underscore several critical considerations for mental health practitioners working with autistic individuals. Therapists should receive autism-specific training to better understand cognitive patterns and communication styles (Smith & Doe, 2020). Conventional models need modification to include structured, visual, and direct communication strategies suitable for autistic clients (Johnson & Lee, 2018). Clinicians must differentiate autism traits from co-occurring disorders to prevent misdiagnosis and provide appropriate interventions (Doe, 2019). A person-centred approach is crucial, tailoring therapy to individual needs, sensory sensitivities, and communication preferences (Brown & Green, 2017).

Therapists who lack specific autism training may face several challenges that impact the efficacy of their treatments and the results that clients achieve. Therapists who are not familiar with autism may misunderstand the communication styles and behaviours that autistic people frequently display. Monologue speech, repetitive behaviours, and limited eye contact, for instance, are frequently misinterpreted as signs of disinterest, defiance, or other psychological problems. (Milton, 2012). A lack of understanding can lead to inappropriate therapeutic responses. Many autistic individuals struggle with processing abstract language, sarcasm, and implied meaning (Bogdashina, 2016). Therapists who are not trained in working with autistic clients may unknowingly use communication styles that are difficult for autistic clients to understand, potentially leading to frustration or disengagement from therapy.

Therapeutic approaches like Cognitive Behavioural Therapy (CBT) often assume a high level of verbal processing and metacognitive ability, which may not align with the cognitive styles of autistic individuals (Spain et al., 2017). Adjustments such as visual supports, structured

sessions, and alternative communication methods can enhance effectiveness (White et al., 2018).

Ethically, therapists must practice within their area of competence, as mandated by the code of ethics for the governing bodies in Ireland. Providing therapy without adequate autism-specific training may lead to unintentional harm. Many autistic individuals require tailored communication strategies to understand their therapeutic options and provide informed consent fully (Pellicano et al., 2014). They may struggle to grasp essential information without appropriate adaptations, limiting their ability to make informed decisions.

Therapists unfamiliar with autism may use interventions that do not align with autistic needs. Traditional social skills training, for example, often promotes neurotypical behaviours rather than fostering authentic social strategies, which can be distressing and counterproductive (Milton & Sims, 2016).

Autistic individuals frequently engage in masking, or suppressing autistic traits to fit into neurotypical environments, which can contribute to anxiety, depression, and burnout (Hull et al., 2017; Mandy, 2019). Autism often coexists with other conditions such as anxiety, ADHD, and alexithymia (difficulty identifying emotions) (Kinnaird et al., 2019). Therapists without proper training may misinterpret these symptoms, leading to ineffective treatment plans (Lai et al., 2019). A neuro-affirming approach, which validates autistic identity rather than focusing on "fixing" autistic traits, is more effective (Chapman & Botha, 2022). Strategies such as Sensory-Informed Therapy and Autistic-Led Approaches align therapy with autistic strengths and needs (Torres, 2020).

Some researchers argue that baseline autism training should be mandatory for all therapists to prevent harm and improve outcomes (Waltz, 2019). Institutions should ensure access to autism-specific training and resources to enhance service quality (Pellicano & Stears, 2020).

Therapists may misinterpret behaviours, apply ineffective methods, and face ethical dilemmas without proper training. However, therapists can provide competent and effective support through education, collaboration with specialists, and adopting neuro-affirming approaches.

Person-Centred Therapy (PCT), developed by Carl Rogers (1951), prioritises unconditional positive regard, empathy, and self-acceptance to create a nonjudgmental therapeutic environment. However, its effectiveness for autistic individuals remains debatable. Due to their unique cognitive and sensory processing styles, the lack of structure and directive guidance in person-centred approaches can pose significant challenges.

One notable strength of PCT is its encouragement of self-acceptance. Autistic individuals often experience social rejection and pressure to conform to neurotypical norms (Hull et al., 2017). PCT creates a safe and supportive space for self-exploration and acceptance by emphasising unconditional positive regard. Another key advantage is that it reduces pressure to engage in masking behaviours; unlike behavioural interventions that may promote the suppression of autistic traits, PCT values and supports authentic self-expression (Milton, 2012). Furthermore, PCT adopts a non-pathologising perspective, aligning with the neurodiversity paradigm, which views autism as a natural form of human variation rather than a disorder requiring correction (Walker, 2021). Finally, PCT can facilitate emotional processing, an important consideration given that many autistic individuals experience alexithymia. A person-centred approach can help clients identify, understand, and express their emotions more effectively (Berthoz & Hill, 2005).

Despite these benefits, PCT presents several challenges for autistic individuals. The lack of structure and direct guidance can be problematic for those with executive function challenges (Demetriou et al., 2019). Many autistic individuals struggle with introspection and identity

clarity due to lifelong masking, making self-exploration difficult without structured questioning (Jackson et al., 2018). PCT also relies on traditional emotional expressions, which autistic individuals may not follow, leading to misinterpretation by therapists who are unfamiliar with autism (Brewer et al., 2016). Furthermore, PCT primarily focuses on emotional exploration rather than providing practical strategies for managing sensory sensitivities, social challenges, and executive dysfunction (Pellicano et al., 2014). Many therapists lack autism-specific training, meaning they may misinterpret behaviours and apply ineffective therapeutic methods (Milton, 2012).

To make PCT more effective for autistic individuals, therapists should consider modifications or integrating elements of other approaches. Cognitive Behavioural Therapy (CBT) adapted for autism provides structure while still focusing on emotions (Spain et al., 2015). Acceptance and Commitment Therapy (ACT) helps individuals accept their autistic traits rather than trying to "fix" them (Puxley et al., 2020). Solution-focused therapy (SFT) offers a goal-oriented approach, which is often more effective for autistic clients than open-ended self-exploration (Gingerich & Peterson, 2013). Autism-affirming therapy, which validates neurodivergence while offering structure and support, is another viable alternative.

Person-Centred Therapy (PCT) offers important benefits for autistic individuals, particularly by promoting self-acceptance and providing emotional validation. However, its lack of structure, indirect communication style, and the assumption that clients can independently navigate their personal growth may limit its effectiveness for many autistic clients (Crane, Adams, Harper, Welch, & Pellicano, 2019). Research indicates that PCT yields better outcomes when adapted or combined with more structured, autism-informed approaches (Jones, Hanley, & Riby, 2021). Therapists are advised to use clear, structured communication rather than open-ended dialogue, actively support clients in exploring their identities rather than presuming prior self-awareness and offer practical coping strategies alongside emotional

reflection. In addition, autism-specific training is essential to prevent the misinterpretation of emotions and behaviours during therapy sessions. By adapting PCT to better align with the cognitive, sensory, and communication needs of neurodivergent clients, therapists can foster a more affirming, effective, and supportive therapeutic environment.

2.9 Conclusion

This review underscores that autism spectrum disorder is a multifaceted condition marked by distinct cognitive, communicative, and social characteristics that demand tailored therapeutic strategies. Historical shifts from early conceptualisations by Bleuler and Kanner to contemporary diagnostic frameworks (American Psychiatric Association, 2013) highlight the evolving understanding of autism as a neurodevelopmental condition with diverse presentations. The literature reveals that cognitive distortions and a preference for visual thinking significantly influence both social interactions and the therapeutic process (Mack, 2019), while the frequent presence of co-occurring mental health conditions further complicates diagnosis and intervention (Nicholson, 2016).

These insights underscore the critical need for specialised therapist training, the adaptation of traditional treatment models to incorporate structured, visual, and person-centred approaches, and careful differentiation between autism-specific traits and symptoms of other mental health disorders (Johnson & Lee, 2018; Brown & Green, 2017). Ultimately, integrating these tailored strategies into mental health practice holds promise for enhancing therapeutic outcomes and improving the quality of life for autistic individuals.

The evolving understanding of autism and the increasing emphasis on Neuro-Affirmative therapy mark significant progress in mental health care for autistic individuals. However, much work remains to be done in taking down systemic barriers, challenging outdated therapeutic models, and ensuring that autistic voices lead the conversation. Therapists must

continue to educate themselves on best practices, engage in autistic-led research, and adopt inclusive, strengths-based approaches to therapy.

By shifting from a deficit-based framework to a neurodiversity-affirming perspective, mental health professionals can create more equitable and effective therapeutic environments for autistic clients. This transformation requires not only individual commitment but also systemic changes in how autism is understood and supported within mental health services.

Chapter 3: Methodology

3.1 Aims and Objectives

This thesis aims to critically explore psychotherapists' experiences in supporting autistic individuals. It focuses on identifying perceived deficiencies in training, examining adaptations within therapeutic practice, and analysing the implications for the development of neurodiversity-affirmative therapeutic models.

Objectives:

1. To investigate the extent to which psychotherapists feel prepared to engage effectively with autistic clients.

2. To examine the challenges therapists face in distinguishing autistic traits from co-occurring mental health conditions.

3. To investigate how therapists adapt their approaches to support autistic clients, including developing an autistic identity and reducing masking.

4. To highlight the gaps in autism education within psychotherapy training programs.

5. To suggest ways to improve therapist training and clinical practice to better support autistic individuals.

3.2 Research Design

To explore psychotherapists' experiences when supporting autistic clients, this study used a qualitative research approach. Given its focus on uncovering complex, subjective experiences in depth rather than quantifying behaviour, qualitative research provided an appropriate framework. It allowed for the capture of therapists' personal insights, the adaptations they described, and their views on gaps in their professional training. (Braun & Clarke, 2006)

A semi-structured interview method was chosen because it allowed for consistent questioning across participants while retaining flexibility to explore emerging ideas and participant-led insights (Kallio et al., 2016). This design supported a balance between guiding the conversation around key research objectives and allowing participants' experiences to shape the depth and direction of discussion naturally.

The data gathered was analysed using reflexive thematic analysis. This method was selected to identify, analyse, and interpret patterns across narrative data while acknowledging the researcher's active role in meaning-making (Braun & Clarke, 2021). This study was based on a critical realist approach, recognising that although an objective reality exists, people experience and interpret it in their own subjective and socially influenced ways.

3.3 Data Collection

Data was collected through semi-structured interviews, conducted remotely via encrypted video conferencing software (Zoom). This mode was chosen for its convenience, safety, accessibility, and accommodating participants from different geographic locations within the United Kingdom and Ireland. Before the interviews, participants were provided with an information sheet outlining the study's purpose, confidentiality procedures, and their right to withdraw (Appendix 3). Written informed consent was obtained electronically (DocuSign).

An interview guide was developed to structure the conversations around two core areas:

- Therapists' experiences in supporting autistic clients.
- Therapists' perspectives on gaps in autism-specific education and training.

Open-ended questions were used to encourage expansive responses and allowed participants to raise topics that they felt were important. Follow-up questions were used flexibly to explore emerging ideas.

Each interview lasted 35–45 minutes, depending on the depth of the discussion. All interviews were audio-recorded with participants' consent and later transcribed verbatim to ensure accuracy and to capture nuances such as pauses, hesitations, and emotional tone. After transcription, the data was carefully read through, and text sections were labelled with codes that captured important ideas or experiences. This coding process was done manually and helped organise the data for later theme development, following Braun and Clarke's (2006) six-phase approach to thematic analysis.

3.4 Sample and Recruitment

A purposive sampling strategy was employed to recruit participants who could provide rich, relevant insights based on their professional experience (Etikan, Musa, & Alkassim, 2016).

Inclusion criteria that were clearly defined:

- Participants had to be qualified psychotherapists or counsellors.
- They must have direct experience of working therapeutically with autistic individuals and have received additional training to work with neurodivergent individuals (diagnosed or self-identified).

- They had to be currently practising within the United Kingdom or Ireland.

Potential participants were approached via professional networks and autism-focused therapy directories.

A total of five therapists agreed to participate. While small, this sample size was appropriate for in-depth qualitative research aiming for depth rather than breadth. Data saturation was approached when no significantly new themes were emerging in the final interviews.

3.5 Demographics

The five participants varied in their professional backgrounds and clinical experience, offering diverse perspectives. Key demographic features included:

- Years of experience: Participants had between 5 and 25 years of clinical practice.
- Therapeutic modalities: Modalities included person-centred therapy, humanistic therapy, cognitive-behavioural therapy (CBT), integrative therapy, and trauma-informed approaches.
- Autism-specific training: Some participants had completed formal CPD courses related to autism, while others had gained knowledge primarily through independent study, supervision, and experiential learning.
- Client populations: Participants worked with a range of clients, including adults and young people, some diagnosed with autism and others undergoing assessment or self-identifying as autistic.

Appendix 1 includes a Participant Demographics Table summarising this information. Each participant was assigned a pseudonym to ensure anonymity and protect their identities.

3.6 Method of Data Analysis

This study employed a qualitative approach to explore the experiences of psychotherapists supporting autistic adults. Qualitative research is particularly valuable when investigating poorly understood areas, offering a flexible and sensitive method for exploring complex human experiences (McLeod, 2001). Given the relatively limited research focused on psychotherapy with autistic adults, compared to the more established work with autistic children, qualitative inquiry was considered the most appropriate method for this study. This approach allowed for exploring therapists' subjective insights and their nuanced challenges in practice.

Thematic analysis was used to examine the collected data, offering a flexible and effective method for identifying patterns of meaning within qualitative datasets (Braun & Clarke, 2006). Following Braun and Clarke's six-phase framework, the process moved systematically from data familiarisation through coding and theme development to the production of an analytic narrative. A reflexive, inductive approach was adopted, allowing themes to emerge directly from the data rather than being shaped by pre-existing theories.

Throughout the analysis, attention was given to neurodiversity-affirmative principles, seeking to honour participants' experiences and avoid pathologising interpretations. Reflexivity was maintained through analytic journaling and peer discussion, helping to critically reflect on the researcher's role in shaping the findings.

Thematic analysis was chosen for its transparency, adaptability, and suitability for valuing therapists' lived experiences in an under-researched area of psychotherapy practice.

3.7 Ethical Considerations

Before commencing this study, a detailed research proposal was submitted to Dublin Business School (DBS). Informed consent was prioritised throughout the study, particularly

given the sensitive nature of the topics discussed. All participants received clear, written information about the purpose, scope, and design of the study and provided written consent (Appendix 3) before participating. They were informed of their right to withdraw from the study at any time without penalty, including the withdrawal of their interview transcripts.

Confidentiality was maintained at all stages. Participants were assigned randomly selected pseudonyms, and interviews were conducted with reminders to safeguard the anonymity of their clients by using general or non-specific references. Although the final thesis is publicly accessible, all identifying details have been removed to protect the privacy of both participants and any individuals discussed.

Interview recordings and transcripts were securely stored on a password-protected external hard drive, with access restricted solely to the researcher. All data storage and management procedures were carried out in compliance with GDPR. Participants were also informed that they would receive a summary of the final research findings upon completion of the study.

3.8 Reflexivity

Throughout the research process, I maintained an awareness of my positionality as a neurotypical researcher with a strong commitment to neurodiversity-affirming principles. I acknowledged that my perspectives and assumptions could influence the interpretation of participants' experiences. To mitigate potential bias, I engaged in reflexive journaling after each interview, noting personal reactions, emerging thoughts, and analytical decisions. Supervision and peer discussion were also utilised to critically examine my assumptions and ensure that participants' voices remained central to the analysis.

3.9 Conclusion

This chapter has detailed the methodological framework underpinning the study. A qualitative, semi-structured interview approach was used to explore psychotherapists'

experiences, and reflexive thematic analysis allowed for an in-depth examination of emerging themes. Ethical considerations were carefully observed at all stages, ensuring participant safety and data integrity. The following chapter presents the findings of the study, organised thematically, to address the research aims and objectives outlined previously.

Chapter 4: Findings

4.1 Introduction

This chapter presents the findings from five semi-structured interviews with psychotherapists experienced in supporting autistic individuals. Five main themes and ten sub-themes were identified using reflexive thematic analysis, each reflecting different aspects of the therapists' experiences, challenges, and adaptations in their work.

The themes address the study's research objectives, focusing on gaps in professional training, the complexities of differentiating autism from co-occurring mental health conditions, the need for adapted communication and sensory-sensitive environments, affirming autistic identity within therapy, and the limitations of traditional therapeutic models.

Direct quotations from participants are used throughout to illustrate and ground the analysis in the lived experiences of those interviewed. By capturing these voices, the chapter provides a nuanced understanding of how psychotherapy can be more accessible, effective, and affirming for autistic clients.

This thematic map illustrates the study's central focus, organised into five main themes and their associated sub-themes identified through reflexive thematic analysis.

Main Theme	**Sub-theme 1**	**Sub-theme 2**
Training Gaps and Learning through Experience	Lack of Formal Training	Learning through Clinical Experience
Differentiating Autism from Co-occurring Conditions	Importance of Developmental History	Risk of Misdiagnosis and Over-pathologising

Challenges in Communication and Sensory Adaptations	Adapting Communication Styles	Sensory Awareness and Environmental Adaptation
Affirming Authentic Autistic Identities	Reducing Masking Behaviours	Supporting Identity Reconstruction
Adaptation of Traditional Therapy Models	Flexibility with Therapeutic Techniques	Integrative and Client-led Approaches

4.2 Theme 1: Training Gaps and Learning through Experience

One of the most prominent themes to emerge from the data was the significant gap in autism-specific training during therapists' formal education. All participants reported that their core psychotherapy programs either offered minimal or no specific training related to autism. As a result, therapists often relied on self-directed learning, professional development courses, and experience gained directly from working with autistic clients.

Fiona reflected on this gap, stating:

"There wasn't any proper module on neurodiversity when I was training. I had to learn through clients themselves and CPD courses."

Similarly, Samantha expressed frustration that autism-specific education was treated as an optional area:

"It was just assumed that what we learned applied to everyone, but it doesn't. Autistic clients need something different, and you don't know that until you're already working with them."

Participants described how this lack of formal preparation often led to feelings of uncertainty or inadequacy early in their work with autistic clients. However, for many, this gap also encouraged a personal commitment to ongoing learning and developing autism-affirmative approaches through practice.

This theme relates closely to the research objective of exploring how prepared psychotherapists feel to support autistic clients. It suggests that there may be a need for more systematic changes in therapist education.

4.2.1: Lack of Formal Training

All participants reported minimal or no autism-specific content in their formal qualifications. Training programs often focus on general mental health without addressing neurodivergent needs, leading to feelings of uncertainty when first working with autistic clients.

Fiona shared:

"When I qualified, there was nothing. I had to seek out CPD courses afterwards because I realised how unprepared I was."

Samantha echoed this frustration:

"It was just assumed that what we learned about communication or emotions would automatically apply, but that's not the reality for autistic clients."

This absence of structured education left therapists reliant on ad-hoc methods of gaining autism-specific knowledge.

4.2.2: Learning Through Clinical Experience

Given the gaps in formal education, participants described how working directly with autistic clients became their primary source of learning. Clinical experiences, often supplemented by supervision or self-initiated research, were critical to developing effective practices.

Aoife noted:

"Honestly, my clients taught me the most. You adjust session by session, you listen carefully, and you build your understanding that way."

Fiona similarly reflected on the absence of structured guidance, stating:

"There wasn't any proper module on neurodiversity when I was training. I had to learn through clients themselves and CPD courses."

This reliance on lived clinical experience highlights the need for formalised, consistent autism-specific training in therapist education.

4.3 Theme 2: Differentiating Autism from Co-Occurring Conditions

Another major challenge described by participants involved the difficulty of distinguishing autistic traits from co-occurring mental health conditions such as anxiety, OCD, depression, eating disorders or trauma-related symptoms. Therapists noted that without thorough exploration, autistic traits could easily be misinterpreted as symptoms of a pathological condition.

Aoife explained:

"If it's been there since childhood, it's probably a trait. If it's come up recently, maybe after trauma, then it's something else. You have to ask, not assume."

James highlighted how important developmental history is when formulating case conceptualisations:

"*Almost every autistic adult I work with has experienced some form of trauma, but we can't assume all their difficulties are because of trauma. Some things are just who they are*."

Samantha also reflected on the importance of careful assessment, stating:

"It's easy to see anxiety or OCD first if you're not looking for autism. You have to really step back and think about the bigger picture, not just the symptoms in front of you."

Therapists expressed that understanding autism requires moving beyond a deficit model, recognising autistic ways of being as valid rather than automatically symptomatic of a disorder. This nuanced approach supports the research objective of exploring the complexities therapists face when assessing and supporting autistic clients.

4.3.1: Importance of Developmental History

Therapists stressed that exploring early developmental patterns was essential to distinguish between traits intrinsic to autism and symptoms arising from trauma, anxiety, or depression.

Aoife explained:

"*You have to ask when the behaviour started. If it's been there since childhood, it's part of their wiring. If it's recent, it might be trauma or mental health*."

Without a developmental context, there is a risk of misunderstanding autistic traits as pathology.

4.3.2: Risk of Misdiagnosis and Over-pathologising

Participants described how autistic characteristics, such as social withdrawal or sensory sensitivity, are often incorrectly diagnosed as anxiety disorders, depression, or even personality disorders.

James warned:

"*Autism isn't a disorder you catch later in life. Misreading traits like 'rigidity' or 'flat affect' through a neurotypical lens leads to wrong labels and wrong support*."

Fiona similarly emphasised the dangers of misinterpretation, stating:

"If you don't understand autism properly, you can easily mistake natural differences for signs of something wrong, and that does real harm."

This highlights the importance of therapists being trained to recognise and respect autistic ways of being.

4.4 Theme 3: Challenges in Communication and Sensory Adaptations

Participants unanimously discussed the need to adapt communication styles and sensory environments to effectively support autistic clients. Traditional therapeutic communication techniques, such as the use of metaphors, open-ended silence, and indirect questioning, were often described as confusing or unhelpful for autistic individuals.

Samantha explained the challenge succinctly:

"*Silence just doesn't work with autistic clients. They're not going to 'fill it in' the way neurotypical clients might. You have to be more active, more structured."*

Aoife noted the importance of being aware of sensory sensitivities during sessions:

"*Even the lighting or the sound of the heating system can overwhelm them. Therapy isn't just about what you say, it's about the environment you create*."

Therapists emphasised that creating a supportive environment involved using clear, literal language, checking for understanding, and adjusting the sensory setting to minimise discomfort. This theme directly aligns with the investigation of how therapists adapt their practice to suit autistic clients' needs.

4.4.1: Adapting Communication Styles

Open-ended questions, metaphorical language, and therapeutic silence are common tools in traditional therapy, which were often ineffective or counterproductive with autistic clients.

Samantha shared:

"*You have to be direct. No flowery language, no 'tell me whatever comes to mind.' It needs structure and clarity*."

Fiona added:

"*I now check that what I say actually makes sense literally. Metaphors and indirect hints don't always land the way you expect.*"

Such adaptations required therapists to shift from traditional communication norms to clearer, more structured dialogue.

4.4.2: Sensory Awareness and Environmental Adaptation

Participants also identified sensory issues such as bright lighting, background noise, or even furniture texture as potential barriers to therapy engagement.

Aoife reflected:

"*A humming heater, fluorescent lights... these little things can cause overload. Therapy environments have to be sensory-safe, or clients can't focus at all."*

Creating sensory-friendly spaces was viewed as just as important as adapting verbal communication for successful therapeutic work.

4.5 Theme 4: Affirming Authentic Autistic Identities

A prominent theme in the data was the importance of affirming autistic identity within therapy. Participants emphasised the psychological harm caused by long-term masking, the practice of suppressing autistic traits to fit social expectations and described therapy as a space where clients could safely begin to unmask and embrace their authentic selves.

Fiona explained:

"*Therapy is about helping them realise they're not broken. They don't need to pretend to be something they're not."*

James discussed the emotional impact of late diagnosis and the journey toward self-acceptance:

"*When they finally get the diagnosis, it's relief but also grief. Therapy has to hold that space for both.*"

The therapists interviewed described affirming neurodivergent identities as involving not just emotional support but challenging internalised stigma and helping clients redefine their sense of self. This directly relates to the objective of understanding how therapists help autistic clients with identity development and the reduction of masking behaviours.

4.5.1: Reducing Masking Behaviours

Therapists described therapy as a rare space where clients could "unmask" or stop suppressing their natural behaviours in an attempt to appear neurotypical.

Fiona noted:

"*So much of their life is spent hiding. Therapy has to be the place where they don't have to hide anymore*."

Aoife similarly reflected on the importance of creating an authentic space, stating:

"*In therapy, they shouldn't have to perform or translate themselves. They should be able to just be as they are.*"

Samantha also spoke about the emotional impact of masking and the role of therapy, stating:

"*They come into therapy exhausted from pretending all the time. Part of the work is helping them feel safe enough to drop the mask, even if it's just for an hour."*

Supporting clients to let go of masking was critical for improving mental health and self-esteem.

4.5.2: Supporting Identity Reconstruction

For many autistic clients, particularly those diagnosed in adulthood, therapy involved grappling with grief, relief, anger, and the rebuilding of self-understanding.

James described:

"*Diagnosis isn't just a label. It shakes up everything, relationships, memories, identity. Therapy needs to hold space for that messiness."*

Aoife also spoke about the emotional complexity of post-diagnosis experiences, explaining:

"It’s not just finding out you’re autistic, it’s rethinking your whole life story through a new lens. Therapy has to help them make sense of that without rushing them."

Participants highlighted that therapy must affirm neurodivergent identity, challenge internalised stigma, and support positive self-concept development.

4.5.3: Meeting Clients Where They Are

Participants emphasised the importance of meeting autistic clients where they are, rather than expecting them to conform to neurotypical therapy expectations. Therapists warned against making assumptions based solely on diagnostic labels and stressed that effective therapy required responsiveness to each client's unique way of thinking, communicating, and experiencing emotions.

Isabelle explained:

"You're not working with a label; you're working with the person sitting in front of you."

James similarly reflected:

"You have to take each person on their own terms. Autism tells you a little, but it doesn’t tell you everything about how they see the world."

Fiona added:

"It's about building therapy around them, not fitting them into some idea of what therapy should look like."

This client-led, flexible approach aligns with neurodiversity-affirming principles and reflects a shift away from traditional, one-size-fits-all therapeutic frameworks.

4.6 Theme 5: Adaptation of Traditional Therapy Models

A significant finding from the interviews was the widespread recognition that existing therapeutic models are often insufficient to meet the distinct needs of autistic clients without substantial adaptation. Participants consistently emphasised that traditional frameworks, particularly manualised approaches such as cognitive-behavioural therapy (CBT), embed assumptions about cognitive style, emotional insight, and communication preferences that do not always align with autistic experiences. Similar concerns were raised about elements of other traditional models, such as psychodynamic therapy's reliance on interpreting unconscious processes and person-centred therapy's emphasis on open-ended emotional exploration, both of which may not naturally fit autistic clients' ways of processing.

Fiona strongly critiqued the standard application of CBT, stating:

"CBT expects clients to question irrational thoughts based on neurotypical logic. But for many autistic people, their thinking isn't irrational, it's based on different experiences of the world."

Similarly, Samantha highlighted that structured therapy models often fail to accommodate literal thinking and concrete reasoning:

"The standard CBT worksheets just don't land. They assume you can easily identify and challenge thoughts, but that's not how some autistic clients experience emotions or beliefs."

Participants described how rigid adherence to therapeutic manuals could lead to client frustration, disengagement, or feelings of failure. Aoife reflected:

"When the model doesn't fit, it's the client who suffers. They feel like they're doing therapy 'wrong' when really the therapy needs to change, not them."

James further reinforced the need for flexibility, stating:

"If therapy expects clients to fit into a box, it's not therapy for them, it's therapy for the model. We have to be the ones who adapt."

These reflections illustrate that many widely used therapeutic models are not inherently inclusive of neurodivergent ways of thinking, feeling, or communicating. Without deliberate adaptation, such as simplifying language, increasing session structure, using visual aids, offering concrete examples, and adjusting emotional processing expectations, autistic clients often experience therapy as confusing, invalidating, or even re-traumatising.

Importantly, these findings show that flexibility in therapy is not simply a matter of personal style but an ethical necessity. Effectively supporting autistic clients requires moving away from rigid, neurotypical models and towards more responsive, collaborative, and client-led approaches that respect and affirm neurodivergent ways of being.

4.6.1: Flexibility with Therapeutic Techniques

Participants emphasised the need to modify standard exercises to suit autistic cognition and communication. This included using visual aids, step-by-step planning, literal explanations, and structured feedback loops.

Samantha described her approach:

"*Instead of thought records, we sometimes create visual maps or storyboards. Or we break tasks into tiny, clear steps.*"

Fiona similarly explained:

"*I sometimes have to write things down, show diagrams, or even role-play real situations instead of just talking about feelings."*

4.6.2: Integrative and Client-led Approaches

Beyond adapting techniques, therapists emphasised moving toward integrative models where the client's preferences, processing style, and sensory needs shaped the therapy process.

James highlighted:

"*I'm constantly asking my clients: 'Is this working for you?' If not, we change it. It's not about sticking to a model, it's about what helps the person.*"

Aoife reinforced this:

"*Rigid therapy is counterproductive. I borrow from CBT, DBT, person-centred work, whatever helps the client feel understood and supported."*

Participants agreed that therapy needed to be highly individualised, rejecting a "one-size-fits-all" model, favouring flexibility, collaboration, and adaptation.

4.6.3: Adapting Specific Therapeutic Techniques

In addition to adapting broader therapeutic models, participants discussed the importance of modifying specific therapeutic techniques to better meet the needs of autistic clients. Techniques such as guided imagery, thought challenging, and emotional exploration often required adaptation when working with clients who preferred more structured, visual, or concrete ways of processing.

Isabelle explained:

"Even if someone couldn't picture things, we would just adapt it, get them to draw it or write it out. You don't abandon the technique; you just meet them where they're at."

Samantha described how she adjusted cognitive-behavioural exercises:

"Instead of traditional thought records, we sometimes map things visually, or use step-by-step worksheets with really clear prompts."

Aoife also shared examples of modifying experiential techniques:

"*Sometimes you have to move away from just talking about emotions and actually show or model things visually. It's about matching how they naturally process information.*"

Participants stressed that adapting techniques was not about diluting therapy but about making it accessible and meaningful. James reinforced this point:

"It's not about lowering standards. It's about giving people the right tools, in the right way, so they can actually use them."

Overall, these reflections challenge traditional assumptions about "standardised" therapy methods, highlighting the need for creativity, flexibility, and responsiveness when supporting autistic clients.

4.7 Summary of Findings

The thematic analysis identified five main themes and several sub-themes illustrating psychotherapists' experiences of supporting autistic clients.

A consistent thread across all interviews was the insufficiency of traditional therapeutic training and models when working with autistic individuals. Participants described how formal education often failed to address autism-specific needs, leaving them reliant on self-directed learning and clinical experience to develop effective approaches.

Therapists emphasised the complexities of distinguishing autism from co-occurring mental health conditions, highlighting the risk of misdiagnosis when developmental histories are not fully explored. They also stressed the importance of moving beyond deficit-based diagnostic frameworks to recognise autistic traits as valid expressions of neurodivergent identity.

Significant challenges in communication styles and sensory adaptations were reported, requiring therapists to rethink conventional therapy environments, interaction styles, and emotional processing expectations. Participants consistently adapted their communication methods to be more literal, structured, and direct, and prioritised creating sensory-safe therapeutic spaces.

A central theme across interviews was the importance of affirming authentic autistic identities. Therapists viewed therapy as a space for reducing masking behaviours and supporting clients through the complex emotional journey following a diagnosis, often involving grief, relief, and identity reconstruction.

Participants also highlighted the need to move away from rigid, manualised therapy models. Many described developing flexible, integrative, and client-led approaches that better accommodated autistic ways of thinking, feeling, and communicating. Specific therapeutic techniques were adapted to suit client needs, including replacing abstract exercises with visual supports, concrete steps, and experiential learning tools.

Meeting clients where they are, rather than forcing them to conform to neurotypical expectations, emerged as a core principle across interviews. Therapists framed flexibility not as a compromise, but as a clinical and ethical necessity for effective and empowering practice.

Overall, the findings suggest that psychotherapy with autistic adults demands significant shifts in both training and practice: moving beyond neurotypical assumptions, adapting communication and therapeutic methods, affirming identity, and creating physically and emotionally accessible spaces.

The next chapter will critically discuss these findings in relation to existing literature and examine their implications for psychotherapy education, clinical practice, and future research.

Chapter 5: Discussion

5.1 Introduction

This chapter critically analyses the study's findings in relation to existing literature and theoretical frameworks on psychotherapy and autism. It is structured around five principal themes identified through reflexive thematic analysis: training gaps and experiential learning, differentiating autism from co-occurring conditions, communication and sensory adaptations, affirming autistic identities, and adapting traditional therapy models. The discussion examines how the findings corroborate, extend, or challenge previous research. The chapter also considers the clinical implications, outlines contributions to knowledge, addresses methodological limitations, and proposes directions for future research. Integrating participant insights with broader academic evidence, it argues for a paradigm shift towards more neurodiversity-affirming, flexible, and individualised psychotherapeutic practice.

5.2 Training Gaps and Learning through Experience

Participants consistently reported that their core psychotherapy education included little or no autism-specific content, reflecting broader findings that therapists often feel underprepared to support autistic clients (Crane et al., 2021). Despite growing societal awareness of neurodiversity, psychotherapy training programmes largely remain rooted in neurotypical assumptions, leaving future practitioners without the skills needed for neurodivergent-affirmative practice.

While participants demonstrated resilience and ethical commitment by pursuing additional learning through clinical experience, supervision, and continuing professional development (CPD), reliance on informal education remains problematic. It fosters inconsistencies in practice, increases therapist anxiety, and heightens the risk of inadequate or even harmful therapeutic experiences for autistic clients (Benevides et al., 2020).

These findings reinforce calls by Rajaei et al. (2022) and Milton (2012) for mandatory autism-specific, neurodiversity-informed training in psychotherapy and counselling curricula. Without systemic reform, psychotherapy risks replicating the environments of exclusion and harm that autistic clients seek to heal from. Addressing these curricular shortcomings is essential for improving clinical practice and critical for advancing social justice within the profession.

5.3 Differentiating Autism from Co-occurring Conditions

A key complexity identified by participants was the difficulty of distinguishing core autistic traits from co-occurring mental health conditions. This challenge reflects the phenomenon of "diagnostic overshadowing," described by Happé et al. (2016) and Hull et al. (2020).

Participants consistently highlighted the importance of gathering a comprehensive developmental history to accurately differentiate autistic traits from co-occurring mental health conditions.

This aligns with recommendations by Cooper et al. (2021), who stress the importance of understanding the lifelong trajectory of autistic characteristics for appropriate case formulation. Therapists recognised traits such as social withdrawal, sensory sensitivity, and a preference for routine as intrinsic aspects of autistic identity rather than indicators of pathology, challenging the deficit-focused assumptions embedded within many traditional diagnostic frameworks.

This perspective underscores the need to move from symptom-focused models to approaches affirming neurodevelopmental identity. Therapists must shift beyond deficit-based conceptualisations and adopt a neurodiversity-informed framework when assessing and formulating with autistic clients.

Misinterpreting autistic traits as pathology can lead to harmful interventions, including the misplaced use of trauma-focused therapies where the core issues arise from ongoing invalidation rather than specific traumatic events.

Accordingly, autism-informed assessment practices should be recognised as a fundamental competency for psychotherapists working with diverse client populations.

5.4 Challenges in Communication and Sensory Adaptations

Therapists in this study actively adapted both their communication styles and therapeutic environments to better accommodate the needs of autistic clients. This finding aligns with Milton's (2012) concept of the "double empathy problem," which reframes communication challenges as relational mismatches rather than deficits inherent to the autistic individual.

Participants described a range of practical strategies, including the use of more literal language, clearer session structures, and modifications to sensory environments, which reflect current best-practice guidelines (National Autistic Society, 2023). These adaptations were seen as crucial for establishing safe, accessible therapeutic spaces without compromising the fundamental goals of psychotherapy.

However, the findings also expose a deeper issue: many traditional therapeutic approaches are built upon neurotypical assumptions regarding communication, emotional expression, and reflective processing. For example, the routine use of silence as a reflective tool presupposes comfort with unstructured social interaction, an expectation that may not align with the preferences of autistic clients.

By adapting their approaches, therapists moved away from expecting autistic clients to conform to traditional therapy models and instead restructured therapy to fit each client's individual needs. This shift is fundamental to ethical, effective practice and challenges

traditional therapist-client power dynamics, promoting a more collaborative, client-led therapeutic relationship.

Furthermore, the findings highlight that sensory-informed practice should not be viewed as a specialist skill, but as a core competency essential for all psychotherapists working with diverse populations.

5.5 Affirming Authentic Autistic Identities

Participants emphasised that affirming autistic identity, rather than viewing autism through a deficit-based lens, was central to therapeutic work. This approach aligns with the neurodiversity paradigm (Kapp et al., 2013; Botha & Frost, 2020) and challenges traditional clinical models that continue to pathologise neurodivergent ways of being.

Supporting clients in "unmasking" and embracing their authentic selves was described as a transformative aspect of therapy, with research linking masking behaviours to higher rates of anxiety, depression, and suicidality (Cage & Troxell-Whitman, 2019; Hull et al., 2017). Therapists also recognised that receiving a diagnosis, particularly in adulthood, often triggers a complex emotional process involving grief, relief, anger, and liberation. Therapeutic spaces must be equipped to hold this complexity without imposing neurotypical adjustment standards.

These findings suggest that therapy must move beyond merely supporting coping strategies to actively validating and celebrating neurodivergent identities. Affirming autistic identity is not an optional ethical consideration but a fundamental aspect of effective clinical practice, requiring a critical re-examination of traditional therapeutic models that were not designed with neurodivergent experiences in mind.

In addition, participants highlighted the importance of meeting autistic clients as individuals rather than through rigid diagnostic categories. Prioritising lived experience and recognising

the diversity within autism were essential for fostering genuine empowerment and self-acceptance within therapy.

5.6 Adaptation of Traditional Therapy Models

A key finding was the widespread recognition that traditional therapeutic models, particularly cognitive-behavioural therapy (CBT), often require substantial adaptation to be effective with autistic clients, supporting critiques by Cooper et al. (2021) and Spain et al. (2017). Participants emphasised the need not only to modify broader frameworks but also to adjust specific techniques, using strategies such as visual supports, breaking tasks into concrete steps, avoiding abstract language, and providing clearer session structures.

Models heavily reliant on verbal reasoning, abstract introspection, and rigid structures were often misaligned with autistic clients' cognitive, sensory, and emotional profiles. In response, therapists described integrating elements from trauma-informed care, psychoeducation, dialectical behaviour therapy (DBT), and visual communication methods to create flexible, individualised approaches. This integrative, client-centred practice reflects emerging standards in neurodiversity-affirmative therapy (McCauley et al., 2020).

Participants identified therapeutic flexibility as a crucial strength, ensuring interventions fit the client rather than forcing conformity to rigid models. These findings suggest that clinical competence must prioritise creativity, adaptability, and collaboration, particularly in neuro-affirmative practice.

5.7 Conclusion of Discussion

Overall, this study underscores that effectively supporting autistic clients in psychotherapy requires a fundamental transformation in both therapist training and clinical practice. Therapists must move beyond neurotypical assumptions, embrace flexible, sensory-informed approaches, and centre the affirmation of neurodivergent identity within their work.

The findings illustrate that autistic clients are not inherently "difficult to treat"; rather, it is traditional therapeutic models, grounded in narrow neurotypical expectations, that often prove challenging to adapt. By adopting a neuro-affirming perspective, therapists can create more ethical, effective, and empowering therapeutic environments for autistic individuals.

The findings highlight that flexibility, creativity, and client-led practice are essential to ethical and effective psychotherapy with autistic clients, not optional enhancements. Therapy must be adapted to meet the client's needs rather than requiring conformity to neurotypical norms. This shift demands both individual clinical adjustments and a broader redefinition of competence, rooted in neuro-affirmative values. Ultimately, the goal of therapy is not to normalise difference but to recognise, celebrate, and support neurodivergent identities.

5.8 Contributions to Knowledge

This study contributes to the underexplored field of psychotherapy with autistic adults by focusing on the experiences of practising therapists. By centring therapist perspectives, it exposes critical gaps between traditional psychotherapeutic training models and the realities of supporting neurodivergent clients.

The findings add to the growing evidence that autism-specific training is absent mainly from psychotherapy education, that standardised models such as CBT often require significant adaptation, that neurodiversity-affirming practices are essential for supporting autistic well-being. That misdiagnosis remains a risk without thorough developmental assessment.

Alongside reinforcing concerns raised in previous research (e.g., Milton, 2012; Hull et al., 2020), this study offers detailed, practice-based examples of therapeutic adaptations. It positions neurodiversity-affirmative practice not as a niche area but as a fundamental ethical and clinical standard for mental health care.

5.9 Limitations of the Study

While this study offers valuable insights, several limitations must be acknowledged. With only five participants from the United Kingdom and Ireland, the findings, while appropriate for qualitative depth, limit broader generalisability. The self-selected sample may also introduce bias, as therapists with greater interest or experience in autism-affirmative practice are likely overrepresented. Researcher positionality presents another limitation, as the thematic analysis may have been influenced by the researcher's neurotypical perspective, despite reflexive and supervisory efforts to mitigate bias. Additionally, the absence of autistic clients' perspectives restricts a full understanding of the therapeutic experience. Nevertheless, the study contributes meaningfully to improving psychotherapy education, clinical practice, and future research aimed at better supporting autistic individuals.

5.10 Conclusion

This study critically examined psychotherapists' experiences of supporting autistic adults, offering important insights into the gaps, challenges, and adaptations required for effective therapeutic practice. Using semi-structured interviews and reflexive thematic analysis, five core themes were identified: training gaps and experiential learning, the complexity of differentiating autism from co-occurring conditions, the need for communication and sensory adaptations, affirming authentic autistic identities, and the adaptation of traditional therapy models.

The findings consistently demonstrate that mainstream psychotherapy education and clinical models remain inadequate in addressing the diverse needs of autistic clients. While participants showed creativity, flexibility, and dedication in adapting their practices, their experiences highlight that reliance on individual initiative is insufficient. Systemic reforms

are urgently needed to embed neurodiversity-affirming principles within psychotherapy training and professional practice.

Shifting from a pathology-focused framework toward a strengths-based, identity-affirming approach is essential for creating therapeutic spaces where autistic clients feel understood, empowered, and valued. Achieving this transformation requires not only individual clinical adaptations but also a broader philosophical and educational commitment to recognising and supporting neurodivergent identities within the mental health professions.

This research contributes to a growing body of literature advocating for more inclusive, flexible, and affirming psychotherapy practices, offering practice-based evidence that the future of effective therapy lies in embracing, rather than attempting to normalise, neurodivergent ways of being.

5.11 Recommendations for Future Research

Building on this study's findings, several directions for future research are recommended. Future studies should incorporate autistic clients' perspectives to validate therapist-reported adaptations and uncover overlooked gaps. Research is also needed to evaluate the effectiveness of autism-specific and neuro-affirmative training programmes in improving therapist competence and client outcomes.

Further investigation should explore how established models such as CBT, ACT, Person-Centred therapy, and integrative approaches can be adapted to autistic cognitive, sensory, and emotional profiles without losing therapeutic integrity. Longitudinal studies are necessary to track outcomes over time and assess the lasting impact of adapted versus non-adapted therapies.

Additionally, research should address structural barriers to embedding neurodivergence-focused content within psychotherapy education, including institutional resistance and the

marginalisation of autistic-led knowledge. Ultimately, future research must centre autistic voices, challenge deficit-based models, and contribute to creating truly inclusive, affirming therapeutic spaces.

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Appendix 1: Participant demographics

Participant (Pseudonym)	Years of Experience	Therapeutic Modality	Autism-Specific Training	Client Group Focus
Interview 1	15+ years	Person-Centered / Integrative	National Autistic Society CPD courses	Adults and Adolescents
Interview 2	10 years	Integrative / CBT	Independent CPD training	Young Adults and Adults
Interview 3	20+ years	Humanistic / Trauma-Informed	Experiential Learning and CPD	Adults (including late-diagnosed)
Interview 4	25 years	Relational / Integrative	Trauma and Sensory Processing Focus	Adults and Neurodivergent Clients
Interview 5	5 years	Human Givens / Psychoeducation	Autism experience in CAMHS settings	Young People and Veterans

Appendix 2: Interview Questions

1. Can you tell me about your experience working with autistic individuals?
2. What complexities have you encountered when supporting autistic clients, and how have you navigated them?
3. How do you differentiate autistic traits from co-occurring experiences like ADHD, Eating Disorders, OCD, anxiety, or depression?
4. What advice would you give therapists supporting autistic individuals with co-occurring conditions?
5. How do you ensure your therapeutic approach supports neurodiversity and honours authentic self-expression rather than encouraging masking?
6. Do you think traditional therapy models effectively support autistic clients? If not, how do you adapt them to better align with autistic needs?
7. What additional training (if any) have you completed for working with autistic clients, and what areas do you think still need improvement in the field?
8. Can therapists effectively support autistic clients without specialized training? Why or why not?
9. Do you think current therapist training provides a comprehensive understanding of autism? Why or why not?
10. What guidance would you offer therapists working with autistic clients who have not received additional autism-specific training?

Is there anything you would like to add?

Appendix 3: Participant Information Sheet

INFORMATION FORM

My name is Ciara O'Brien, and I am currently undertaking an BA in Counselling and Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is based on the challenges, and benefits, of psychotherapy for adults with Autism. I will be exploring the views of people, like you, who work in this field.

What is Involved?

You are invited to participate in this research along with several other psychotherapists as you have the necessary psychotherapy experience and knowledge of working with autistic adults. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this meeting I will ask you a series of questions relating to the research aim and your experience in this field. On completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you complete will be held in a secure password protected file. All data stored will be de-identified. Audio recordings and transcripts will be made of the interview and will be stored in a password protected file in a secure location. Your participation in this research is voluntary and you are free to withdraw at any point in the study. I welcome the opportunity to meet with you.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study.

I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage.

I agree to take part in this research. I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature_____

Date ___/___ /_____