An Investigation into The Use of Play Therapy Principles as A Nondirective Therapeutic Approach for Autistic Adolescents

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Author Declaration

The candidate confirms that the work submitted is their own, except where work which has formed part of jointly authored publications has been included. The contribution of the candidate and the other authors to this work has been explicitly indicated below. The candidate confirms that appropriate credit has been given within the thesis where reference has been made to the work of others.

The work in Chapter 2.4 of the thesis has appeared in publication as follows:

Use of nondirective therapy for adolescents with autism spectrum disorder: A systematic review, 2021, Casper, R, Shloim, N and Hebron, J. Journal of Counselling and Psychotherapy Research. I was responsible for conducting the systematic review and the write-up for publication. The contribution of the other authors was editing and feedback on drafts.

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Abstract

The intersection between autism and mental health has gained traction with researchers and health professionals in the last ten years. It is accepted that autistic individuals experience poor mental health at higher rates than their neurotypical peers and suggested that autistic adolescents (11-18-year-olds) may be more vulnerable to these challenges. In addition, COVID-19 has exacerbated mental health difficulties across populations but has disproportionately affected neurodivergent and SEND individuals. Despite this, the current therapeutic offer for autistic adolescents remains skewed towards behavioural interventions and parent support which negates the concept of autism as a spectrum condition. A systematic review by Casper et al. (2021) identified the potential of nondirective therapy for autistic adolescents and suggested Play Therapy guidelines (Axline, 1947) had potential for future research.

This thesis presents a research design of mixed-methodologies across three phases and five studies that explore: 1) the current perceptions of therapeutic working with autistic adolescents from a therapist perspective, 2) the impact of COVID-19 on autistic adolescents' mental health and therapeutic need and 3) the viability of a nondirective therapeutic intervention guided by play-therapy principles.

The main findings identify an urgent need for training for therapists that is informed by autistic individuals, highlight the worsening state of mental health for autistic adolescents post-COVID-19 and suggest that a nondirective therapeutic approach informed by play therapy guidelines has potential to be beneficial in supporting adolescents' mental health based on therapists' experiences, autistic adolescents and trainee therapists' perceptions.

Together these findings indicate a crucial and time-sensitive need for further research that develops and assesses the efficacy of this nondirective approach as well as developing targeted training for therapists. This research addresses important gaps in knowledge that can be built upon with future co-created studies to meet the needs of the autistic community and support improved mental health and access to services for a vulnerable population of adolescents.

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List of Abbreviations

ABA – Applied Behavioural Analysis

ACE – Adverse Childhood Experience

AHA – American Humane Association

APA – American Psychological Association

BACP – British Association for Counselling and Psychotherapy

CAMHS – Child and Adolescent Mental Health Service

CBT – Cognitive Behavioural Therapy

CDC – Centers for Disease Control and Preventions

CPD – Continuous Professional Development

DfE – Department for Education

DSM – Diagnostic and Statistical Manual of Mental Disorders

EHCP – Education, Health and Care Plan

HCPC – Health and Care Professions Council

ICD – International Classification of Diseases

IPA – Interpretative Phenomenological Analysis

LD – Learning Disability

MA – Master of Arts

NCPS – National Counselling and Psychotherapy Society

ONS – Office for National Statistics

RCT – Randomised Control Trial

SEND – Special Educational Needs and Disabilities

SHREC – School of Healthcare Research Ethics Committee

TA – Thematic Analysis

TCS-ID – Therapist Confidence Scale for Intellectual Disabilities

UKCP – UK Council for Psychotherapy

UPR – Unconditional Positive Regard

WHO – World Health Organisation

ZPD – Zone of Proximal Development

INTRODUCTION

Chapters 1-3

Chapter One: Background

'Inclusion is not bringing people into a space that already exists; it is making a new space, a better space for everyone' **- (George Dei, 2000 in Marwala, 2022)**

1.1 The Conception of Autism

Autism as a term was conceptualised in 1911 by the psychiatrist Eugen Bleuler (B. Evans, 2013). Autism was originally characterized by Bleuler as 'infantile wishes to avoid unsatisfying realities and replace them with fantasies and hallucinations' (B. Evans, 2013, p.4). The term autism had roots in Freud's (1905) 'autoerotism' as a hallucinatory thinking style infants held before merging their inner reality with the external world (B. Evans, 2013). Through this influence, autism was used to understand an aspect of schizophrenia presentation with the belief that a lack of connection to reality, encouraged the substitution of fantasies for reality 'that more readily satisfied their affective needs'. Autistic thinking was viewed as 'not bound by rules of logic' (B. Evans, 2013. p.6).

Child psychologists and psychiatrists viewed autism as an element of psychosis based on Bleuler and Freud's definitions. However, World War Two created greater interest in childhood development and the Mental Health Act (1959, in B. Evans, 2013) transformed the way mental illness was treated and researched. As empirical research and research methodologies came to the fore, the field of childhood psychology shifted from one of unconscious thought processes and theories of hallucinations and fantasies to observations of behaviours. Accompanying this shift was the significant change in the understanding of autism, furthered by Kanner's (1943) novel observations.

Kanner (1943) reported vignettes of N=11 children between 3-11 years who presented with an 'inability to relate themselves in an ordinary way to people and situations'. Kanner (1943, p.250) suggested all children were distinctly different yet shared some common characteristics of difficulties which he suggested formed the syndrome 'autistic disturbance of affective contact'. His research considered ability testing, IQ and relational ability and from this he created a list of common difficulties. These commonalties included some delayed development, different communicative styles to neurotypical children, sensory sensitivity, a desire for routine and consistency, problems with affect and relating to people and difficulties with fantasy, play and spontaneity. In addition, all children seemed to be intelligent, with good memories and age-appropriate cognitive abilities but were born into intelligent families with ‘few warm-hearted fathers and mothers’ (Kanner, 1943, p.250).

Kanner (1943) concluded these children were not schizophrenic or ‘mentally-defective’, rather had been born with an ‘affective handicap’ which may have been further influenced by the familial environment. Kanner’s (1943) suggestion of the autistic syndrome and subsequent ‘symptoms’ formed the first understanding of autism as a distinct entity, unrelated to schizophrenia. Kanner (1949, p.423) extended his research by suggesting environmental factors may be related to the development of autism and proposed that all of the N=11 children he studied were raised in an ‘emotional refrigerator’. Kanner (1949, p.425) expanded this to suggest a lack of maternal warmth or interest in perfection from fathers led the children to turn ‘away from such a situation to seek safety in solitude’.

1.2 A Change in Autism Understanding and Research

Kanner’s (1943, 1949) observations and definition of autism as separate to schizophrenia led other researchers to radically change their perception and understanding, aided significantly by the Mental Health Act (1959, in B. Evans, 2013). The Act confirmed the closure of institutions for those deemed ‘defective’ or ‘retarded’ and encouraged integration within mainstream education and communities. Until this point the terms schizophrenia and autism were being used interchangeably. The Act saw the development of research councils which focused solely on behavioural observations and statistical methods. This stricter focus was influenced by Hans Eysenck (1990) who was influential in the formation of the research council and loudly denounced psychoanalytic psychotherapy (the work of Freud and Bleuler) as speculative with questionable efficacy. The behavioural methods enabled large population samples to be researched and symptoms of autism to be created with a suggested prevalence rate of 4.5 per 10,000 in the UK (Lotter, 1966). It is important to acknowledge the shift to purely observational and behavioural research. The behaviourist movement in the 1950’s proposed the child’s ability to relate to others was purely a function of behaviour and not a cognitive relational faculty. The behavioural methods enabled large samples to be investigated and an understanding around norms and patterns to be gained within society; a stark contrast to the psychotherapist's theoretical concepts based on lengthy case-studies.

1.3 The Development of Research Methods

As research methods continued to develop, studies became concerned with validity, reliability and replicability. Kolvin (1971) demonstrated this when creating rigorous criteria for comparisons of children (N=80) who were diagnosed with early and late onset childhood schizophrenia. As a result, Kolvin (1971, p.21) found a distinct difference in the groups of children he was comparing: hallucinatory thought did not accompany symptoms of the early onset group. Instead, they were defined by 'abnormal movements' and 'ritualistic behaviour'. This gave rise to a new understanding of autism as a communication disorder, rather than a psychotic disturbance. Interestingly, this definition was the exact opposite of the original suggestion that autism was a form of hallucinatory thinking as suggested by Bleuler (in B. Evans, 2013). Kolvin's (1971) work was replicated successfully and a new consensus was formed: researchers could not attribute 'odd' behaviour to hallucinations and fantasies within the child, if the child did not state this was their experience.

DSM or ICD Edition	Year of Publication	Diagnostic Criteria	Reported Rates of Autism
DSM III	1980 & 1987 (revised)	• 'Infantile Autism' later revised to 'Autistic Disorder' (1987) • Classed as a Pervasive Developmental Disorder. • 3 subgroups: social communication and behaviour	1989: 4 per 10,000 (Ritvo et al., 1989)
ICD-10	1992 & 2004 (revised)	• Changed to Pervasive Developmental Disorder from previous classification of Childhood Psychoses • Expanded to include atypical autism, childhood autism, Rett Syndrome, PDD and PDD-NOS	2000: 1 in 150 (CDC, 2020)
DSM IV	1994	• Expanded to reflect separate diagnoses: Aspergers, Retts disorder, Autistic disorder, PDD-NOS and Childhood Disintegrative Disorder • 3 subgroups: social, communication and behaviour	
DSM V	2013	• Collated separate diagnoses into one spectrum condition: Autism Spectrum Disorder	2016: 1 in 54 (CDC, 2020)

		• Introduced rates of severity • Two subgroups: social-communication and behaviour • Suggested there may be co-occurring conditions with Autism at a higher prevalence than neurotypical children, affecting language and cognitive abilities as well as higher rates of psychological and medical conditions.	
ICD-11	2019	• Mirrored the move to 'spectrum disorder' • Considered co-occurrence of intellectual disability	

Table 1: The Development of the Autism Diagnosis and Criteria

These new developments kickstarted the distinction between autism and schizophrenia which was reflected in the DSM III (1980) with autism as a distinct entity. At this point the concept of autism and hallucinations or fantasies had been abandoned and the behavioural research techniques gave rise to a of continuum of severity for autism and other diagnoses. Wing (1981) believed autism to be a social impairment and part of a larger group of conditions. This research enabled a different understanding of autism to be gained, that encompassed Asperger's syndrome and the beginning of the idea that there may be varying levels of severity and presentations of autism. Table 1 shows the development of the autism diagnosis to the present day based on the Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association) and the International Classification of Diseases (ICD, WHO, 2004) which are used in America and the UK respectively to inform diagnostic tools and assessment protocols.

1.4 Rates and Co-occurrence of Mental Health Diagnoses and Autism

Table 1 suggests autism diagnosis rates are increasing with more recent research taken from data collected in 2016 supporting the figures (Maenner et al., 2020). There is yet no concurrence as to whether the increase reflects actual prevalence or better diagnostic criteria and understanding (Davidovitch et al., 2020). However, the increasing rates are a growing concern and cost to society with Cakir et al. (2020) suggesting an approximate lifetime social cost of $3.6 million per autistic individual in the USA. The UK has limited data on the lifetime cost of autism with the most recent research in Buescher et al. (2014) stating a cost of £1.5 million if intellectual disability co-occurred with autism and £0.92 million lifetime cost without intellectual disability. However, it is likely this cost is much higher given the increase in rates of autism since 2014. It is unclear why more recent data has not been collected within the UK. It may be that healthcare in the USA is privatised so families are more aware of costs which creates a higher priority for research. Alternatively it could reflect the UK's prioritsation of research for other conditions and healthcare needs. Despite this, the increased prevalence rates suggest an urgent need for updated costings to better understand autism on both an individual and societal level.

Table 1 also highlights the growing recognition of psychological/mental health conditions in co-occurrence with autism. The Centers for Disease Control and Prevention (CDC, 2023) suggest 'Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices'. The link between the co-occurrence of mental health conditions and autism is supported in research by Koenig and Levine (2011) which identifies autistic individuals are more likely to experience depression, anxiety and OCD than their neurotypical peers. Research suggests rates of co-occurrence with mental health disorders are increasing generally for children and young people, with a significant increase at adolescence (NHS, 2017). However, (Casper, 2020) identifies 'ASD adolescents may be more vulnerable to the difficulties that teenage years bring due to their struggles in social communication/interaction and behaviours'. Due to the COVID-19 pandemic, future research is likely to indicate a significant impact on mental health thus exacerbating this problem.

1.5 Societal Understanding of Autism

Autism was described as a distinct entity in the DSM III (1980) with subsequent research focusing on directive interventions (e.g., Cognitive Behavioural Training (CBT), skills-training and parent-training). Potential explanations for this include the lack of inclusion within society pre-1960s which placed individuals classed as 'mental defectives' (B. Evans, 2013) into institutions or the history of autism relying on behavioural explanations/treatments due to the rise of behaviourism in the 1950's coinciding with Kanner's (1943) observations.

The publication of the DSM V in 2013 defined autism as 'persistent difficulties with social communication and social interaction and restricted and repetitive patterns of behaviours, activities or interests (this includes sensory behaviour), present since early childhood, to the extent that these limit and impair everyday functioning' (National Autistic Society, 2020). See Table 1 for the development of autism diagnosis and criteria (Rosen et al., 2021).

The altered diagnoses have contributed to a change in societal understanding which has been influenced by the autistic community. Despite this, medical terminology still phrases autism as a 'disorder' instead of a condition and the DSM V (2013) refers to deficits in functioning. Alternative views of autism as difference instead of a disability are starting to appear (Baron–Cohen, 2000) with recent research proposing autism may be an example of diversity within the human condition, rather than something that is seen as 'less than' (Wright et al., 2020). This change has been influenced by greater understanding, media coverage and autistic people's voices. However a poll commissioned by the charity Autistica (2022) highlighted there are still key misunderstandings within the UK about autism, with the results suggesting 30% of adults believe autism can be cured and 35% believe autism is a learning disability.

1.6 Cultural Understanding of Autism

The understanding of autism varies between countries and cultures. Research conducted by Kim (2012) found differing perspectives and associated stigma between Korea and Leon, Nicaragua (central America). In Korea, there was a significant lack of education around autism and it was viewed as the mother's responsibility. Blame and guilt were attached to her for the child's diagnosis; resulting in a lack of support and services. Although there was also very little understanding about autism in Leon, Nicaragua, families approached autism from a community perspective with professionals and family members looking to adapt the environment to best support the child. The lack of knowledge but differing understanding of autism between these cultures, led Kim (2012, p.543) to hope that 'someday autism may be viewed and accepted as a difference by the majority within a culture, as opposed to a disability'.

More recent research by Atherton et al. (2023) suggests that culture is essential when considering how autism is perceived between countries. Atherton et al. (2023, p.12) found that the Western values which likely influenced the DSM V creation are not applicable to non-Western countries such as Japan, as 'aspects of autism may match more closely with Japanese ideals' and there are distinct differences in communication between these cultures e.g., lack of eye contact and silence is more accepted in Japanese discourse. In addition to this, the neurodiversity movement which focuses on valuing the uniqueness of individuals may not be appropriate in collectivist cultures.

Collectively this research suggests that whilst autism is gaining traction on a global stage, the degrees to which this is happening varies between countries and the medical, biopsychosocial model of disability may not be appropriate when comparing autism rates and understanding between cultures.

1.7 Terminology

As the understanding and diagnostic criteria of autism has changed, so has the terminology used to describe it. This reflects the change from autism's links with schizophrenia as a significant mental health condition and a condition people live with, rather than being who they are. Within research there is a distinction between the terminology that is used, with stakeholders (autistic individuals) tending to have a preference for 'individual-first language' e.g., autistic person. In contrast 'professionals are more likely to use 'person-first language e.g., person with autism' (Lei et al., 2021, p.1349). A recent publication by a range of autistic scholars, researchers, individuals and neurotypical allies stated that 'practical and inclusive terminology enables discussion of heterogeneity in autism presentation, is less likely to reinforce bias, and is more respectful than terminology with negative connotations' (Natri et al., 2023, p.673).

This thesis will use the terms 'individuals with autism' and 'autistic children/adolescents/individuals' interchangeably, to reflect the range of terminology within the UK autism community (L. Kenny et al., 2016).

1.8. The Neurodiversity Movement

It is important to place the current research within the context of the overarching neurodiversity movement. The neurodiversity movement has gained traction in the last two decades, primarily due to the efforts of the autistic community in defining neurodiversity as 'cognitive variation, as a form of biodiversity' (Leadbitter et al., 2021, p.2). Within this context, the neurodiversity movement suggests policy and research needs to change from positioning the autistic individual as ‘the problem’ and consider the problem as rising due to an interaction between a neurodiverse individual and a non-inclusive environment (Leadbitter et al., 2021). The researcher considers the neurodiversity movement as underpinning the current research, with the focus on better understanding how the therapeutic environment can support autistic adolescents mental health.

Chapter Two: Literature Review

'Neurodiversity may be every bit as crucial for the human race as biodiversity is for life in general. Who can say what form of wiring will prove best at any given moment?'

– Harvey Blume (1998)

This literature review aims to present the prior research in relation to autism and the challenges still faced within the research community. This section will address terminology and present and expand on the prior systematic review findings (Casper et al., 2021). The systematic review findings have informed the structure of the literature review with a focus on nondirective therapeutic interventions and challenges in autism research. The collective findings from the literature and systematic review subsequently inform the proposed research which aims to address the research gaps and further the psychotherapeutic field (see Chapter 4 onwards).

2.1 Directive vs. Nondirective Therapy:

For the purpose of this research, literature review and prior systematic review the following terminology has been and will be used consistently when referring to directive and nondirective therapy. These definitions have been taken from the American Psychological Association (APA). The APA definitions have been chosen for their clarity and the reputable standing APA holds with the psychological and psychotherapeutic research fields.

Directive Therapy (APA, 2022a) : 'an approach to counseling and psychotherapy in which the therapeutic process is directed along lines considered relevant by the counselor or therapist. Directive counseling is based on the assumption that the professional training and experience of the counselor or therapist equip him or her to manage the therapeutic process and to guide the client's behavior'.

Nondirective therapy (nondirective approach, (APA, 2022b): 'an approach to psychotherapy and counseling in which the therapist or counselor establishes an encouraging atmosphere and clarifies the client's ideas rather than directing the process. The client leads the way by expressing his or her own feelings, defining his or her own problems, and interpreting his or her own behavior. This approach is a cornerstone of client-centered therapy.'

2.2 The Current Research Field

The introduction highlights how the understanding of autism has increased since its conception in the 1950s. This understanding is reflected in the changes to the diagnostic criteria and a general understanding of autism as a spectrum condition, presenting individually with a range of difficulties and support needs. Despite this, the prior systematic review (Casper et al., 2021) identified a research bias towards directive therapeutic interventions which the researcher believes to highlight a lack of diversity in treatment options and ignorance for the range of support autistic individuals may require. Whilst the researcher acknowledges some directive interventions aim to tailor therapy to the individual based on their goals, research about adapting therapy for autistic individuals is mixed (Santomauro et al., 2016; Murray et al., 2015) and the structured nature of directive interventions limits the ability for the individual to tailor the therapy.

In addition, directive therapies tend to target specific behaviours e.g., OCD, social anxiety etc. rather than provide a holistic offer of mental health support that recognises mental health as multi-faced that 'includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices' (CDC, 2023). This has ethical, time and cost implications for both individuals and healthcare professionals and provides the rationale for the proposed research.

2.3 Challenges in Autism Research

2.3.1 Empirical studies

The prior systematic review identified large-scale empirical studies are most commonly undertaken when investigating interventions for autism. These focus on directive approaches that can be scientifically investigated by RCT's (randomised control trials) and meet the 'gold-standard' of research. Casper et al. (2021) identified a lack of evidence supporting the efficacy of directive interventions over nondirective and a need for individualised and tailored interventions based on the spectrum nature of autism. This is supported in recommendations from research by Mesibov and Shea (2011, p.126) who highlight the 'importance of contributions from a variety of research designs' due to practicality and the heterogenous autistic population, as well as a need for research on 'soft variables', e.g., happiness, quality of life, wellbeing. This is further supported by Stinckens and Becaus (2008) in (Carrick and McKenzie, 2011, p.79) who highlight the importance of a phenomenological stance when working with autistic individuals to appreciate their 'way of living and experiencing'. Howlin (1998, p.307) provided further support for individualised intervention in concluding that 'no single mode of treatment is ever likely to be effective for all children and all families. Instead, intervention will need to be adapted to individual needs'. The phenomenological stance alongside the recommendations of tailoring therapy to autistic individuals, suggests these adaptations should be led by the autistic individual's therapeutic needs.

2.3.2 Cultural Differences in Autism Support

The literature review highlighted a lack of research within the UK into therapeutic interventions for autistic adolescents. The majority of research thus far has been conducted in the USA and Israel; suggesting poor acknowledgment from the UK's research field and wider society of autism. This continues to be concerning based on the aforementioned financial implications of autism and ever-increasing diagnosis rates. Research in Israel has seen societal changes in acceptance of autistic individuals into the army, tailored intervention based on a needs evaluation, diagnosis before age three and health and financial aid provision (Brezis, 2015). Collectively this promotes a society where prejudice and discrimination towards those with autism is actively reduced and autistic individuals are integrated. This not only benefits the individuals by improving opportunities and quality of life, but also has economic benefits for society as a whole. This further supports the need for and the potential benefits of the current research within the UK.

2.3.3 Stakeholder Involvement

In addition, there is a growing request for stakeholder involvement through participatory research. Participatory research involves 'incorporating the views of autistic people and their allies about what research gets done, how it is done and how it is implemented' (Fletcher-Watson et al., 2019, p.943). A large-scale community research project conducted by Pellicano et al. (2014) highlighted the disparity between the UK's current research activities and what the autistic community believed to be urgent and important research priorities. The findings suggested autistic individuals believed the current research focusing on the aetiology of autism was ‘neurotypical priorities regarding us – not autistic people’s priorities’ (Pellicano et al., 2014, p.760). The UK’s autistic community identified a need for research focusing on ‘developing evidence-based interventions’, ‘managing everyday life e.g., anxiety’ as well as ‘practitioner training’ for autism and support post-diagnosis for families (Pellicano et al., 2014, p.761). A limitation of this research is the lack of autistic voice across age-ranges as the study only included autistic adults. Furthermore, there is the potential for a change in attitudes given this research was conducted in 2014. However, it highlights the benefit and importance of stakeholder involvement in research and identifies a further gap for all autistic voices to be heard.

2.3.4 Ethical Implications

Cromar (2019) identifies the potential discrimination autistic individuals face due to the routine offering of cognitive behavioural therapy (CBT) over other therapeutic options. In additional research, Blainey et al. (2017, p.01483) suggests an urgency for ‘parity of choice’ in thepaeutic support for autistic individuals due to the range of mental health needs. The restricted therapeutic offer may be due to therapists’ lack of confidence in supporting autistic individuals (K. Cooper et al., 2018) or due to ‘diagnostic overshadowing’, whereby the co-occurring mental health concerns are incorrectly attributed to the autism diagnosis (Blainey et al., 2017, p.01481). Collectively, this supports the need for a nondirective intervention that is led by the client and supports their holistic self and mental health (Casper et al., 2021). Continued prescription of behavioural interventions raises ethical concerns due to a lack of treatment choice and ignorance of individual presentation, whilst skills-training specifically may promote non-acceptance of autistic individuals’ strengths within society. It is hoped the current research can provide a more ethical and fair mental health provision to autistic adolescents by maintaining their individuality as a priority within therapy.

2.3.5 Outcome Measures

A further challenge within autism research is the validity and accessibility of outcome measures in this population. Blainey et al. (2017, p.01481) propose that autistic individuals may have ‘difficulty understanding some internal states, such as thoughts and feelings'. This raises concern for using generic outcome measures that were not created specifically for this population. As a result, the measurement findings may be invalid due to difficulty understanding the question terminology. In research conducted by Blainey et al. (2017) using the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM, C. Evans et al., 2002) to measure distress, autistic adult's scores worsened as they continued in therapy and gained more understanding of their mental wellbeing. Blainey et al. (2017) acknowledge this paints an inaccurate picture of progress in therapy and propose that measurements need to be developed specifically for individuals with autism or be more sensitive to neurodiversity and a range of cognitive styles.

Supporting research by Proctor and Cahill (2021) highlights the importance of co-production in the development of outcome measures for autistic clients and raises the question of ableism in continued usage of generic outcome measures. Additionally, a concern for the validity and efficacy of generic measures was raised, if these results are influencing public spending and funding for mental health services. Proctor and Cahill (2021, p.170) also suggest that 'more idiosyncratic personal measures' such as qualitative data collection, may provide more accurate information to the therapeutic process experienced by individuals.

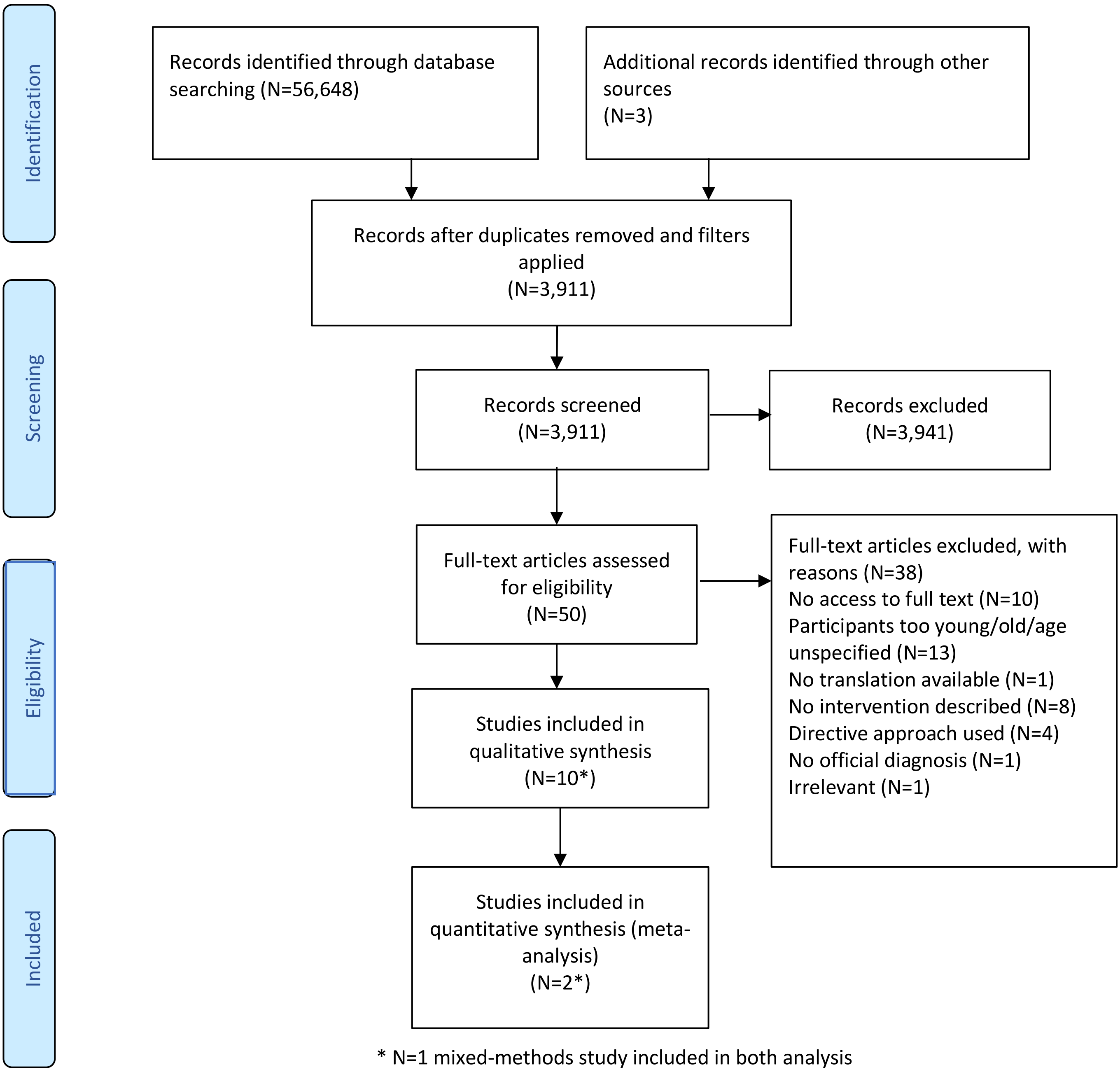
Collectively this prior research identifies a significant concern in how therapy outcomes and mental health are measured within the autistic community. This could have significant implications for access to services as well as personal and professional understanding of the need within this population. These findings also raise questions for the general efficacy of large-scale reviews and studies into directive interventions, which have used outcome measures developed for neurotypical populations and yet claim the intervention was effective based on these results.

2.4 Prior Systematic Review: An Overview

Casper et al. (2021) conducted a systematic review of nondirective therapy for autistic adolescents to identify any gaps within the current research field for autism and therapeutic interventions. The search criteria were broad in order to include as many studies as possible and provide a comprehensive view of the literature. The systematic review findings suggest a research bias for directive vs. nondirective interventions (see

Figure 1) with only N=12 studies included. Additional findings from the included studies were: 1) nondirective interventions can have positive effects on wellbeing; 2) there were underlying commonalities across the different types of nondirective interventions used; 3) there is a potential benefit of including parents/professionals in the interventions and 4) therapists should hold some knowledge of autism and its individual presentation.

Figure 1 evidences a large number of research articles (N=56,651) investigating autism, therapy and adolescence collectively. After applying filters and screening out directive therapies only N=3,991 research articles remained, of which only N=50 were eligible for inclusion. Upon further reading, another N=4 articles were removed due to researching directive therapies. Please see Table 2 in Casper et al. (2021) for the full list of included studies.



* N=1 mixed-methods study included in both analysis

Figure 1: PRISMA Diagram (Casper et al., 2021)

2.4.1 Systematic Review Finding One: The Research Bias

A possible explanation for the focus on directive therapies could be the rise of the behavioural movement in the 1950s coinciding with a change in the understanding of autism. Generic research into the efficacy of directive therapies had begun advocating behavioural techniques as ‘twice as effective’ (Lazarus, 1966) as nondirective techniques for behaviour change. As the behaviourist movement gained traction, there was increased focus on quantitative research methods using larger samples, e.g., Lotter (1966). Directive therapies lend themselves to quantitative research methods as the focus tends to be on behaviour change, e.g., CBT or acquiring skills through skills training. Directive therapeutic interventions usually have clear, definable outcomes in the form of goal-setting and observable change; enabling large-scale empirical studies to be completed. However, this has created a research bias in which funding and continued interest has been maintained on one form of therapeutic intervention, which may not be appropriate given autism is a spectrum condition.

In support of this, the autistic community are asking for 'a range of treatments and support, tailored to individuals. A 'blanket' treatment for all, is not the answer'. (Autistica, 2021). This, alongside the research bias identified from the prior systematic review, suggests research into nondirective therapies is vital and actively called for to promote acceptance, inclusion and an equal offer of provision to all.

2.4.2 The Research Bias of Behavioural Interventions

As behaviourism focuses on observable behaviour change, studies in the 1950s soon took over from previous qualitative research and prompted an influx of quantitative studies. In the present day, 'behavioral approaches remain the most widely researched intervention for individuals with autism spectrum disorders' (Koenig and Levine, 2011, p.30). This has continued to skew the research field with the majority of research investigating behavioural (and directive) interventions (Casper et al., 2021) such as CBT, social skills training and parent training. This continued focus has overshadowed the need for therapeutic mental health support; potentially mis-attributing mental health difficulties to the autism diagnosis.

Social skills training aims to 'help address social deficits in individuals with autism spectrum disorder' (Soares et al., 2021., p.168). It involves teaching autistic children how to interact with their peers and has shown efficacy in improving relationships and decreasing loneliness (Soares et al., 2021). A meta-analysis conducted by Soares et al. (2021) included 18 RCT's investigating social skills training for autistic young people, delivered either face-face or by technology. There was a total N=1266 participants ranging from age 4-17 years who had completed a social skills intervention. The results were measured via the Social Responsiveness Scales (Constantino and Gruber, 2005) and the Social Skills Rating System (Gresham and Elliott, 1990). These outcome measures test for social awareness, social anxiety and autistic traits such as restricted interests and repetitive behaviours to form an ‘an overall measure of social behavior deficits’ (Soares et al., 2021, p.170). The results found improvements in social deficit scores which were maintained at a 3-month follow-up for both face-face and technological interventions.

Although these findings suggest benefit for social skills training, there is an inherent ethical issue with such ‘treatments’. The focus on reducing autistic behaviours and teaching skills that situate the young person better in a neurotypical world does not promote inclusivity or acceptance of difference in society or within the individual and it perpetuates the view that autistic individuals are deficient in certain attributes. Additionally, there was no assessment of the impact on the young person and specifically the potential impact of altering their way of being on their mental health. Furthermore, neither scale included the child or adolescent’s voice and the findings are based on parent and teacher perceptions of the social skills improvement and reduction in autistic behaviours.

Collectively, whilst behavioural and skills-training interventions continue to be widely researched and offered, autistic adolescents’ mental health and individuality is unlikely to be prioritised. This is likely to have a devastating impact on autistic adolescents sense of self-worth and self-belief as authenticity and self-esteem are inherently linked (Bottema-Beutel et al., 2018) and creates an urgent need for therapeutic interventions that value individuality and support mental health.

2.4.3 The Research Bias of Ages

Research conducted by the UK Parliament (2020) suggests the average age for diagnosis in the UK is 4.5 years. This may explain why there is a large amount of research into younger autistic children, especially if these individuals are in contact with health services as they are easier to contact for research. In contrast recent research by Russell et al. (2021) presented a 20 year overview of autism diagnosis within the UK. This research suggests the current mean age of diagnosis (in 2018) is actually 14.5 years, rising from 9.6 years in 1998. The research by Russell et al. (2021) also suggested a significant increase in the diagnosis of females and autistic adults. The potential explanations for this were better diagnostic criteria and autism assessments for adults being made statutory in 2009. This may explain why the mean age from this study was higher than the UK Parliament (2020) research.

The researchers also acknowledged the impact of increased request for assessments and subsequent longer waiting times, as well as predicting further impact of COVID-19 on this trend. It is possible that a younger average diagnosis age and the impact of statutory autism assessments for adults have driven research into these two age groups; seemingly forgetting autistic adolescents in the process. This pattern is consistent worldwide with large-scale research across 40 countries including >120,000 participants found the mean age of diagnosis to be approximately 5 years old (van't Hof et al., 2021).

Despite these alarming statistics, caution should be taken when interpreting any information regarding rates of diagnosis. The increased rates of diagnosis in adulthood highlight missed diagnosis in childhood as an issue. Furthermore, research conducted by Aggarwal and Angus (2015) in Australia suggested it was common for autism to be a secondary diagnosis to a mental health concern, mainly depression, in adolescents. This will be discussed further in section 2.5.

2.4.4 The Research Bias of Teacher/Parent

Of considerable concern is the research skew towards interventions that prioritise parental feedback, parental wellbeing or teacher perceptions over the child's or teenager's experience. Although this research is necessary to create a community of support and a better understanding of autism and its presentation, the over-focus at the expense of research into young people further disregards their needs and their voice.

A systematic review conducted by Adams et al. (2019) focused on current research into autistic individuals' (aged 5-17 years) anxiety levels within school environments. The review included N=32 studies, but only N=7 included a self-report measurement for the child or teenager and of those, only N=4 were comparable based on measures used. This raises a significant concern in researchers valuing parent and teacher perceptions of the child's anxiety over the child's own experience.

The findings from Adams et al. (2019) suggested N=1 study found a correlation between anxiety ratings between parent, teacher and child, whereas other's found the child to rate their anxiety as lower (N=1), higher (N=1) or the same as the parent but different to the teacher (N=1). Furthermore, 'no studies used qualitative approaches to explore or describe anxiety symptomatology in children with autism in school settings.' (Adams et al., 2019, p.12). Qualitative research can add significant value to studies investigating people's experience as it provides more detail and richer information. This research collectively presents a mixed picture of anxiety within school for autistic young people and further identifies a biased research focus. The findings suggest that parent or teacher ratings of a child's anxiety do not accurately reflect the child's experience which raises validity concerns when using these measures to better understand a child's experience.

These findings could be explained by difficulties with outcome measures or concern over research quality impacting on the ability for findings to be compared. However, the review suggests a power-imbalance whereby researchers are prioritising parents' and teachers' opinions of the child's mental health and yet neglecting the thoughts, feelings and experiences of the child who is suffering. This identifies a bigger concern for researchers investigating children and young people's experiences and directly contradicts the suggestions of child-led, client-centred and co-produced research and therapeutic intervention. The researcher is of the opinion that research investigating children's experience should include their voice as a priority above others' to ensure their views and experiences are accurately captured and the results can inform meaningful change to their lives.

2.5 Systematic Review Finding Two: The Involvement of Others

The systematic review also suggested that involvement of parents/carers/professionals within the therapeutic process had benefit to the autistic adolescent's wellbeing. The involvement of others provided a 'team of support' to the young person (Casper et al., 2021, p.10) via psychoeducation or information sharing. These findings are not surprising given the importance of others in children's play, learning and development has been accepted since Vygotsky and Cole (1978) suggested the 'zone of proximal development' (ZPD). The ZPD distinguishes between the 'actual developmental level'…and the 'potential developmental level…with adult guidance or in collaboration with more capable peers' (Vygotsky and Cole, 1978, p.86). Vygotsky and Cole (1978) believed play to be an integral aspect of ZPD, especially in early childhood. The concept of adult or more knowledgeable peer involvement does lead to a perception that the child is incapable without support and suggests a directive approach to intervention is necessary. However, Bodrova and Leong (2015) extended this work and challenged the literal meaning by suggesting the original statement referred to ‘assistance provided by a group of peers’ (2015, p.376); better explaining the original theories of ZPD and play.

The systematic review findings alongside Vygotsky and Cole’s (1978) theory are further supported in other studies investigating the involvement of teachers, mental health professionals and parents in mental health interventions. The results from a systematic review by (García-Carrión et al., 2019) suggested the involvement of teachers, health professionals, communities and parents led to a reduction in disruptive behaviour, anxiety and depressive symptoms whilst increasing social skills and wellbeing. Further research highlights the benefit of involving parents/carers in physical health interventions e.g., reducing childhood obesity (Chai et al., 2019). Collectively previous research has highlighted the benefit to the involvement of others for young people’s health interventions, however there is a need to ascertain best practice for this involvement and still prioritise the child’s voice in the research above the parent’s perceptions. The current study aims to further explore the best way this could be achieved.

2.5.1 Therapists’ Knowledge of Autism And Tailoring of Interventions

The prior systematic review also identified the importance and necessity of therapists holding knowledge of autism, adolescent development and an awareness of autistic presentation (Casper et al., 2021, p.10). This enables the therapist to tailor their support to the individual which is a cornerstone of both person-centred therapy (C. Rogers, 1957) and play therapy (Axline, 1969). This idea of tailoring support is prevalent in education already with the use of Educational Health and Care Plans (EHCP), sensory profiles, etc., for young people who may need additional support to access learning due to a Special Educational Needs and Disabilities (SEND) diagnosis. These findings influenced the development of Phase One into therapist and counsellor perceptions of therapeutic working with autistic adolescents.

2.6 Systematic Review Finding Three: Nondirective Therapy and Wellbeing

The systematic review included a range of nondirective studies with a diverse participant population (N=40). Although every participant held a diagnosis of autism, the individuals presented with a range of co-occurring mental health concerns and individual difficulties. This reflects the nature of autism as a spectrum condition and highlights the need for intervention to be tailored. The N=12 nondirective studies included reported improvements across multiple wellbeing domains for N=39 participants such as a 50% improvement in mental health conditions and a 22.5% improvement in communication. The systematic review findings highlight a difference to directive studies which only report on one/two outcomes. This may be due to the differing outcome measures used and qualitative data capturing more in-depth information. However, it may be that nondirective interventions provide holistic support to the adolescent; improving more aspects of wellbeing and quality of life. Collectively the findings justify further investigation into nondirective intervention for autistic adolescents and the associated improvements on wellbeing and mental health.

2.6.1 Autism and Mental Health

The introduction to this thesis highlighted the increased co-occurrence of autism and mental health difficulties, whilst the systematic review highlighted the potential benefit of nondirective therapeutic interventions for wellbeing generally. This further supports the literature review focus on autism and mental health. The current section discusses the challenges of autism and mental health research and presents the reality of mental health difficulties for autistic individuals, with a progressive focus on adolescents.

2.6.2 General Information and Statistics

The DSM V (2013) identified that individuals with autism may experience co-occurring mental health conditions at higher rates than neurotypical individuals. This is supported in a large scale systematic review conducted by Lai et al. (2019) outlining the rates that autistic individuals experience co-occurring mental health conditions (see Figure Two).

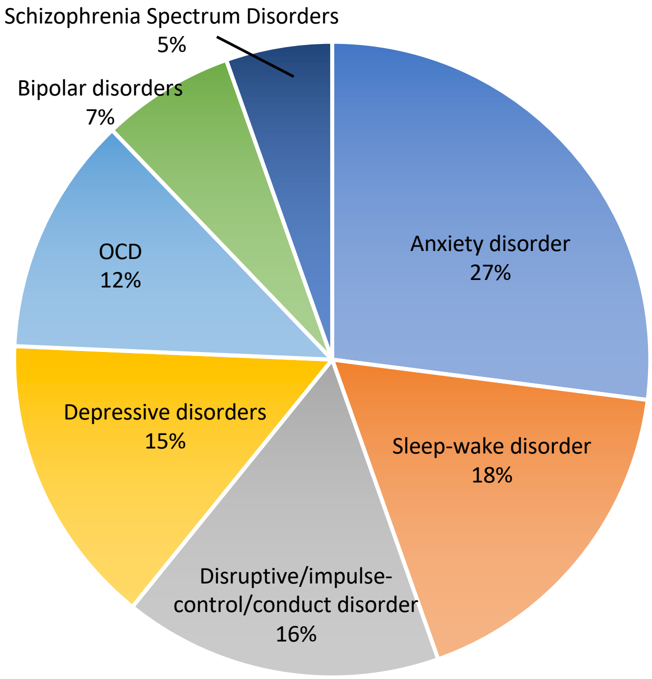


Figure 2: Co-occurrence Between Other Disorders and Autism (adapted from Lai et al., (2019))

These rates were higher in every category in comparison to rates of these mental health conditions in the general population (Lai et al., 2019). Despite the increased rates of mental health difficulties in autistic populations, the results suggest the general trends seen in a neurotypical population were still followed e.g., depressive disorders were more common in women and diagnosis rates of schizophrenia, bipolar and depression increase with age (Lai et al., 2011, p.11).

Autistic individuals have also been identified as having higher mortality rates with a lower lifespan than neurotypical individuals. Research conducted by Hirvikoski et al. (2016) suggests the mean age of death within their sample of controls (non-autistic participants) was M=70.6 years. In comparison, the autistic participants had a mean age of death of M=53.87. The main causes of death for the autistic individuals were suicide and nervous system diseases (Hirvikoski et al., 2016, p.235). This study was a large population-based investigation in Sweden that linked the National Patient Register and Causes of Death Register, which may limit the generalisability of the findings. However, it is pertinent that the cause of lower mortality rates is suicide and the World Health Organisation (WHO, 2021b) identifies mental health issues and experiencing stigma as the main cause of suicide globally.

2.6.3 Potential Reasons for Mental Health Difficulties in Autism

Explanations for why autistic individuals are more vulnerable to mental health conditions vary. A study conducted by Schiltz et al. (2021) utilised a battery of questionnaires to investigate social and emotional behaviour for N=69 autistic adults. The results suggested that loneliness may contribute to the higher rates of co-occurring mental health problems. Additional research conducted by Botha and Frost (2020) utilised the 'Minority Stress Model' (Meyer, 2003). This theory aims 'to explain disparities in health between majority and stigmatized minority groups' (Botha and Frost, 2020, p.22). Under this theory individuals with autism may be a minority group that experience stigma and have fewer resources to cope. The study included N=111 participants and the results suggest 'minority stressors such as victimization and discrimination, everyday discrimination, expectation of rejection, outness, internalized stigma, and physical concealment of autism consistently predicted diminished well-being and heightened psychological distress' (Botha and Frost, 2020, p.28). The main limitations of this research relate to the perception of autism as a minority which directly contradicts the concept of neurodiversity in the human condition.

Additional findings from Mandy (2019) support this theory with the suggestion that camouflaging or masking autistic difficulties are linked to mental health challenges including depression (Cage and Troxell-Whitman, 2019), anxiety (Livingston et al., 2019) and higher suicidality (Cassidy et al., 2018). The need to mask or camouflage is often 'motivated by a sense of alienation and threat, and frequently represents an attempt to avoid ostracism and attacks' (Mandy, 2019, p.1879).

Collectively the research identifies mental health in autistic populations as a significant concern and highlights the emergence of these problems follows the trends seen in neurotypical samples, but at higher rates. Although preliminary, studies suggest the main contributor to these mental health difficulties seems to be stress, ostracism and discrimination. It is of note that all the aforementioned studies are recent in publication; highlighting a shift in focus and awareness around autism and mental health. In order to substantiate some of the claims made, there is a distinct need for further longitudinal research to better understand these possible risk factors and investigate potential neurobiological influences to poor mental health within autistic populations.

2.6.4 The Prevalence Of Bullying Across Ages

As the research identifies, bullying, discrimination and stigma seem to be the main factors in developing mental illness and increasing suicidality. Large scale research including a national sample of N=20,849 was conducted to consider the prevalence of bullying across the lifespan (Wang et al., 2019). The findings suggested that instances of bullying decrease with age. Within the New Zealand sample of adults, the most common age to experience cyberbullying was between 18-25 years and this gradually decreased with the lowest age being 66+ years (Wang et al., 2019, p.736). Although focusing on cyberbullying and not being conducted in the UK does limit this study's generalisability, the findings support prior international research that bullying decreases with age and that children and adolescents are more vulnerable than adults (Due et al., 2005).

A further meta-analysis by Maiano et al. (2016) investigated the experience of bullying for autistic individuals aged 6-21 years. The results suggested that autistic young people are significantly more likely to experience victimisation within a school setting than their neurotypical peers, and rates were highest for adolescents. This raises concern for adolescents with autism who may experience discrimination at higher rates, potentially resulting in increased risk of co-occurring mental health problems.

Support for the link between bullying and poor mental health in autism comes from research by Hebron and Humphrey (2014) who utilised questionnaires and semi-structured interviews with N=22 participants. The results from the qualitative findings suggested bullying was an influential factor in developing mental health difficulties such as anxiety and anger. Furthermore, bullying also led to the development of coping mechanisms that may exacerbate the mental health issues e.g., self-reliance and internalisation. These findings are supported in research with N=1221 parents of autistic children in the USA (Zablotsky et al., 2013). Although caution should be taken when interpreting these results as Zablotsky et al. (2013) included ADHD, ODD and CD under the umbrella term of autism which differs to the understanding of autism as distinct in the UK. This may be explained based on the year of publication as the DSM V (2013) changes may not have been incorporated in the research and definition of autism.

2.6.5 The Impact on Adolescents' Mental Health

The research previously discussed highlights autistic adolescents and therapeutic intervention is the least studied, despite this population potentially experiencing victimisation at a higher rate and being more vulnerable to mental health issues. The World Health Organisation (WHO, 2022) suggest that 'mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes'. Research conducted by the NHS (2017) identified adolescents generally as the most at risk for developing mental health issues such as depression and anxiety. The WHO (2021a) have identified risk factors for poor mental health in adolescence, these include: pressure to conform, identity exploration, violence (sexualised and bullying), media influence, gender norms, exposure to adversity, home life and relationship quality as well as harsh parenting and socioeconomic problems.

In contrast, research by Mandy et al. (2016) suggested that mental health problems may be present in younger autistic children (under 11 year olds) but go undetected. Mandy et al. (2016) argued that transitioning from primary to secondary school was not a negative life-event for autistic young people. This challenged the idea that secondary school transition and adolescence was when mental health problems appeared. However, Mandy et al.'s (2016) suggestions were taken from parent and teacher perspectives of the child in primary school vs. secondary school. On closer inspection of the data, adolescent reports of mental health problems were significantly worse for anxiety and depression in secondary school than in primary school which further highlights the need to include young people within all research about their mental health experience.

Collectively the prior research indicates that adolescence is a prime time for mental health problems to develop and furthermore autistic adolescents are at increased risk due to the adversities they face within society. Additionally, the most researched and offered therapeutic interventions are directive with limited focus on adolescents and limited inclusion of adolescent voice. This places autistic adolescents as a therapeutic priority. As such this research aims to explore potential barriers to accessing therapeutic intervention, investigate current mental health difficulties and consider an alternate nondirective intervention to increase the therapeutic offer and reflect the spectrum nature of autism.

2.6.6 The Impact of COVID-19 on Mental Health

Due to the recency of the pandemic, there is limited research into the effect of COVID-19 on mental health but it has been proposed that similar to other natural disasters, COVID-19 will have an increased impact on children with chronic conditions (Rath et al., 2007).

There are some preliminary findings relating to the impact of COVID-19 on the mental health of adolescents. A recent large-scale systematic review conducted by Samji et al. (2022) included N=116 studies on children and adolescents. The findings suggested increased depressive and anxiety symptoms compared to pre-pandemic and neurodiverse young people were more likely to experience negative mental health outcomes than their neurotypical peers. This is supported in research in the UK by Ozsivadjian et al. (2023) with N=18 autistic young people who reported increased anxiety, lower mood and lower self-esteem in comparison to neurotypical young people.

Some initial suggestions for this worsening in mental health include a lack of access to mental health support through school (Golberstein et al., 2020), increased exposure to parental stress or maltreatment (Imran et al., 2020), increased screen time during the pandemic (Pandya and Lodha, 2021) and loss of routine and specialist interventions for neurodiverse young people (Samji et al., 2022).

The available research is limited in location and methodology, with most focusing on parent perceptions and not being conducted in the UK. This highlights a need for further investigation into the impact of COVID-19 on autistic adolescents that captures an accurate picture of their experience.

2.7 Systematic Review Finding Four: Commonalities in Nondirective Interventions

The systematic review included N=12 studies (Figure 1) which investigated N=9 types of nondirective interventions. The interventions included play therapy, narrative therapy, counselling, sandplay, long-term individual psychotherapy, mentalisation based therapy, counselling and medication, group therapy or a combination. 25% of interventions with autistic adolescents utilised a form of play therapy; however most were case-studies or small-scale research on a handful of participants. This highlights the need for larger scale research investigating the applicability to autistic adolescents.

2.7.1 Play Therapy Principles

Play therapy was originally proposed by Virginia Axline in 1947 and further revised in 1969. Research in play therapy has developed since Axline's initial proposal, however the key principles remain the same: grounded in nondirective techniques and providing holistic support to the child. Axline (1969, p.73) created eight principles of play therapy and suggests these can 'guide the therapists in all nondirective therapeutic contacts' and are based on the 'nondirective counselling techniques as suggested by Dr Carl R. Rogers' (p.26). Axline (1969, p.27) highlights that these principles rely on the therapist being 'humble in his role and does not at any time precede his client, since he knows full well that the client is the master of his own self'. Furthermore Axline (1969, p.26) writes that 'such attitudes are not put on and taken off like a coat, but are an integral part of the personality of the counsellor'.

Axline (1969, p.73-74) outlined the eight principles as follows:

1. 'The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child's exactly as he is
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognise the feelings the child is expressing and reflects those back to him in such a manner that he gains insight into his behaviour
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and the institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognised as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.'

These eight principles mirror the nondirective, person-centred therapeutic approach that C. Rogers outlined in 1957. Virginia Axline was a student and colleague to C. Rogers so her theories are heavily influenced by C. Rogers' person-centred theories. Both C. Rogers and Axline believed all humans (children included) to be motivated towards self-actualisation or 'the complete realisation of the self' (Guerney, 2001, p.16). It was on this basis that Axline developed child-centred play therapy. The aforementioned eight principles directly contradict other therapeutic interventions, such as behavioural and directive therapies as mentioned in Section 2.3. The acceptance of the child as they are and the therapist taking a non-expert position outlines an alternative way of working with clients and young people that provide the cornerstone for child-centred play therapy. A meta-analysis of N=93 studies identified play therapy to be effective for a range of issues, ages and genders (Bratton et al., 2005).

2.7.2 Play Therapy and the Systematic Review

Despite the different interventions, the systematic review findings suggest commonalities in all approaches. All studies highlighted the importance of putting the adolescent at the centre of the intervention, with the therapist holistically accepting the participant and holding an awareness of autism. Across all interventions there were four components that underpinned the nondirective approach (Casper et al., 2021):

1. Collaboration between adolescent and therapist
2. Adolescent-led discussions
3. Reflection and reframing utilised by the therapist
4. Encouragement and acceptance of the adolescent as they were

Casper et al. (2021, p.13) suggest that 'placing the adolescent at the centre of the therapeutic process encourages agency over their emotions and identity and scaffolds the development of an internal locus of control'. The four components encompass C. Rogers (1957) nondirective therapeutic conditions and have commonalities with Axline's (1969) play therapy principles.

Collectively these components all promote a move away from 'ableism' in the therapy room. Ableism is defined as: 'a network of beliefs, processes and practices that produce a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human. Disability, then, is cast as a diminished state of being human' (Campbell, 2009, p.44). The findings of the systematic review therefore highlight the importance of nondirective therapy for adolescents with autism and also the potential nondirective interventions, possibly guided by play therapy principles, have for changing the therapeutic offer and improving the wellbeing of autistic adolescents.

Overall, the systematic review findings suggest there is no valid reason as to why nondirective therapy is not more commonly offered to adolescents with autism. The researcher suggests this is likely due to the research skew towards directive therapy as these studies tend to be empirical and conform to the 'gold-standard' of research. In contrast nondirective methods may not be easily assessed by current outcome measures and may lend itself to a qualitative or mixed-methods approach. Furthermore, the reported results of these studies suggest nondirective methods may be more effective at holistically supporting autistic adolescents than directive interventions as there are improvements reported across numerous wellbeing domains and developmental skills (Casper et al., 2021, p.307). Despite the small number of studies included, the findings of the systematic review highlighted a need for further research into this under-reported area and raise awareness of the current publication bias for empirical studies.

2.8 Limitations of the Systematic Review

The main limitation of the systematic review is the small number of studies included. However, this is an accurate reflection of the available research which further justifies the current research objectives. The small number of studies included in the systematic review highlights the publication bias for empirical research. Empirical studies lend themselves to directive interventions that can be quantified and easily replicated. However, a continued focus on directive studies maintains the bias and raises ethical concerns over treatment options, accessibility to therapy and inclusion in the therapy room for autistic adolescents. Therefore, this research aimed to build upon the systematic and literature review and bridge the research gap with larger scale mixed-methods research.

2.9 Conclusion

In summary, there is a vast quantity of research into directive therapeutic techniques for the autistic population. However, this literature review highlighted significant gaps in research and understanding. Of growing concern is the lack of support, yet increased vulnerability, of autistic adolescents to mental health problems especially post-COVID-19. In addition, the reliance on behavioural and directive techniques, despite research identifying that nondirective, play-based techniques hold promise, maintains the publication bias and discrimination towards adolescents with autism. Collectively this highlights an urgent need for the current research to meet these gaps, include autistic voice and potentially improve the therapeutic offer for autistic adolescents and their mental health.

Chapter Three: The Current Research

***'I know there is strength in the differences between us. I know there is comfort where we overlap.'* - (Ani DiFranco, 1994)**

The prior systematic review (Casper et al., 2021) and the findings presented in the information and background chapters have informed the creation of the current doctoral research. The current section summarises the research with further chapters providing additional detail to individual studies.

3.1 Ethical Approval

Ethical approval for the study was granted by the University of Leeds School of Healthcare Ethics Committee (SHREC) on 16th June 2022 and was given the ethics reference: HREC-21-010. Additional amendments were granted on 23rd June 2023.

3.2 Philosophical Framework

A philosophical framework is necessary when commencing research to better define the research question, acknowledge the researchers' position and guide the research in all aspects. Based on the exploratory nature of this research and previous limited investigation, it is important to take a philosophical stance of pragmatism in reference to the paradigm that will shape this research. Pragmatism enables the researcher's subjectivity to be accounted for and lends itself naturally to a mixed-methods approach (B.C. Evans et al., 2011). This allows ontology to be viewed through the lens of pragmatism with the reality cycle (Maarouf, 2019). This reflects the belief that mental health, autism and therapeutic experience both exist in reality and are individually constructed and experienced by individuals in their own realities. As such, an 'intersubjective approach' (Morgan, 2007) to the research process will be applied to better understand the complex interaction between mental health, autism and nondirective therapy for each individual. Pragmatism and the intersubjective ontological approach of the reality cycle suggests there is 'both a single "real world" and that all individuals have their own unique interpretations of that world' (Morgan, 2007, p.72), which also has parallels with autism as a spectrum condition.

There is no theoretical framework that could be applied to this research due to the identified lack of prior investigation into nondirective therapy, autism and mental health.

Therefore, to better shape the research Figure 3 has been suggested to demonstrate how the research will explore the interaction and integration between the three interrelated constructs, in order to contribute new understanding to each field individually and collectively. The research and is well suited to a mixed-methods approach influenced by stakeholder involvement. A mixed-methods approach will be undertaken based on the understanding that qualitative and quantitative methods provide a unique contribution to research that complement each other and enable abductive reasoning (Morgan, 2007) between theory and data by moving between the inductive and deductive approaches as well as both methods of data collection.

The explanatory sequential mixed method (Maarouf, 2019) will be employed across the research (see Figure 4). This method collects quantitative data first, followed by qualitative data to add further explanation to the quantitative findings. Abduction (Morgan, 2007) will also be used to ascertain the correspondence between both the qualitative methods of focus groups, semi-structured interviews and the quantitative methods of surveys and Likert-items. Collectively the researcher hopes that the philosophical and framework applied to this research will allow for a novel and holistic insight to be gained which fills a significant research gap, adds to a currently small but important field of research and leads to the development of a useful theory.

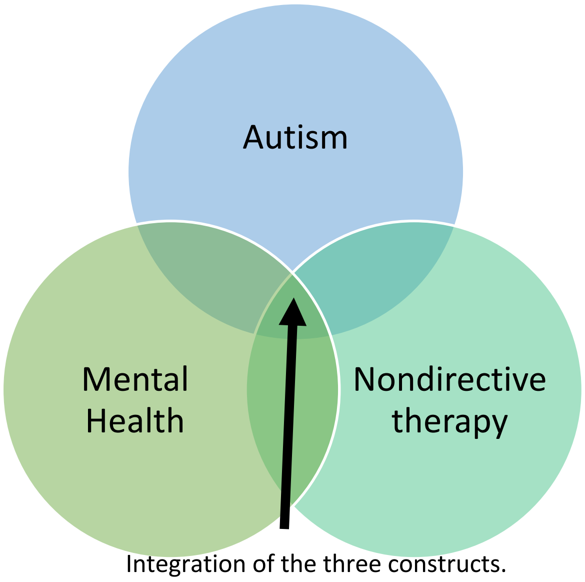
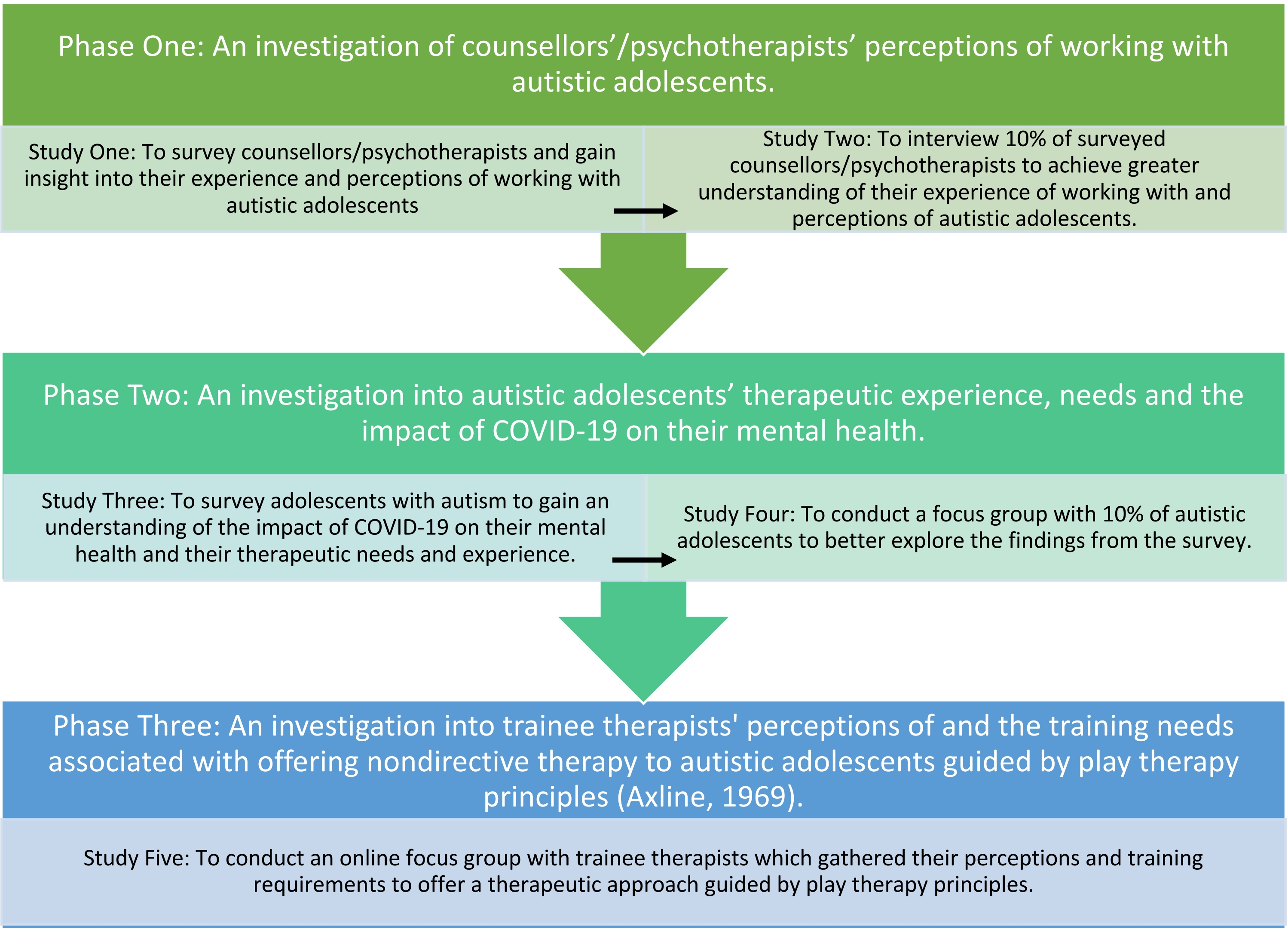


Figure 3: The Interaction and integration of inter-related constructs



Phase One: An investigation of counsellors'/psychotherapists' perceptions of working with autistic adolescents.

Study One: To survey counsellors/psychotherapists and gain insight into their experience and perceptions of working with autistic adolescents

Study Two: To interview 10% of surveyed counsellors/psychotherapists to achieve greater understanding of their experience of working with and perceptions of autistic adolescents.

Phase Two: An investigation into autistic adolescents' therapeutic experience, needs and the impact of COVID-19 on their mental health.

Study Three: To survey adolescents with autism to gain an understanding of the impact of COVID-19 on their mental health and their therapeutic needs and experience.

Study Four: To conduct a focus group with 10% of autistic adolescents to better explore the findings from the survey.

Phase Three: An investigation into trainee therapists' perceptions of and the training needs associated with offering nondirective therapy to autistic adolescents guided by play therapy principles (Axline, 1969).

Study Five: To conduct an online focus group with trainee therapists which gathered their perceptions and training requirements to offer a therapeutic approach guided by play therapy principles.

Figure 4: An Outline of the Research Process

3.3 Research Question, Aims & Objectives

Overall Research Question: How applicable are play therapy principles to nondirective therapeutic working to support autistic adolescents' mental health?

Phase One Research Question: How do counsellors and psychotherapists experience and perceive nondirective working with autistic adolescents?

Phase Two Research Question: How has COVID-19 impacted autistic adolescents mental health within the UK?

Phase Three Research Question: What are trainee counsellors and psychotherapists perceptions of and training needs for offering a nondirective therapeutic approach guided by play therapy principles to autistic adolescents?

Aim: To investigate the use of nondirective therapy based on play therapy principles with autistic adolescents experiencing mental health difficulties.

Objectives:

1. To conduct a literature review of current research based on the findings of the previous systematic review and use to inform the development of the proposed research design.
2. To survey and interview counsellors/psychotherapists and gain insight into their experience and perceptions of working with autistic adolescents (Phase One).
3. To survey and hold a focus group with autistic adolescents to gain insight into the impact of COVID-19 on their mental health (Phase Two).
4. To conduct a focus group with trainee therapists to understand the training requirements for working in a nondirective way with autistic adolescents (Phase Three).
5. To utilise all the data from the research to re-develop guidance for nondirective therapy with autistic adolescents experiencing mental health difficulties.

PHASE ONE

Chapters 4-8

Chapter Four: An Investigation Into Counsellors' and Psychotherapists' Perceptions Of Nondirective Therapy with Autistic Adolescents (Phase One)

4.1 Introduction

Counselling and psychotherapy are known as 'talking therapies' and were first proposed by Breuer and Freud (1893). Breuer and Freud (1893) suggested talking therapies were a way to uncover the causes of mental and/or physical illnesses and believed the cause to be a repressed traumatic incident. Breuer and Freud (1893) proposed that by putting a client into a hallucinatory state or by allowing them to freely talk, the therapist could uncover painful, hidden events that could explain the client's current presentation, this was termed psychoanalysis. Freud held a monopoly over the counselling/therapy realm, both academically and in practice with his suggestion of psychoanalysis until the 1950s. Carl Rogers in 1957 developed a person-centred therapeutic approach which proposed 'the individual has within him or herself vast resources for self-understanding' (C. Rogers, 1979, p.98). This was a differing approach to Freud which had previously relied on the therapist's understanding and explanation as crucial to the client. Around the time of C. Rogers' person-centred theory, traction was also being gained for the behaviourist theory which has roots from the early 1900's. Behavioural therapy focuses on goal-setting, challenge and includes an element of education. It is these aspects that behaviourists believe result in change of cognitions and emotions.

Within the UK there are several counselling and psychotherapy bodies such as the BACP, UK Council for Psychotherapy (UCKP) and the National Counselling and Psychotherapy Society (NCPS) that act as governing organisations for different orientations. Each body outlines what counselling is, has an ethical framework for therapists to follow, outlines training requirements and defines the role of the counsellor or therapist. Due to the different orientations within each professional body, the definitions of what counsellors/therapists do are very general and open to interpretation (see Figure 5).

The BACP (2022a): ‘Your therapist may offer information but they won’t give their opinions or advice or try to persuade you to a particular point of view’

The UKCP (2022): ‘Some [therapists] will support you to talk generally about your feelings, behaviours and thoughts and others will have specific exercises to do this. They won’t tell you what to do but will listen and may ask questions which can help you to see things in a new light.’

The NCPS (2023): 'Some counsellors, for example, will encourage you to take the lead in what is discussed and to support you in realising that you are actually more capable and resourceful than you may feel'

Figure 5: Professional Bodies Definitions of Counsellors Roles

As outlined in Chapters One and Two, theories and orientations of counselling and psychotherapy have changed significantly from Freud’s conception of psychoanalysis (1893) and as such, so has the understanding of the therapeutic relationship and the role of the counsellor. Theoretical orientations can be loosely defined as either psychoanalytic (Freud, 1893), behavioural (Pavlov, 1904) or person-centred (C. Rogers, 1957) and within these definitions, orientations can also be considered as directive or nondirective (see Chapter Two). The individual therapeutic orientations propose different ways of working with clients who are experiencing mental distress with varying degrees of directivity; each placing different emphasis on the role of the counsellor.

4.2 The Role of Counsellors/Psychotherapists

Counsellors and therapists are widely acknowledged as mental health professionals, who undergo significant training to better understand themselves in order to understand and support others. The role of counsellors/therapists has changed over the years, beginning with Freud’s perception of the therapist (psychoanalyst) as the expert who drives change by interpreting and analysing the client’s material (Leonard and Dawson, 2018). Proctor (2008) identified CBT (behavioural) therapists to have ‘the knowledge about how to think in a more helpful way…the therapist is assumed to be in an objective position to present this knowledge…[and] the assumption in the CBT model is that the therapist can be in an objective position to decide scientifically what is best for the client (pp.233-234). This positions both psychoanalysis (in its Freudian form) and CBT/behavioural interventions as directive approaches whereby the 'the therapist is believed to be in a better position to decide what the client needs than is the client' (Proctor, 2008, p.240). In contrast C. Rogers 'was concerned that placing the therapist in an expert role and reducing therapy to technique would interfere with the ability to rely on the individual's ability to guide his or her own growth and development' (Greenberg, 2004, p.53). C. Rogers' (1957) development of the person-centred theory aimed to be nondirective and focused on a way of being for the therapist that moved away from the expert position and focused on the therapeutic relationship between counsellor and client.

4.3 The Therapeutic Relationship

The therapeutic alliance/relationship is 'viewed as playing a central role in determining the outcome of treatment' (Marziali and Alexander, 1991, p.383). Marziali and Alexander (1991) conducted a review of the literature focusing on the impact of the therapeutic relationship on client outcomes across different orientations. The review highlighted, that despite the orientation used (behaviour, person-centred or psychoanalytic), client outcomes were consistently predicted by the quality of the therapeutic relationship rather than any specific treatment method. The researchers termed the therapeutic relationship a 'potent curative factor' (Marziali and Alexander, 1991, p.388).

As this research is focused on the nondirective approach to therapy in relation to autism, the therapeutic relationship is explored through a nondirective lens. This lends itself naturally to focusing on and further exploring C. Rogers' person-centred theory (1957). C. Rogers (1957) developed the six necessary and sufficient conditions for therapeutic change, which contained the three core conditions and believed these to be applicable across orientations. Specific modalities, interventions and treatments were deemed less important than the interpersonal relationship between client and therapist for resultant personality change.

The following sections outline part of C. Rogers (1957) theory to better illustrate the importance of the therapeutic relationship pertaining to the three core conditions of empathy, congruence and unconditional positive regard (UPR) and to provide the foundations of the current research. C. Rogers (1957) believed the counsellor's role was to offer these three characteristics as a way of being.

4.3.1 Empathy

C. Rogers (1957, p.99) proposes empathy is when a therapist can 'sense the client's private world as if it were your own, but without ever losing the "as if" quality'. Empathy enables the therapist to 'communicate his understanding of what is clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware' (C. Rogers, 1957, p.99). A meta-analytic study of N=57 studies with N=3599 participants suggested that empathy has a medium effect on therapy outcome and accounts for more variance than specific therapeutic interventions (Elliott et al., 2011). Collectively this provides support for Marziali and Alexander's research (1991) that the therapeutic alliance is more important than the specific intervention used.

In relation to therapeutic work with autistic clients, Milton et al. (2022) identified the 'double empathy problem' between neurotypical and autistic individuals which may challenge the therapists' ability to be empathic. The double empathy problem 'refers to a breakdown in mutual understanding (that can happen between any two people) and hence a problem for both parties to contend with, yet more likely to occur when people of very differing dispositions attempt to interact' (Milton et al., 2022, p.1901). Originally the double empathy problem was termed to explain the potential difficulties of interacting between different neurotypes, however unfortunately 'the locus of the problem has traditionally been seen to reside in the brain of the autistic person' (Milton et al., 2022, p.1901). Despite this, misunderstandings and ruptures are a common and essential part of a therapeutic process. Further research suggests that rupture resolution leads to better therapeutic outcomes (Eubanks et al., 2018) and highlights the importance of therapists awareness and adaptability to different clients.

4.3.2 Congruence

C. Rogers (1957, p.97) identified the need for the counsellor to be a 'congruent genuine and integrated person…in this hour of the relationship'. The basis of congruence within the therapeutic relationship is that the therapist does not present a façade or mask themselves as an individual, nor do they take on a 'role' or hide behind a professional status. Kolden et al. (2011, p.69) extended the idea of congruence: ‘There are two facets of congruence. The first reflects a mindful genuineness on the part of the therapist, underscoring present personal awareness as well as authenticity. The second facet of congruence refers to the therapist’s capacity to conscientiously communicate his or her experience with the client, to the client. Congruence is thus ‘both a personal characteristic (intrapersonal) of the therapist, as well as an experiential quality of the therapy relationship (interpersonal)’. In Kolden et al.’s (2011, p.68) meta-analytic review of N=16 studies with N=863 participants there was a small-medium effect of congruence on client outcome, suggesting congruence to be a ‘noteworthy facet of the therapy relationship’.

Research conducted by Ray et al. (2012) suggests that therapist congruence is essential in nondirective play therapy with autistic children as it allows the therapist to offer full acceptance of the child and the child to receive this. Ray et al. (2012) suggest that without this, UPR for the child cannot develop and highlights the benefit of congruence in offering acceptance to an autistic child. The research suggests that autistic children may not have experienced acceptance for who they are based on societal views of their diagnosis; further highlighting the importance and benefit of congruence in these therapeutic relationships.

4.3.3 Unconditional Positive Regard

C. Rogers (1957, p.98) explains positive regard as ‘the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client, he is experiencing unconditional positive regard.’ Unconditional Positive Regard (UPR) is a way for the therapist to wholeheartedly accept the client and their experiences without any conditions attached. Wilkins (2000, p.34) states UPR ‘requires that therapists approach their clients without prejudice, with respect for who and what they are, and with a recognition that they are self-determining persons’. It is only in being unconditionally regarded by another, can we begin to unconditionally regard ourselves, with C. Rogers (1951, p.17) proposing that ‘we cannot change, we cannot move away from what we are, until we thoroughly accept what we are’. A meta-analysis of N=64 studies found a strong relationship between UPR and client outcome (Farber et al., 2018); further identifying UPR as an essential and beneficial component of the therapeutic relationship.

Additional research conducted by Robinson et al. (2020) identified the benefit of UPR for autistic clients from a therapists' perspective in creating feelings of acceptance and non-judgement but identified this does not always come naturally and needs to be practiced. A further study by R. Hume (2022, p.179) investigated the effect of UPR for autistic adult clients of therapy and also found that a non-judgemental attitude was essential for acceptance, 'however, moments of epiphany and profound shifts in the relationship arose only from expressions of UPR that were more explicit and tangible'.

4.4 Therapist Awareness

There is a plethora of research into the effectiveness of the therapeutic alliance building upon C. Rogers' (1957) work on person-centred therapy and the six necessary and sufficient conditions. However, a central tenet of C. Rogers' theory is that therapists and counsellors are still human beings with their own experiences and feelings and in order to create a beneficial therapeutic alliance, the therapist must have an awareness of themselves and their limits. This was echoed by Lammert (1986, p.370) who coined psychotherapy to 'consist of an interaction between two personalities'. This highlights self-awareness to be an essential element for therapists to develop and utilise within the therapeutic alliance.

It is widely recognised that the development of self-awareness is essential to becoming a successful counsellor, this is mirrored in training programmes and continual professional development opportunities. Research conducted by Pieterse et al. (2013, p.191) outlined self-awareness to be gleaned from two aspects: 'global knowledge of one's perceptions and experiences (cognitive understanding) or a more temporary condition of focusing on the self (physiological and affective reactions)'.

The current study investigated therapist/counsellor perceptions of nondirective working with autistic adolescents. The presented research has thus far identified that therapist awareness of their own perceptions is vital for the therapeutic alliance and for successful therapy outcomes. Similarly, the prior systematic review (Casper et al., 2021) identified therapist knowledge and understanding of autism as essential for positive outcomes of nondirective therapy. The following literature review aimed to gain an understanding of previous research into core conditions, therapist perceptions and therapist experience of working with autistic adolescents to identify gaps in knowledge in which to build the proposed research on.

4.4.1 Autism and Therapist Awareness

The literature review identified a considerable quantity of research focusing on parent perceptions of autism and interventions as well as neurobiological research but not of psychotherapist and counsellor perceptions of working with autism (either adult or child). Of the studies identified, the focus was on therapists' perceptions of the intervention (Epstein et al., 2019; Hodge, 2013; Viefhaus et al., 2021), guidance for therapists working with autistic individuals (Ennis-Cole et al., 2013; S. Murphy et al., 2017; Rutten, 2014) or ignores the therapist's voice in outcome measures (Mossler et al., 2019; Brookman-Frazee et al., 2020). From the review, few studies addressed the therapist's perceptions of working with autistic individuals; highlighting the need for the present research. Of note is the recency of the identified publications. Despite autism being identified as a diagnosable condition in the 1980s, the research field has only just begun to consider the impact of practitioner perceptions of therapeutic working with autistic individuals. This provides further justification for the proposed study as a clear research gap is identified.

4.4.2 Therapist Training

Research conducted by K. Cooper et al. (2018) conducted a small-scale survey of N=50 therapists' experiences when adapting therapy for autistic clients. The results suggested 64% of therapists had not received any specific knowledge or skills guidance on autism throughout their core training. This is further supported in research by Chandrasekhar and Hu (2020) and Hu and Chandrasekhar (2020) focusing on university students and mental health centres. These findings suggested directors of university care centres perceived a 'lack of staff interest or expertise in ASD' and structural problems causing inadequate support provision (Hu and Chandrasekhar, 2020, p.343).

Qualitative research by Brookman-Frazee et al. (2012a) conducted focus groups with N=17 therapists to better understand the training received and training needs of therapists when working with autistic clients. The subsequent findings suggested a therapists found this population challenging due to 'slow rate of progress, perceived ineffectiveness of treatment strategies, and system issues' (Brookman-Frazee et al., 2012a, p.370). Participants shared a need for training on autistic characteristics as well as how to work with parents and the system around the child. In contrast to the research by Hu and Chandrasekhar (2020) the findings also suggested that 98% of participants were highly motivated for further training on autism.

In addition, Dagnan et al. (2018) conducted a mixed-methods study and identified that training on intellectual disability increased confidence across N=44 practitioners. Follow-up qualitative data (N=12) suggested that training had made participants more aware of adaptations for materials, communication and interventions. Collectively this research highlights a need to consider therapists confidence as well as training experience and the potential impact of this.

4.4.3 Therapist Knowledge

K. Cooper et al. (2018) found that 54% of participants believed therapeutic outcomes to be less favourable for autistic clients than non-autistic clients and 96% of participants employed a CBT approach. This may be explained due to participant recruitment coming from attendees of a Continual Professional Development (CPD) training course which aimed to teach how CBT can be adapted for individuals with autism; suggesting therapists were more familiar with CBT and potentially unaware of the efficacy of other approaches for this client group. The participants attending the training and completing K. Cooper et al.'s (2018) survey all reported previously making adaptations to CBT interventions to ensure accessibility for autistic clients. Research by Casper et al. (2021) raises concern for adapting CBT programmes in relation to cost-effectiveness and efficacy in comparison to other interventions. It is interesting that CBT therapists view therapeutic outcomes (from their experience of using CBT and adapted CBT) as less favourable. This seems to further highlight a need for research into alternative approaches and the importance of improving therapists' knowledge of autism; providing further justification for the current research.

Furthermore, Maddox et al. (2019) conducted semi-structured interviews in the USA with N=44 mental health clinicians. The findings suggest clinicians perceived several barriers to supporting this client group including: lacking in knowledge, competence and confidence. Of concern were additional findings reported by Kara and Demirtas (2020) which found some school counsellors in Turkey still held incorrect beliefs that autism is caused by vaccinations. These claims were discredited by the General Medical Council and the research was retracted in 2010 in a high-profile case (Godlee et al., 2011).

In further support of these findings, recent research conducted by Lipinski et al. (2022) looked at education and knowledge of autism in N=498 therapists working with autistic adults in Germany. The results from this large-scale cross-sectional survey suggest that some psychotherapists still hold incorrect beliefs about autism; reflecting the lack of knowledge and education held and supporting K. Cooper et al's (2018) findings (see Figure 6). Additionally, the research suggested that the lack of knowledge and training for psychotherapists was reflected in their openness to 'treating' autistic adults. Although 71% of participants stated they would be open to offering therapy if they received further education, there was still 15.5% of participants who felt talking therapies were not suitable for autistic adults and 11.5% believed the 'otherness of autistic adults is strange/disconcerting' (Lipinski et al., 2022, p.1515).

This raises concern for numerous reasons e.g., therapists may be unaware of clients with a diagnosis possibly due to a lack of knowledge, therapeutic provision is not accessible to autistic individuals, therapists are not open to seeing autistic individuals or autistic individuals are not accessing therapeutic provision for mental health.

The findings are echoed with research by D. Jones et al. (2021, p.12246) who conducted an implicit associations test with the general public and found N=238 'non-autistic adults associating autism-related labels with unpleasant personal attributes' such as weird, creepy and helpless'. Although this research was conducted in Germany which may limit the generalisability to other countries and cultural contexts, the research design has numerous strengths. This was a large-scale study; increasing validity in findings and this study was also co-designed and authored by a participatory autism group. This further ensures the research being carried out within the autism community is shaped by and holds the utmost important to the population it wishes to support.

The results from Lipinski et al. (2022) further highlight the need for the current research. The data shown in Figure 6 is extremely concerning to the researcher as a practitioner working with and as an ally of the autism community. The data acts as additional motivation to conduct the current research.

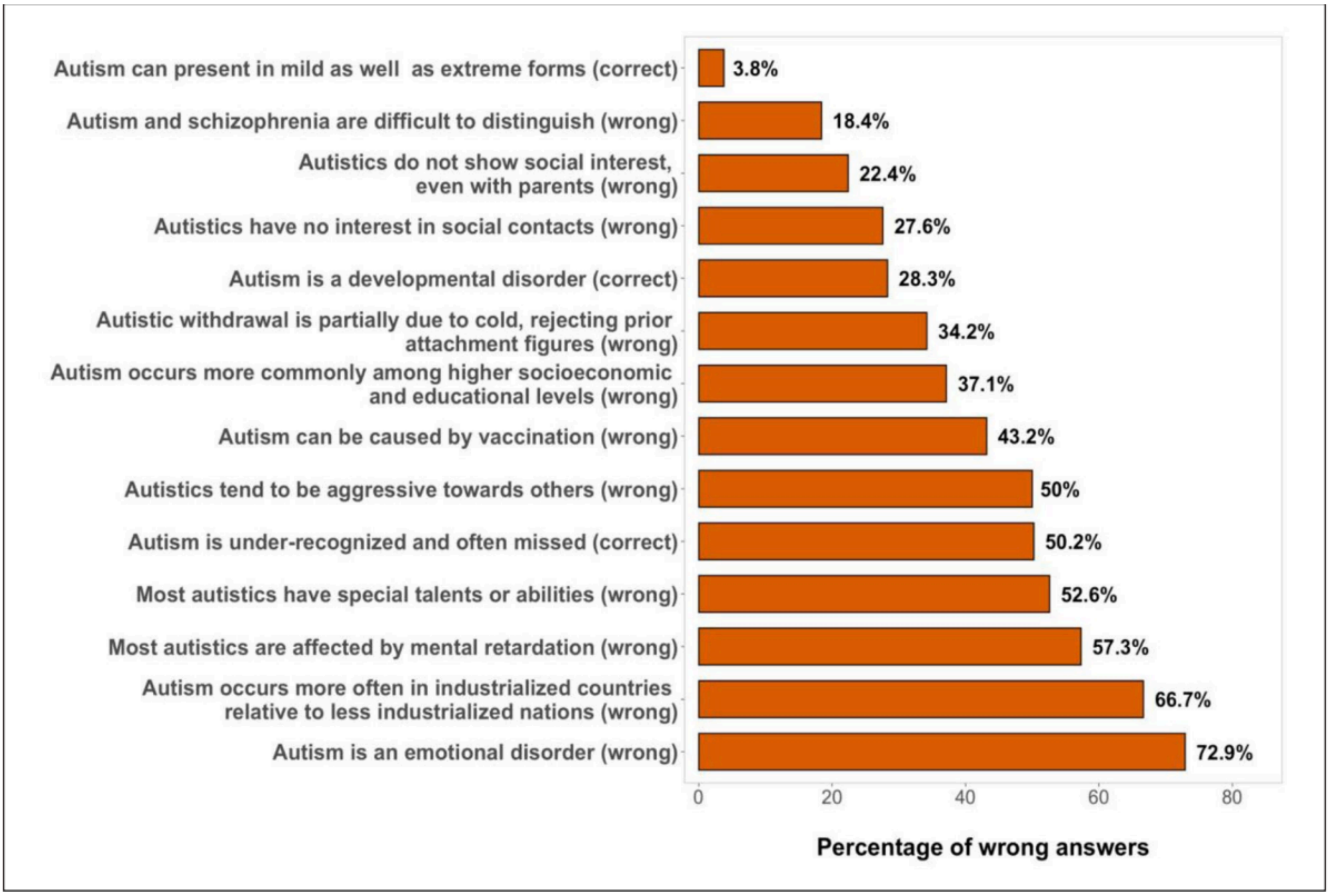


Figure 6: Percentages Of Incorrect Answers To The 14 Questions Targeting General Knowledge About Autism. Taken From Lipinksi et al (2022, P.1514)

Additional research conducted by Roudbarani et al. (2022) investigated factors relating to the delivery of psychotherapy for autistic and ADHD adolescents. This large-scale research with N=611 practitioners in Canada, suggested practitioners had a lower intention to treat autistic adolescents in contrast to ADHD adolescents. This relationship was partially mediated by knowledge, normative pressures and attitudes. This is the first known study to consider therapist perceptions and the findings further support previous work by Maddox et al. (2020) and Lipinski et al. (2022), highlighting therapist attitudes as potential barriers to accessing mental health support for autistic clients.

Although there is similarity in Roudbarani et al.'s (2022) research and the current study's aims, the aforementioned study focuses specifically on perceptions and intention to treat which differs to the current study's interest on experience. The prior study utilised an adapted version of the Therapist Confidence Scale – Intellectual Disabilities (TCS-ID) (Dagnan et al., 2015), this measure has not been validated for therapist confidence working with children and adolescents which questions the validity of the findings. Therapeutic working with children and adolescents requires additional knowledge of child development as well as theory and adaptations to practice and should not be seen as ‘scaled-down adult therapy' (Prout, 2007, p.1). In addition, the large sample included a range of practitioners including social and youth workers who mostly offered CBT and behavioural interventions (54%); reducing the generalisability of findings to counsellors and psychotherapists and different therapeutic orientations. The proposed research intends to build upon these findings within the context of the UK.

4.4.4 Therapist Experience

Further research by Vulcan (2016) conducted interviews with N=28 therapists in Israel who worked with autistic clients aged between 2-16 years. The themes identified from qualitative analysis suggests therapists hold a frustration when working with autistic clients, struggle with the differing communication styles, experience strong countertransference and reverie of their own childhood as well as intense bodily sensations of emptiness and fatigue. Vulcan (2016, p.335) suggests the findings highlight the difficulties of working with autistic children based on the challenges the client provides to therapeutic interventions e.g., ‘reciprocal interaction, play and symbolic thought’. Vulcan (2016) proposes these findings could be utilised in training of therapists to better prepare them for working with autistic clients. Despite this being a detailed study with clear themes defined and potential for replicability, some of the conclusions drawn highlight consistent problems within therapeutic understanding of autism. Specifically, the concern that autistic children cannot participate in play.

Research by Casper et al. (2021) present a review of studies providing numerous examples of autistic adolescents participating in play and nondirective therapeutic interventions with positive outcomes for wellbeing. Furthermore, the age-range of participants in Vulcan’s (2016) study is too broad to make generic statements of challenges autistic clients provide and there was no data collection on therapist knowledge of autism prior to the study’s commencement. The previous literature outlined the influence of therapist and knowledge on the therapeutic relationship and as such it is difficult to ascertain the validity of Vulcan’s (2016) findings. In addition, N=11 of the therapists included were dance/movement therapists who bring ‘a somatic orientation…to their work’ (Vulcan, 2016, p.336) thus favouring or ‘overvaluing’ their own bodily sensations compared to the therapeutic space between them and the client.

Research by Dagnan et al. (2015) whilst assessing the validity and reliability of the TCS-ID, found that CBT practitioners were less confident than psychodynamic or eclectic practitioners when working with intellectual disabilities. This suggests there may be an influence of therapeutic orientation on confidence to work with certain populations which has not been previously explored in relation to autism. The current study intends to explore any potential relationships between therapeutic orientation and therapist experience and perceptions.

It is worth noting that therapist experience should also cover therapists who are autistic themselves. Whilst this is outside the scope of the current research (and there is currently no published research investigating autistic therapists experience), the researcher is part of several networks alongside neurodivergent therapists and believes autistic therapists and clients have the potential to shape the future therapeutic offer in an unparalleled way.

4.5 Conclusion

To conclude, the main findings of the aforementioned literature review highlight a lack of therapist knowledge, training, confidence and experience. The literature review identified that incorrect assumptions about autistic individuals are still held in wider society and by psychotherapists. This poses a practical dilemma when collating this literature with previous literature about the importance of therapeutic alliance and therapist awareness on the outcome of therapy. To date the research considering psychotherapist and counsellor perceptions on working with autism has been small samples of therapists working with broad age-ranges, across orientations, in various countries or non-specific to counsellors and psychotherapists. Only N=1 research was conducted in the UK (K. Cooper et al., 2018) and this focused specifically on a CBT approach, perhaps reflecting the main offer of therapy within the UK. The researcher can find no prior investigation that has specifically focused on autistic adolescents, different therapeutic orientations, therapist experiences and perceptions that has been conducted within the UK; identifying a limitation of the previous research. As a result of these findings, Phase One aimed to conduct an online survey and hold individual interviews within the UK investigating counsellor and psychotherapist perceptions of nondirective working with autistic adolescents (see Chapter Five).

Chapter Five: Phase One Methodology

Phase One utilised both quantitative and qualitative methods. The studies were descriptive and exploratory, utilising a cross-sectional design. Study One gathered quantitative data regarding experience and perceptions of therapeutic working with autistic adolescents via an online survey (see Appendix A). Study Two gathered qualitative data from open-questions during an online interview to further understand opinions and experiences (see Appendix B). The pragmatic approach of abduction where the deductive goals of a quantitative approach can serve as inputs to the inductive approach of qualitive research (Morgan, 2007) was employed in the mixed-methods approach of Phase One. The previous studies cited in the literature review presented either quantitative or qualitative data and yet 'differing approaches have the potential to provide a greater depth and breadth of information which is not possible utilising singular approaches in isolation' (Almalki, 2016, p.288).

5.1 Aims & Objectives of Phase One

This phase aimed to investigate counsellors'/psychotherapists' perceptions of working with autistic adolescents. Phase One was split into two study's each with one objective:

1. Study One: To survey counsellors/psychotherapists and gain insight into their experience and perceptions of working with autistic adolescents
2. Study Two: To interview 10% of surveyed counsellors/psychotherapists to achieve greater understanding of their experience of working with and perceptions of autistic adolescents.

5.2 Survey – Study One

5.2.1 Rationale for Methods

The survey method of data collection was chosen due to its ease in online administration and ability to share widely to reach as many participants as possible. Research by Granello and Wheaton (2004, p.388) identified online web surveys to have several advantages including 'reduced response time, lower cost, ease of data entry and flexibility of and control over format'. The literature review identified that previous larger-scale studies have used online surveys and achieved a good response rate. Utilising an online survey allowed quantitative data to be easily extracted and analysed which reduced financial and time-constraints of data analysis for the researcher. Limitations of online web-surveys were considered such as low response rates or lack of representation in the sample. The researcher mitigated the impact of this with regular posting of the survey across several forums to encourage responses and sharing the survey on different medias and groups to try reach a representative sample of participants.

5.2.2 The Survey

Previous measurement tools were researched to identify if any validated outcome measures could be used for the current study. The pool of research from which to find a suitable outcome measure was small as the literature review identified only N=7 suitable studies for inclusion. Upon further investigation N=3 (K. Cooper et al., 2018; Maddox et al., 2019; Roudbarani et al., 2022) studies employed an adapted version of the Therapist Confidence Scale – Intellectual Disabilities (TCS-ID) (Dagnan et al., 2015). This measure provides a rating of therapist confidence on a Likert scale. The TCS-ID was not used as a measure of confidence in this study as it was not developed specifically for its use with young people or children. Whilst N=1 previous study has employed the measure when assessing therapeutic confidence with children/adolescents (Roudbarani et al., 2022), the training requirements and knowledge of theory required for working with children and young people is different to therapeutic working with adults (Prout, 2007). Therefore, the validity of the TCS-ID is questioned in this population and was not implemented in the current study. Furthermore, the current study was exploratory and interested in perceptions and experiences of therapists. As such it was not necessary to gain detailed information about levels of confidence or variables affecting this for the research aims and purposes.

The remaining N=4 prior studies had developed outcome measures guided by related research but tailored specifically to the study being conducted. On this basis the researcher created the survey questions to ensure the questions allowed conclusions to be drawn in relation to the current research aims. This study may be limited due to the lack of validated and standardised outcome measure used and the nominal properties of the data, however the methods employed were suitable to the research aims. The researcher investigated the possibility of statistical methods to assess internal validity of the survey, however the sample size was not large enough to run a confirmatory factor analysis on the data. This does not allow for an appropriate internal validity analysis to be conducted.

The survey questions created (See Appendix A) were similar and guided by previous research as outlined below; improving validity and reliability in the findings:

5.2.2.1 Demographic Questions

The current research asked N=8 demographic questions relating to age, gender, ethnicity, training level, professional body membership, years since qualified, theoretical orientation and current role. These demographic questions were informed by previous research which consistently asked the same demographic questions in related research to investigate potential relationships between demographic information and therapist experience and perceptions (K. Cooper et al., 2018; Maddox et al., 2019; Brookman-Frazee et al., 2012b). Guidance by the American Psychological Association (APA, 2013) cited by Hughes et al. (2016) investigated why certain demographic questions were routinely used in research. The APA suggest that researchers should 'describe the groups as specifically as possible, with particular emphasis on characteristics that may have bearing on the interpretation of results' (Hughes et al., 2016, p.29). The previous studies all asked the same demographic questions based on prior studies' identification that therapist experience and training may impact the findings (see Chapter Four).

5.2.2.2 Therapist Experience Questions

The current research asked N=3 questions relating to therapist experience. Participants were asked: 1) if they had experience working with autistic adolescents; 2) how many autistic adolescents had they worked with (if previous answer was yes) and 3) if they were trained to work with autism as part of their qualification. These closed questions were asked in the form of yes/no answers which allowed for straightforward quantitative data analysis. Asking about therapist experience either directly or indirectly was evident in prior research studies (Lipinski et al., 2022; K. Cooper et al., 2018; Maddox et al., 2019; Brookman-Frazee et al., 2012b; Chandrasekhar and Hu., 2021) which highlighted these questions as valid measures for gaining information and enabled relationships to be identified between experience, perceptions and demographic information. There is not yet an outcome measure that gathers data about therapist experiences working with autistic clients and thus the current research relied on previous studies' to guide the creation of questions.

5.2.2.3 Therapist Perception Questions

The survey consisted of N=5 questions to gain insight into therapists' perceptions of therapeutic working with autistic adolescents. There were N=3 closed questions asked about therapist's confidence, competence and the importance of therapist knowledge about autism. A further N=2 questions were asked about therapist perceptions of nondirective therapy as beneficial and perceptions of involving parents/carers in therapy. These questions were asked as yes/no options but provided free text boxes. The optional free text boxes allowed therapists to expand on their answers and provided an opportunity to collect richer qualitative data should the participant want to share more. Asking about therapist perceptions of working with autistic clients was also evident in prior research studies (K. Cooper et al., 2018; Maddox et al., 2019; Brookman-Frazee et al., 2012b; Chandrasekhar and Hu., 2021); providing further rationale and validation for the inclusion in the current study. These questions enabled relationships between perceptions, experience and demographic information to be identified which met the aims of the exploratory study.

5.2.3 Participants and Recruitment

Participants were recruited using email, social media and networking platforms such as: Facebook, Instagram and LinkedIn. The researcher emailed colleagues and peers inviting them to participate and asked them to share within their networks. The poster and supplementary text was shared on social media groups that were aimed at therapists and counsellors as well as on relevant business and community pages (see Appendices C and D for recruitment poster and text, respectively).

Participants were required to have received formal therapeutic training at an educational establishment that was accredited by a professional body e.g., British Association of Counsellors and Psychotherapists (BACP), United Kingdom Council for Psychotherapy (UKCP), Health and Care Professions Council (HCPC), etc. This ensured all participants were trained to a similar and comparable standard. Participants had to be a member of their respective professional bodies, have a minimum of 3 years' experience since qualifying and also had experience working with autistic adolescents. This was to ensure their practice was regulated, followed sufficient ethical guidelines and they held a solid knowledge and experience base from which to answer. These criteria aimed to reduce the risk of bias in the results and increase generalisability of findings. For demographic information see section 5.3.1 and 6.1.

5.2.4 Analysis

The survey yielded quantitative date that was analysed using IBM SPSS software (IBM, 2021). The statistical analysis utilised Fisher’s Exact Test (Fisher, 1992) to look for trends and patterns in the data and the demographic information provided descriptive statistics. Fisher’s Exact Test was used instead of the Chi-quare test as the assumptions for the Chi-square test could not be met due to sample sizes in categories. As this research was exploratory there was no hypothesis guiding the analysis. The data gained dictated the statistical tests run based on the patterns presented.

5.3 Methods for Study One

5.3.1 Participants and Demographics

N=103 participants completed the online survey. However only N=95 responses were included in the data analysis, N=8 were removed for not meeting the inclusion criteria (been qualified under 3 years, were not psychotherapists/counsellors, did not have experience working with autistic adolescents or were not a member of a professional body). The majority of participants were female (N=87), the most common aged selected was 45-54 years (N=41) and majority were White-British (N=82) (see Table 4 in Chapter Six).

5.3.2 Ethics

Ethical approval for all phases of the research was gained from the School of Healthcare Research Ethics Committee (SHREC) on 16th June 2022. An initial application was submitted in April 2022 and revised based on recommendations before final approval was given.

5.3.3 Materials

Study One utilised an online survey which was developed for this research. The online survey provider used was Online Surveys (JISC, 2023). This provider was chosen due to its availability of use to Leeds University Researchers as well as its functionality and the ability to anonymise participants. The online survey consisted of an information sheet (see Appendix E) , an informed consent form (see Appendix F) and a participant privacy notice (see Appendix G). The survey asked eight demographic questions and eight closed-questions about therapists perception and experience (see Appendix A). The questions were followed up with an invite to further participate in Study Two by leaving the email address in the text box and a final comments box.

5.3.4 Procedure

A small pilot study (N=5) was conducted to test the accessibility and logic of the survey and interviews before publishing the survey online. The survey was open for two months between 24th June 2022 and 24th August 2022. Participants clicked the link provided to them either online or via email, depending on how they were recruited. This link took them to the online information form which outlined the right to withdraw, the estimated 5 minute completion time and that all questions were optional. This was followed by the consent form which participants' had to provide in tick box format to continue with the survey. The participants then viewed the privacy notice and completed demographic questions.

Before the survey questions were asked, participants viewed a terminology notice, outlining definitions and providing rationale for their usage within the questionnaire (see Appendix A). This is good practice and ensured all participants had the same understanding of what directive and nondirective therapy was based on the APA guidance (VandenBos, 2007). The participants were asked the eight closed questions about their perceptions and experience of nondirective therapeutic working with autistic adolescents. The survey then asked participants to leave their email address should they wish to participate in Study Two and then provided a textbox to leave any further comments.

Participants were directed to a page that thanked them for their participation, provided with the researchers contact details again and reminded of the two-week window to withdraw their responses. Participants were asked to make a note of their unique submission ID as this would be essential for withdrawing participation. Participants then clicked to submit their answers.

5.4 Interviews – Study Two

5.4.1 Rationale for Methods

Semi-structured interviews were chosen for Study Two to gain further insight into participants experiences and perceptions. Qualitative analysis 'is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem' (Creswell, 2014, p.32). Semi-structured interviews gain qualitative data and allows for researcher and participant flexibility in question and response and are recommended for small-scale research (Drever, 1995). This method was also chosen due to its repeated usage in previous healthcare and education research (Pathak and Intratat, 2012; Maddox et al., 2019; Aira et al., 2003) further highlighting its credibility and accessibility for research of this nature.

All interviews were conducted online via Microsoft Teams (Microsoft, 2023). Using online interviews enabled researcher and participant flexibility in timetabling as there was no requirement to arrange rooms or consider travel, this also reduced financial implications for participants. The limitations of conducting interviews online were considered e.g., potential difficulty with technology, the impact on rapport building, privacy limitations and lack of physical/visual cues regarding body language (de Villiers et al., 2021). The researcher believed these could be mitigated by trialling the technology beforehand and using video functions, supported in research by de Villiers et al. (2021).

5.4.2 The Interview

The prior literature search identified previous research utilising similar interview methods. The literature review identified there was not a standardised and validated interview schedule used due to a lack of availability and validity for similar healthcare research. Therefore, previous studies had created their own questions to meet the needs of their research. This is not surprising given semi-structured interviews are routinely chosen for the flexibility they provide in research (Creswell, 2014) and are regularly used as part of an inductive, qualitative approach to data collection in which the researcher is interested in meaning assigned by individuals and leads to thematic exploration of the data.

The interview comprised of N=8 questions (see Appendix B) created to better understand therapist experiences and perceptions of therapeutic working with autistic adolescents. These questions were guided by the outcomes of Study One and prior research investigating therapist perceptions (Maddox et al., 2019; Brookman-Frazee et al., 2012b) and tailored to address the specific objectives of the current study. N=4 questions asked about therapists experience in relation to involving parents/carers, general experience, referrals and training. A further N=4 questions asked about perceptions of working in a nondirective way, opinions on nondirective vs. directive therapies offer rates, challenges to practice and how therapists could better support autistic adolescents.

5.4.3 Recruitment

The penultimate question on the online survey in Study One asked participants to leave their email address if they would like to participate further in a 30 minute online interview. This enabled recruitment for Study Two to easily happen from Study One; reducing recruitment time and increasing participation. Participant ID's were entered into a random number generator and 10 were chosen. The researcher contacted the corresponding email address to the chosen ID via email. There was a total of three email requests before all N=10 participants had been recruited.

5.4.4 Analysis & Rationale

The study yielded qualitative data and Clarke and Braun (2018)'s approach to reflexive thematic analysis (TA) for counselling and psychotherapy research was used to guide the TA. Thematic analysis was chosen due to research being pragmatic in nature and producing qualitative data from semi-structured interviews. Other qualitative analysis options were considered such as content analysis, grounded theory, narrative analysis or interpretative phenomenological analysis (IPA). However, the current research is not 'theoretically bounded' and is not intending to 'generate a plausible – and useful – theory' (Braun and Clarke, 2006, p.80) and consequently allows for more flexibility in analysis. In contrast to IPA, the current research does not seek to examine 'the detailed experience of each case in turn' (J.A. Smith and Osborn, 2015, p.43), rather it intends to use analysis for 'identifying, analysing and reporting patterns (themes) in the data' (Braun and Clarke, 2006, p.79). Reflexive thematic analysis therefore better aligns to the current research objectives of gaining insight and awareness of experience. Thematic analysis enables reflexivity and acknowledges the impact of the individual standpoint of the researcher on the data analysis. The current research is in line with the development of reflexive thematic analysis (Braun and Clarke, 2019). This adds to the original procedure outlined but further clarifies that '

Quality reflexive TA is not about following procedures 'correctly'…, but about the researcher's reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process (Braun and Clarke, 2019, p.594). The researcher identifies the proposed research as primary and an essential starting point for future research to build upon. It is then unnecessary to use methods that focus on creating theory or require theoretical underpinnings.

The analytic process followed the pragmatic framework outlined in Chapter Three with the researchers intending to capture the realties and experience of participants to further the understanding gained in Study One. An inductive approach was employed whereby there was no pre-determined coding framework, rather the researcher was interested in the meanings and patterns within the data. The analysis began within supervision meetings where the researcher and supervisors discussed what was being noticed from interviews as they were being conducted. Once interviews were completed and transcribed, the researcher who completed the interviews then immersed themselves in the data by reading and re-reading interviews several times and highlighting observations (see Appendix H for evidence of the coding process and Appendix I for the coding outline). The researcher then noticed patterns between these observations across the data items which formed the original codes. These codes were handwritten with supporting data items, when the researcher felt saturation was achieved and there was no more data items to code, they began to group the codes into potential subthemes which led to overarching themes.

The researcher shared the draft codes and interview transcripts with both supervisors independently. Feedback was provided on all the original codes and possible themes/sub-themes and then a group discussion allowed for these to be further refined and collective agreement sought between all parties which captured and respected the researchers' reflexivity, the meaning in the data and portrayed individual realities using participants language as much as possible. Analysis was therefore collaborative and reflexive, with the researcher attempting to acknowledge any 'bias' whilst also recognising and appreciating the necessity of subjectivity within truly reflexive qualitative research (Braun and Clarke, 2019).

5.5 Methods for Study Two

5.5.1 Participants and Demographics

N=10 participants completed an online semi-structured interview. All participants were recruited from Study One. N=8 participant were female, N=2 were neurodiverse and N=4 had a family member who was neurodiverse. All participants were White-British, N=8 practised a nondirective therapeutic approach, N=5 had worked with 10+ autistic adolescents and N=5 were registered with the BACP.

5.5.2 Materials

Study Two provided a paper version of the information sheet again (Appendix J) and a paper consent form (Appendix K). This was emailed to participants for them to electronically sign and return. The semi-structured interview consisted of a questionnaire with N=8 open-questions which was conducted via Microsoft Teams (Microsoft, 2023). Microsoft Teams was utilised as Leeds university's preferred method of online communication and the ability to audio and video record and transcribe interviews.

5.5.3 Procedure

The semi-structured interview questions (see Appendix B) were shared with the same N=5 participants who completed the survey pilot study. All participants agreed the questions were logical and a clear follow-up from the survey.

The participants in Study Two were randomly selected and contacted via email by the lead researcher based upon their consent obtained in Study One. Participants were asked if they wished to still participate and provided with optional dates for online interviews. If participants responded in agreement, they were emailed the information sheet and consent form for Study Two and a date and time was booked in. The interviews were conducted online via Microsoft Teams and utilised the online transcription function. The interviews were transcribed and edited in real time so there was no need for audio or video recording. Participants were advised the interview would be approximately 30 minutes.

The interviewer/researcher read the N=8 questions from a script to ensure consistency across all interviews. Interviews ranged from 15-50 minutes depending on the participant. After the interview was finished, the participants were thanked for their time and reminded of researcher contact details should they wish to withdraw. The researcher then read through the transcript and corrected any spelling errors before uploading data to the University OneDrive system for GDPR compliant storage.

Chapter Six: Results of Quantitative Analysis for Phase One Study One

This section presents the results of the quantitative analysis for Phase One Study One (see Tables 2-5 for the descriptive statistics and demographic information). This is supported with a further narrative summary. Further data analysis was conducted for therapist confidence and therapist competence when working with autistic adolescents (see Tables Seven, Eight and Nine).

6.1 Demographic information

Of the N=95 participants, N=87 were female and N=8 were men, N=82 were White-British and all had been practicing as a counsellor/psychotherapist for at least 3 years. All participants had experience working with autistic adolescents and most (N=57) had seen 10+ autistic clients in their career. N=77 participants had not received any training on working with autism during their qualification (see Table Two for demographic information).

Table 2: Demographic Information for Phase One Study One

Demographic Information	N=	Demographic Information	N=
Age		**Years Since Qualifying**	
25-34	6	3-5	24
35-44	25	5-8	20
45-54	41	8-10	15
55+	23	10+	36
Gender		**Professional Body**	
Female	87	BACP	66
Male	8	UKCP	10
Ethnicity		CPCAB	1
White-British	82	COSCA	0
White-Other	9	Other	31
Mixed	1	**Qualification Level**	
Indian	1	Level 4	12
Black-British	1	PGDip	14
Black-Other	1	PGCert	4
Theoretical Background		Degree	15
Person-Centred	66	Masters	35
Directive: Behavioural/CBT/Skills	44	Other	15

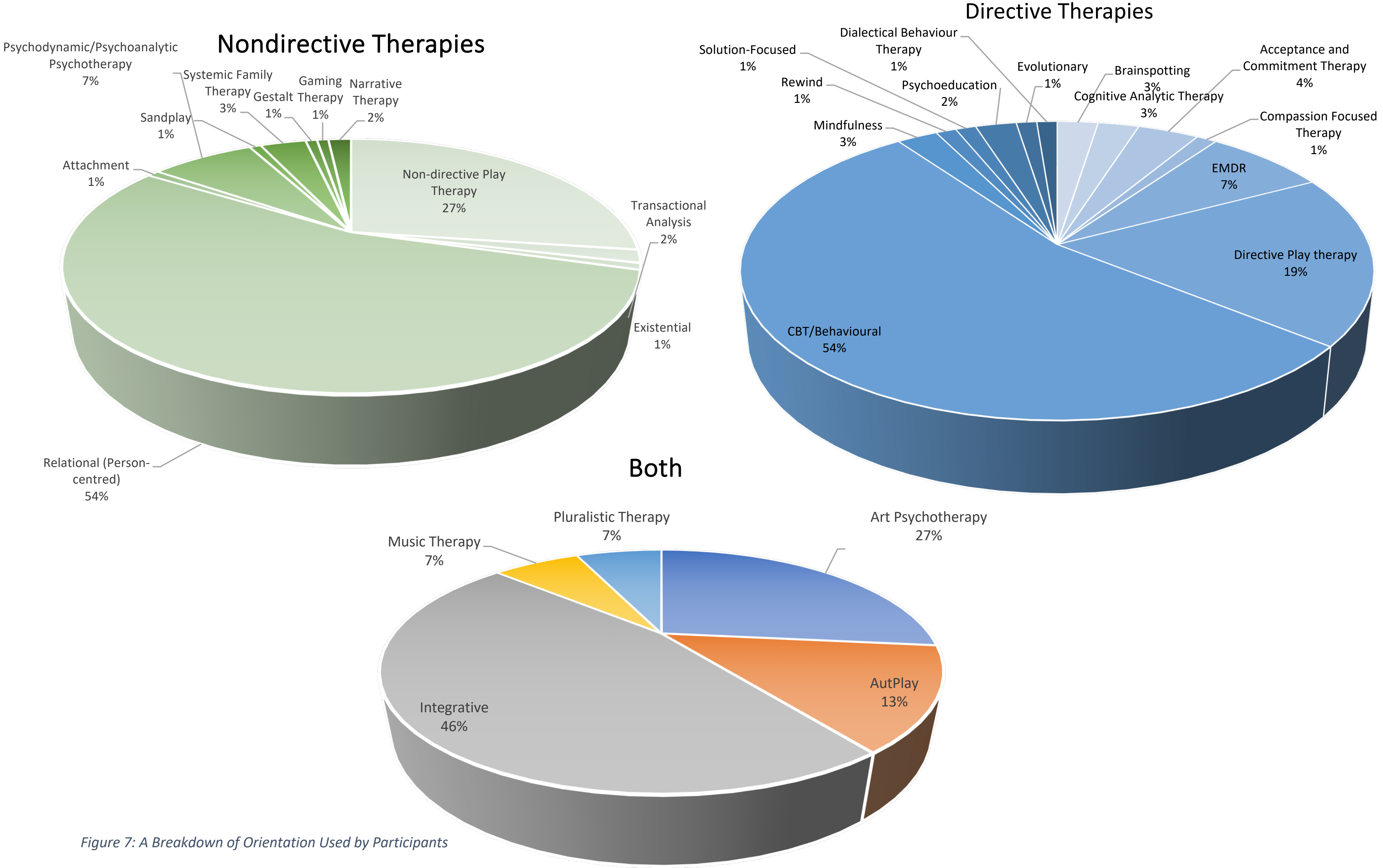
EMDR	6		
Nondirective Play Therapy	33		
Directive Play Therapy	15		
Other	39		

6.1.1 Age

All participant were over the age of 25 years with a M=47.32 years (SD=7.14). The ages were input as ranges on the survey and had to be recoded to their middle value (+5 from minimum range) for data analysis (30, 40, 50 and 55, see Table Two).

6.1.2 Theoretical Background

The most commonly used orientation was person-centred (N=66 , see Table Two). Participants could choose more than one option for this question which explains the higher total of responses and Figure Seven data. Of the N=39 ‘Other’ responses, there was a mix of directive vs. nondirective and some orientations could be directive or nondirective depending on the therapist/activity. Figure Seven shows directive approaches tend to be based on behavioural orientations, whereas psychodynamic/psychoanalytic psychotherapy and Systemic Family Therapy were most common for nondirective approaches. An integrative orientation was used by N=7 therapists which included a mixture of art therapy, relational therapy, couples counselling and transactional analysis (see Figure Seven for a further breakdown of the data).


Nondirective Therapies

Directive Therapies

Both

Figure 7: A Breakdown of Orientation Used by Participants

6.1.3. Professional Body

The most common professional body stated was the BACP (N=67, see Table Two). Of the N=32 'Other' responses, participants most commonly stated: The Association of Child Psychotherapists, The American Counselling Association, Play Therapy UK, The Health and Care Professions Council, National Counselling and Psychotherapy Society, British Psychological Society and the American Psychological Association.

6.1.4 Qualification Level

Table Three identifies a Masters' level qualification as the most frequently chosen (N=35). Of the N=15 'Other' responses, participants stated: Doctorate (professional and philosophical), Level 5, Level 6 and Level 7. The different levels represent different educational establishment classifications of qualification.

6.1.5 Therapist Experience

Three questions were asked about therapist experience which included the number of autistic adolescents worked with and training (see Table Three).

Table 3: Therapist Experience

Therapist Experience	
Worked with Autistic Adolescents	**N=**
Yes	95
No	0
Number of Autistic Adolescents worked with	**N=**
1-5	19
5-10	19
10+	57
Given training during qualification to work with autism	**N=**
Yes	18
No	77

6.1.6 Therapist Perceptions

N=5 questions were asked about therapists perceptions of working with autistic adolescents. The questions were yes/no answers however did provide a textbox to explain answers if the participant chose a no option and wished to do so (see Table Four for descriptive data).

Table 4: Therapist Perceptions

Therapist Perceptions	
Feel confident working with autistic adolescents	**N=**
Yes	85
No	9
Do you feel competent working with adolescents with autism?	**N=**
Yes	84
No	9
Do you think it is important for the therapist to have knowledge of autism?	**N=**
Yes	95
No	0
Do you think nondirective therapy has potential to be beneficial for autistic adolescents	**N=**
Yes	88
No	7
Do you think there is benefit to parents/carers being involved in therapy?	**N=**
Yes	91
No	4

The fourth question: Is nondirective therapy beneficial for autistic adolescents had an option to provide an explanation if the 'No' answer was given. Participants could choose multiple options from: 1) Not enough research; 2) Research shows directive is effective; 3) Autistic adolescents cannot engage in nondirective therapy or 4) Other (free textbox provided). Of the N=7 participants who chose 'No': N=1 stated research showed directive was effective, N=4 stated autistic adolescents cannot engage in nondirective therapy and N=3 chose 'Other'. In the 'Other' responses, the N=3 participants stated (see Table Five):

Table 5: Textbox Responses

Free Textbox Response:
"It depends on the client but often non directive is not so effective with any adolescents"
"I work using which ever model suits the individual"
"I work with 16+ students. They like to understand what they can do (boundaries) and how long it's going to take. Most but not all may need to understand the rules and expectations of the counsellor. In my experience they struggle to imagine / fantasise their situations and can often be unaware how others feel or their perception of events. A nondirective approach can be effective after the initial introduction to the experience when they have a clearer understanding of environment and the

purpose of therapy. Therapy does need to be directive at times because they often want to see change, or monitor it. Also. learn to understand their emotions and how to regulate them."

6.2. Statistical Analysis

Statistical analysis was conducted to explore psychotherapist and counsellor perceptions and experience of working with autistic adolescents. This was exploratory analysis to look for relationships between variables. The first analysis investigated whether there was a relationship between therapist confidence and other variables: number of clients worked with, number of years since qualifying and qualification level. Fisher's Exact Test was reported as the cell count for some variables was <5; the assumptions for Chi-Squared tests were not met (see Table Six).

Table 6: Statistical Analysis for Therapist Confidence

Independent Variable	**Dependent Variable**	**p-value (two-tailed)**
Number of clients worked with	Therapist confidence	<.001**
Number of years since qualifying	Therapist confidence	.03*
Qualification Level	Therapist confidence	.25
Training received during qualification	Therapist confidence	1.00

** = significant at p<.05*
*** = significant at p<.001*

The results suggest a statistically significant relationship between the number of clients worked with and therapist confidence (*p<.001)* and the number of years since qualifying on therapist confidence *(p=.03)*. There was no relationship found between qualification level or training received on therapist confidence.

A second analysis was conducted to explore any potential relationship between therapist competence and other variables: number of clients worked with, number of years since qualifying, qualification level, training received during qualification and therapist confidence. Fisher's Exact Test was reported as the cell count for some variables was <5; the assumptions for Chi-Squared tests were not met (see Table Seven).

Table 7: Statistical Analysis for Therapist Competence

Independent Variable	**Dependent Variable**	**p-value (two-tailed)**
Number of clients worked with	Therapist competence	.11
Number of years since qualifying	Therapist competence	.17

Qualification level	Therapist competence	.22
Training received during qualification	Therapist competence	1.00
Therapist confidence	Therapist competence	<.001**

*** = significant at p<.001*

Table Seven shows the results of five further statistical tests to assess for relationships between variables and therapist competence. The only statistically significant result was between therapist competence and therapist confidence *(p<.001).*

A final 3x2 analysis was conducted to see if there was any relationship between therapeutic orientation and therapist confidence and competence. Theoretical orientation was coded and grouped into purely nondirective, directive or integrative. Fisher's Exact Test was reported as the cell count for some variables was <5; the assumptions for Chi-Squared tests were not met. The results suggest there was no significant relationship between the theoretical orientation on either confidence or competence levels when working with autistic adolescents (see Table Eight).

Table 8: Statistical Analysis of Therapeutic Orientation on Therapist Confidence and Competence

Independent Variable	**Dependent Variable**	**p-value (two-tailed)**
Therapeutic Orientation	Therapist Confidence	.85
Therapeutic Orientation	Therapist Competence	1.00

Chapter Seven: Results of Qualitative Analysis for Phase One Study Two

This chapter presents the qualitative results of Phase One Study Two, for demographic information see section 5.5.1. Following the analysis five themes were identified and are outlined in Figure Eight. There was generally high concordance between all participants and the results both confirm and further explain the findings in Study One. The individual themes and sub-themes are presented below with supporting quotes from participants to illustrate meaning.

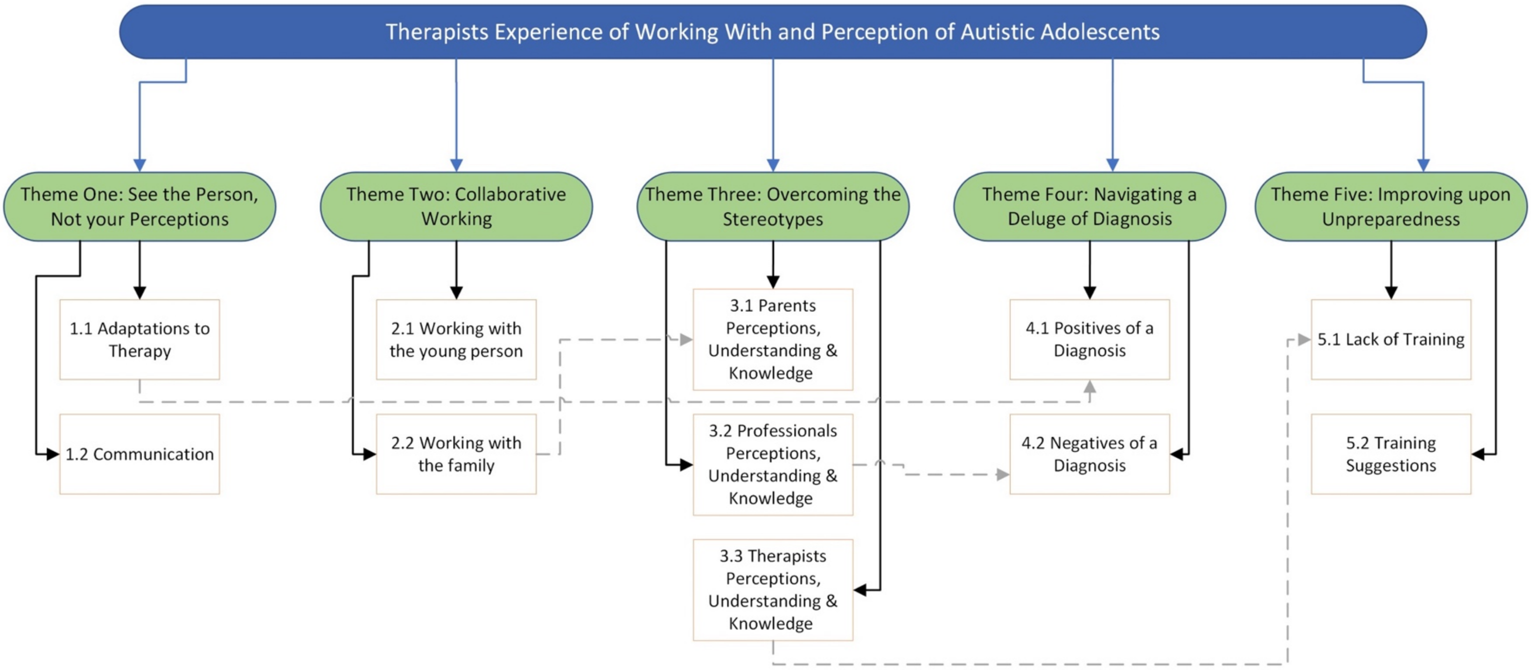


Figure 8: Thematic Map from Phase One Study Two

7.1 Theme One: See the Person, Not your Perceptions

The first theme captures the perceptions and experiences of therapists working with autistic adolescents and highlights the need to *'remember they're still an individual'* (Participant Five). Theme One identifies the need to have enough knowledge, awareness and understanding to increase access to therapy with a focus on communication, being flexible and making adaptations. However, this must be balanced with not allowing a knowledge of autism or rigid perceptions to determine the therapeutic process. Theme One is split into two subthemes: 1) Adaptations to therapy and 2) Communication.

7.1.1 Subtheme One: Adaptations to Therapy

All participants stated that a knowledge of autism was essential in making adaptations to the therapy process that valued the client and increased accessibility to therapy. Without this there was a risk that *'if you do not understand the lens of autism, all you are doing is shoving your crap down an autistics throat…and you're gonna make them ill'* (Participant Five). Participants highlighted that this knowledge must be balanced with a respect for clients *'finding their own unique way forward, their own path'* (Participant Five) and the therapist *'knowing the patient they're working with'* (Participant Seven). In order to do this, therapists must be willing to adapt and be flexible in their therapeutic approach as *'just because someone has an autism diagnosis, that doesn't in itself inform me'* (Participant Nine) about how therapy will proceed. All participants mentioned having a knowledge about development, autism presentation and the individuality of this, masking, co-occurring mental health problems and the challenge in navigating a neurotypical world as autistic clients *'know [they're] on the wrong planet'* (Participant Five).

All participants were in agreement that therapy should never focus on *'correcting the neurodivergence'* (Participant Two) and that *'autism wasn't the focus of the work'* (Participant Six). There was an acknowledgement of how harmful this was to young peoples' mental health as this cannot be biologically achieved and leads to *'blaming them when they failed at it'* (Participant Two). In contrast, therapists felt their work was around supporting mental health and helping the young person to lead an '*authentically autistic life'* (Participant Two) and *'getting to know them and their nuances and supporting them to feel safe. So going at their pace so that they can bring what they need to'* (Participant Ten).

Participants noted that therapy in itself is *'neuro-normative'* (Participant Two) and anyone (regardless of diagnosis) needs to be '*socialised into therapy…because it is intimidating for any adolescent. It is intimidating for adults too'* (Participant Three). This was where valuing the individual was vital and removing pre-conceived ideas about therapy or autism was important. Participant Ten stated '*there needs to be more to make [therapy] accessible. I think we need to be creative and I think we need to let go of those boundaries that, we are bound by the rigid you know, [therapy] has to be in four walls and it has to be sat opposite each other…Let's enter their world so to speak and support them in a way that fits for them rather than fits our strict guide of boundaries'.*

Within this sub-theme there was consideration to starting therapy and how *'therapy is not a normal conversation'* (Participant Three). In relation to different therapeutic approaches the N=8 participants who were generally nondirective practitioners considered the usefulness of directiveness when beginning therapy to provide '*guidance [about]…what a space is for and what a space is not for*' (Participant Three) or to ease the clients' nerves in the earlier sessions by being *'a little bit direct. Why don't you just pick up the clay and work with it. Let's see what happens'* (Participant Seven).

Some participants commented on adapting the physical space, *'setting up the room* (Participant Eight) and giving the client a choice of therapy type, such as using walk and talk, offering creative methods e.g., clay, sand, art, play or going outdoors. Participant Seven noted *'offering them the different tools that they need to engage...or even just walking. I have an Arboretum behind my office…as long as it is okay with parents we just go for a walk and that takes away the fear of being in the room'.* This should be balanced with being mindful of '*sensory overload and…the physical environment*' (Participant Nine) with a focus on creating *'an environment that works for them'* (Participant Six) and knowing that whilst the Arboretum *'worked for her, I'm aware that for other autistic adolescents that would be too much stimulation, too much noise'* (Participant Seven).

7.1.2 Subtheme Two: Communication

A recognition of differences between communication styles, learning different ways to communicate and adapting the style of communication was also deemed important when valuing the autistic adolescent client. A key aspect of this was noting the differences between neurotypical and neurodiverse communication styles and how as '*a neurotypical therapist, it's not something that you've ever given thought to'* (Participant Two). In order to support and value the individual, therapists need to understand how the client communicates and how they navigate a neurotypical world in relation to social codes, norms, friendships etc. This involves not making assumptions about things that are shared, clarifying and asking questions to better understand, accepting things may be misunderstood but having a good rapport to overcome them and *'adapting away from educating first'* (Participant Two). Participants believed it was not the therapist's role to teach a neurotypical way of being to an autistic client unless this is requested by the child specifically and is therefore child-led (and not the parent). Instead, therapists focus was on *'finding the right kind of language together'* (Participant Nine).

Another aspect was an awareness of different types of communication which highlighted the need to be flexible and offer *'alternative forms of…therapy'* (Participant

Seven). Therapists identified that *'not everything has to be oral because the unconscious can be accessed in so many different ways'* (Participant Seven) and that this was where creative methods were important to give the client a voice, *'get on the young person's wavelength…[and find out] how they wanna use therapy'* (Participant Nine).

7.2 Theme Two: Collaborative Working

Alongside Theme One and the importance of valuing the individual, participants described their experiences of working with autistic adolescents in a collaborative way. Theme Two highlights the need for therapy to be adapted, flexible, relational, child-led and co-created whilst recognising that *'autistics need an army of support'* (Participant Five). Theme Two also outlines experiences, types of and the importance of working with clients' families for overall improved outcomes. Theme Two is split into two sub-themes: 1) Working with the young person and 2) Working with the family.

7.2.1 Subtheme One: Working With the Young Person

Theme Two builds upon Theme One with reference to working with the young person and the differing opinions on directive or nondirective approaches. One participant identified as directive but made no mention of using directive methods in any of their work except when there was a safeguarding concern. The majority of participants (N=7) identified themselves as relational and nondirective practitioners but acknowledged that adapting to the client and being child-led might mean sliding the *'scale from directive to nondirective depending on what day it is, how the person is and what they need in the moment'* (Participant Three). Client-led therapy also allows the client to dictate the type of therapy *(I can do directive work, but that needs to be initiated by the young person,* Participant Two*)* and the level of directiveness as outlined by Participant Eight: *'[the client] wanted me to be more directive, to ask questions and bring things in you know, that was fair enough. So if it is coming from the young person, then I am very happy with that'.* Some participants discussed positive experiences where directive and nondirective therapy had been '*offered alongside each other'* (Participant Two) and really adapted to the child in a *'stepped approach'* (Participant Six) with a much more *'holistic view'* (Participant Two).

The N=8 participants aforementioned were all very passionate and confident in the nondirective approach with Participant Two stating *'I don't think I'd be comfortable doing* *anything else to be honest'*. There was some suggestion that nondirective therapy was harder for the therapist (Participant Six) and more time consuming, so it may not always be an option in some settings with Participant Four recognising that their work setting meant they *'had the luxury'* of working nondirectively.

Some participants did mention their concerns or experiences with directive therapeutic approaches relating to autistic clients' ability to mask or *'say what they think the other person wants to hear'* (Participant Ten) which leads to the effectiveness of therapy being *'very limited'* (Participant Ten) and *'the challenges really come from what modality you're trying to push in the room'* (Participant Four). Other concerns related to the over-reliance on directive methods with *'not enough open-mindedness that we could achieve the same outcomes but in a much less directive way'* (Participant Two) and Participant Three stating: *'every problem is a nail. We have one big hammer and that hammer is directive therapy'.* This highlighted the need to be child-led as therapy is *'not one size fits all'* (Participant Nine) and that there is a *'misconception that CBT is what is needed, that it's all about behaviour. It's the belief among therapists that they can't use the [nondirective] space'* (Participant Two).

N=2 participants considered nondirective working to be *'really uncomfortable'* (Participant One) or ineffective *('good luck with that',* Participant Five). However, this seemed specific to the eating disorder and secondary school settings they were working in. Participant One identified that when working with eating disorders, pure nondirective therapy is not applicable because clients *'gotta eat enough to not end up in an inpatient unit'*. This was echoed with Participant Five who worked in secondary schools and referenced the time constraints of clients having *'a meltdown and be rocking literally and half an hour later we've calmed them down and got them back into class'.* Within both of these interviews the importance of Theme One was evident with *'do what works'* (Participant One) and *'you meet one autistic, you meet one autistic. For [clients] that are very creative…we will 100% use some nondirective stuff'* (Participant Five) and so the preference for directive therapy seemed to be specifically related to setting.

Specific suggestions around adapting therapy or being flexible in the therapeutic approach involved giving clients a choice over type of therapy, being child-led and co-creating the therapeutic work. The majority of participants mentioned that therapy should be child-led and offering creative methods of working can be helpful with this population such as sandplay (Participant Four), using meta-narratives and special interests (Participant Two), play therapy or art therapy (Participant Seven).

On the surface there appeared to be some difference in opinion about approaching therapy differently with autistic vs. neurotypical clients. Participant Four stated *'I don't think counselling autistic adolescents need to be any different to counselling any other person. I think the challenges remain firmly with the flexibility of the counsellor and the knowledge and understanding of the counsellor'.* In contrast Participant Two felt *'there's an arrogance I think, that just doesn't help…it is there among purist person-centred therapists. In my experience, they're the absolute worst for believing they don't need to do anything different with neurodivergent clients.* However, both participants considered the understanding of autism and flexibility in knowing *'some of these general principles might not be a thing if your client is neurodivergent'* (Participant Two) as the adaptations that were needed.

7.2.2 Subtheme Two: Working With the Family

The participants generally agreed that involving parents in a collaborative way was something they *'100% insist [upon]' (Participant 5)* and *'being open to that is important'* (Participant Two). Some spoke positively about their experiences working with parents although all agreed there were notable challenges in getting *'parents involved when they can be [but] sometimes it's the worst thing in the world'* (Participant Seven) (see Theme Three). Participants described various ways in which they have included parents via psychoeducation, initial assessment, review sessions or facilitated family discussions.

All participants agreed that it was imperative the adolescent directed and felt in control of the parental involvement and so they *'give young people the option'* (Participant Three) and ensured the client did not *'feel that you're running to the parents'* (Participant Eight). There was a need to gauge *'how much the young person might want the parent involved and how much they don't* (Participant Nine) and also to ask permission and share with clients *'what do you want me to tell them? What do you want me to teach them? And [clients] will literally tell me'* (Participant Five). There had to be flexibility and collaboration between the client and therapist in how parental involvement looks in practice, *'so either the young person…will sit in the room and just watch and make sure…they can approve my drafts [of feedback to parents]. And then in some cases redraft my drafts and send them* *back to me. Tell me what I got wrong, which is again a useful but of the process'* (Participant Three).

In reference to other ways participants work with parents, there was mention of *'working [parent involvement] into business contracting [and] sharing resources, like coming into the last five minutes of the session to discuss what we might be working on and how they can help at home'* (Participant Two). As well as recognising that involving parents initially might be *'the only way the young person was going to actually come in [to the therapy room]'* (Participant Eight) and that the clients background and *'family picture influences it [involvement]'* (Participant Nine).

7.3 Theme Three: Overcoming the Stereotypes

Despite all participants talking favourably and with passion about their work with autistic adolescents and a consensus that parental involvement could be valuable if directed by the young person, there was a collective agreement that there were several barriers to working with this population. However, participants felt strongly that these challenges were always related to *'the system…it's never been the teenager'* (Participant One). Theme Three encompasses three sub-themes that refer to the perceptions, understanding and knowledge of: 1) parents; 2) professionals and 3) therapists, as barriers to therapy.

7.3.1 Subtheme One: Perceptions, Understanding and Knowledge of Parents

Although Theme Two outlines the details and the benefits of collaborative working with parents, all participants recognised this was a real challenge to therapy. Some of these challenges related to parents perceptions of autism with *'one version of autism in her head, the incredibly disabled version'* (Participant One) which leads to a real reluctance to accept the young person. Participants noted that getting *'the parents to understand and accept…is sometimes the hardest part'* (Participant One). This incorrect perception or understanding of autism can lead parents to be either *'dismissing or disabling'* (Participant One) towards their child and *'a lot of invalidation,…sometimes the parents are overinvolved in the opposite way. They disable the child by saying they can't do any of these things that they might be able to do if you just gave them the right environment and the right support'* (Participant One).

In trying to support parents to understand, widen their knowledge of autism and encourage them to *'get knowing your child better'* (Participant Five) there was an acceptance that therapists frequently experience a *'reticence or reluctancy…[and] you're gonna hit some resistance at some points because no-one likes being told how to parent, no especially not by me'* (Participant Three). In addition, participants mentioned a misperception from parents about autism and therapy collectively with some parents questioning the process with *'they've not come to play with clay. They've come to talk and sort out…why they're making that funny noise'* (Participant Seven) and requesting *'you make it better, my guilt is relieved'* (Participant Seven). Participants discussed the challenges this raises for therapists: *'I just want you to fix my kid, like for that you need Harry Potter…we have no magic wands here'* (Participant Two) and *'a lot of parents see you as a light in the darkness, some sort of parenting guru'* (Participant Four).

Finally, participants mentioned the difficulties in managing relationships with parents when *'parents have called me and kind of demanded that I do something or demanded to know something about what's being talked about…and I've had to say no, that's not the arrangement here'* (Participant Two). Confidentiality, boundaries and educating parents about how therapy would proceed and why, was an important but difficult aspect of the therapeutic work and was often a barrier to overcome when working with the adolescent. This also related to considering who referred for therapy and if the adolescent actually had a choice and '*wanted it to be their therapy'* (Participant Nine) as participants had found that *'with an autistic adolescent, someone else tells you what the problem is'* (Participant Four).

Some participants did demonstrate an empathy and an understanding of why this communication may be difficult with an acknowledgement that parents of autistic adolescents have *'often had to fight for the needs of their child'* (Participant Six) and this can make *'parents very, very anxious about letting them be independent, Because of their diagnosis and because of other things that have come up and that have been difficult in the past'* (Participant Nine).

7.3.2 Subtheme Two: Perceptions, Understanding and Knowledge of Professionals

Participants identified that the referral source or the support network around the child can also be a barrier if there is a lack of knowledge, understanding or outdated perceptions of autism. Referrals for therapy had been received with an emphasis on '*the people outside the counselling room are still seeing this as an autistic person rather than a* *young person who is going to struggle with emotion regulation or anger…[referrals state] this young person is autistic or neurodiverse, as though that is some sort of barrier'* (Participant Four). This generally dictated the type of therapy suggested with *'the idea that this person is autistic and therefore somethings not gonna work, that's a hugely flattening way of representing things and looking at things'* (Participant Three) and a belief and over-reliance that *'CBT is what's needed'* (Participant Two) and *'CBT has won the war on that [referrals] for now'* (Participant Three). Participants also commented on the disbelief that sometimes upon receiving a referral it is clear there have been or are lots of other organisations and services involved that *'are supposed to deal with this and then you come to me and I can't be the only person in the world that can work with this young person'* (Participant Four).

This lack of awareness from professionals also related to a lack of services which the majority of participants mentioned in reference to *'a complete erosion of statutory services' [with] 'CAMHS less than, that's not fit for purpose. It's not doing what it is supposed to and it can't in its current circumstances'* (Participant Three). This was also linked to an increase in referrals and diagnosis (see Theme Four).

Finally, participants mentioned education and schools specifically as a barrier to therapeutic working. This encompassed the perceptions, knowledge and understanding of the schools in supporting the young person with reference to assessment and the use of *'a ridiculous screen that's designed for boys…all the sort of really classic things. And they were like, she's got friends and makes eye contact. She hasn't got autism. And I'm like (rolls eyes)* (Participant One). There was also concern over these perceptions and where the support was best placed *'it's like do I need to work with this person to reduce their stimming? Or do I need to be working with this person's school…the help them understand what the role of stimming is for a neurodivergent person?'* (Participant Two).

7.3.2 Subtheme Three: Perceptions, Understanding and Knowledge of Therapists

Participants also considered their own experiences and perceptions as potential barriers if they were outdated or incorrect. This built upon Theme One and Two and was underpinned by a significant lack of training and subsequent awareness for therapists and counsellors in working with neurodiversity (see Theme Five). Consideration was also given to how therapeutic services or workplaces could be barriers if there was limited time or resources to adapt or offer nondirective working, with Participant Eight remembering an earlier time when they were researching: *'How could I soften the environment. I was doing everything I could to try and research what the best environment was and it was saying everything but what we had, and that was very limited'.*

7.4 Theme Four: Navigating a Deluge of Diagnoses

Participants recognised a significant increase in clients receiving an autism diagnosis and a sense of *'having a deluge'* (Participant Two) of referrals for therapy to support co-occurring mental health conditions. COVID-19, social media and increased awareness of autism were cited as explanations for this increase. There were a range of experiences and feelings shared which has been split into two subthemes: 1) Positives of a diagnosis and 2) Negatives of a diagnosis.

7.4.1 Subtheme One: Positives of a Diagnosis

Participants generally felt *'there's just a lot more noise being made about it…I'm certainly having more conversations'* (Participant Two) which *'on one hand it is helpful because to have a diagnosis…it's positive because a lot of kids that need some adjustment, get the adjustment'* (Participant Six). There was also an acknowledgement that *'young people find the diagnosis quite comforting in some ways, because it explains stuff'* (Participant Eight) with comments that *'the stigma seems to be being challenged'* (Participant Eight). Some participants also mentioned the increased awareness filtering into the education system with '*teacher training…CPD, we know that in schools there are designated workers'* (Participant Five).

A potential reason for these increases was suggested to be the impact of COVID-19 as *'we've spent a lot of time in super close proximity with people and we've realised that our partners, children, friends, whatever are doing things in a really different way to how we thought'* (Participant Three). A couple of therapists shared that *'for a lot of autistic kids, staying home was better'* (Participant Two), because *'who did not love COVID? We don't even have to come up with an excuse as to why we don't want to go to school, go to social functions or even pick up the bloody phone. So we're loving it. We're living the dream'* (Participant Five). However, *'we're having to reintroduce it…So you've got some very, very* *frightened kids'* (Participant Five) and *'people just haven't been able to do it'* (Participant Two). This has led to increased demand for help and therapeutic services.

As well the increased awareness post-pandemic, social media and media representation were thought to generally be giving *'a big push towards people suddenly going, hang on a minute, that's me'* (Participant Ten). Accessible online information and movements within social media was encouraging *'kids are talking to themselves, they're flagging it up'* (Participant Five).

7.4.2 Subtheme Two: Negatives of a Diagnosis

In addition to the positives raised about increased awareness and subsequent increased referrals and diagnoses, there was a collective feeling that *'practitioners…very quickly go with an autism diagnosis'* (Participant Seven) which was likely due to autism being '*far more on the radar now'* (Participant Eight). Several practitioners queried this and asked *'if you were to take out trauma, parenting and everything else, you know, there's possibly not neurodiversity, there's not autism there'* (Participant Four) because *'there are a lot of kids who got significant trauma in the background…being in a domestically violent household…they're looked after or they're adopted and it's as if that doesn't count…and those kids get diagnosed with autism…but it's not true'* (Participant Six). There was concern over the future of these young people who may have been misdiagnosed.

Of note were N=2 participants who spoke about increased referrals and diagnosis in gender identity services specifically. There was a suggestion that *'you can't have gender issues because you're autistic. But then the other issue is ignoring the autism and saying , well, they've got gender dysphoria and therefore need to be treated on a medical path'* (Participant Six). These participants' held experience in *'70% of our referrals are now females with a diagnosis of autism or a presentation that is clearly autistic, now that's a big alarm bell, you don't get that presentation in any other service…there is something going wrong somewhere'* (Participant Six).

7.5 Theme Five: Improving upon Unpreparedness

Most participants recognised a barrier to working with autistic adolescents was a lack of training during their qualification. These conversations naturally led to participants suggesting ways this could be improved and what they would have benefitted from. N=2 participants had training or placement opportunities during their training, but only N=1 stated this was compulsory. There was a recognition from all participants that training was essential and should be non-optional. Theme Five is split into two subthemes: 1) Lack of training and 2) Training suggestions.

7.5.1 Subtheme One: Lack of Training

Participants reported either not receiving any training or it being minimal as '*the training doesn't prepare you. Not on any level'* (Participant Five). The training may also be non-inclusive, non-affirming or not up to date with theories with Participant Two stating*: 'I remember on our training, you know if somebody's fidgeting with something it means they're avoidant…but if you're neurodivergent. No it doesn't'* (Participant Two). Some participants ensured *'we touched on it, because I made sure it was brought up in conversation* (Participant Ten) whereas others completed further training *'once qualified [to] help'* (Participant Eight).

There was a recognition that due to the lack of training therapists had to *'fumble your way through'* (Participant One) and concern over the impact of this on their practice when they were newly qualified as *'at the beginning I was really nervous and overcompensated a lot…I just didn't have the confidence'* (Participant Eight) and *'in the beginning of my training, when I look back now, I think Oh my God, what were you doing'?* (Participant Six). Participants recognised that learning and confidence *'came with experience'* (Participant Six) and *'by doing, getting it a little bit wrong and being supervised'* (Participant One) however also felt concern and frustration as *'that's not the only way to learn'* (Participant One). This led to suggestions about how to improve training and what should be included.

7.5.2 Subtheme Two: Training Suggestions

The discussions about the lack of training naturally led most participants to suggest what would have been helpful or what could be improved. There was a consensus that all training about autism should have been influenced by an autistic voice and a recognition that still in most CPD participants experienced *'no-one at any point has spoken to somebody who is autistic'* (Participant Three) and there was a need for *'lived experience [because] you can only learn about it if those people are willing to come in and work with you'* (Participant Seven). Furthermore, there continued to be a disbelief that there was still *'a massive hole* *where neurodiversity should be*…*it strikes me as kind of wild we don't do that'* (Participant Three).

Chapter Eight: Phase One Discussion (Studies One and Two)

The exploratory quantitative (Study One) and qualitative (Study Two) analysis in Phase One aimed to understand counsellors/psychotherapist's experience and perceptions of working with autistic adolescents. As this is novel research there was no directional hypothesis specified for quantitative analysis. This section will firstly discuss the quantitative results, then the qualitative results before considering how combining the data further informs and impacts the research field. The limitations will be discussed alongside a plan for dissemination of findings and suggestions of future research.

8.1 Quantitative Results from Study One

The results of the quantitative analysis suggest that there is a positive relationship between the number of autistic adolescents therapists have worked with and the number of years since qualifying on therapist confidence. As such this data suggests increased experience and client contact correlate to therapists feeling more confident to work with autistic adolescents. In contrast the only correlation with therapist competence was confidence; suggesting increased experience has no impact on clinicians perceived ability to work with this population. The results also found no significant relationship between therapeutic orientation, confidence or competence; suggesting therapists working within a specific modality are equally as confident and competent as therapists working in other modalities when it comes to supporting autistic teenagers. Further exploration of descriptive statistics and non-significant results are outlined below.

8.1.1 Therapist Experience

The findings from the current study suggest that participants were experienced practitioners working with the autistic population; suggesting reliability and high validity. A main and concerning finding from this research was the shared experience that practitioners were not provided with training on autism during their formal qualifications. This finding is supported in previous studies (K. Cooper et al., 2018; Maddox et al., 2019, Lipinski et al., 2022), however, the current research identified more practitioners without training at 82% in comparison to K. Cooper et al.'s (2018) findings of 64%. The variation in these findings may be explained with the larger sample size in the current study.

The lack of training identified within this study is of significant concern when considered in conjunction with prior research about knowledge and attitudes towards autistic populations from therapists (Lipinski et al., 2022) and the general public (D. Jones et al., 2021). The research by Lipinski et al. (2022) suggested a link between therapists' lack of openness to working with autistic individuals and low knowledge held about autism. The results from the current study did not support this link as all participants had experience working with autistic young people. However, the inclusion criteria may have negated this as therapists needed to have worked with autistic adolescents in order to participate. Lipinski et al. (2022) also found a large amount of incorrect beliefs held about autistic individuals and suggested these may be due to a lack of training.

Although the current research is limited by not assessing therapist knowledge of autism, the lack of training received by therapists/counsellors may predispose practitioners to hold harmful and inaccurate assumptions, similar to those aforementioned by D. Jones et al. (2021). The impact of this on vulnerable autistic adolescents is likely to result in a barrier to accessing mental health support (as supported in findings by Lipinski et al., 2022; Roudbarani et al., 2022) which may have disastrous consequences for future adult mental health and mortality (Hirvikoski et al., 2016; McMaughan et al., 2023). In order to better understand the current training offer, gain insight into therapist experience and inform future provision, qualitative data was collected in Study Two and will be discussed in Section 8.2.

8.1.2 Therapist Perceptions

Therapist perceptions of working with autistic adolescents were explored based on the prior research by Maddox et al. (2019) and Roudbarani et al. (2022) that identified a therapist's lack of confidence, competence and knowledge were all barriers to working with autistic clients. The current study suggests that 90% of participants felt confident to work with autistic adolescents and 91% felt competent. These high levels may be explained as all participants in the current study had to be working as therapists and have worked with/be working with autistic adolescents to meet the inclusion criteria. Further exploration into therapist confidence and competence can be found in section 8.1.3 and 8.1.4 respectively.

All participants in the current study believed it was important for the therapist to have some knowledge of autism. This is supported by Adams and Young's (2021) research that suggested lack of therapist knowledge about autism is a barrier to accessing mental health support. Despite this, 82% of participants had not received any formal training during their qualification. This finding is worrying as the BACP (2018) and UKCP (2019) ethical frameworks both outline and identify that counsellors/therapists should only ever work within their competency. The lack of training on autism experienced by the participants brings into question how competent qualified practitioners are when they begin working with this population of clients. The follow-up qualitative analysis in Study Two aimed to better understand this finding (see section 8.2).

In contrast to previous research by Lipinski et al. (2022) which found 15.5% of participants did not believe nondirective therapy had potential to benefit autistic adolescents, the current study found only 7% of participants held this belief (see Table Six). This lower percentage may be explained by the current study having a 4 times smaller sample size and therefore lower power and reliability in the findings. Another explanation is that this study was investigating nondirective therapy specifically. Participants were made aware of this via the information sheet, consent form and study title. This may have resulted in a response bias, whereby only participants who had experience of providing nondirective therapy responded to the participant invite. However, the research was shared multiple times across varied social media platforms to engage a variety of participants in order to mitigate this impact. It is possible the differing results could also be explained by social desirability bias, in that the participants knew the aim of the study and therefore responded in a desirable way to meet the research aims. In order to reduce this bias, all participation was anonymous and voluntary. Finally, differing terminology may also account for the different findings. Lipinski et al. (2022) asked about ‘talking therapies’ which is a much broader term and could be interpreted as nondirective or directive based on the individual’s theoretical orientation and knowledge. The current study therefore offers a more focused insight into nondirective vs. directive therapies with autistic clients and builds upon previous findings.

Although not a majority, N=4 participants stated nondirective therapy is not suitable for autism. These perceptions directly oppose prior research by Casper et al. (2021) proposing nondirective therapies for autistic adolescents are effective just under-researched. However, it may be that participants are unaware of the research into the effectiveness of nondirective therapy, due to the research bias for directive approaches. A further N=3 participants responses indicated a mixed-orientation approach depending on the individual e.g., directive and nondirective therapies used in tandem to better meet the client's needs. Interestingly some of these responses suggest incorrect beliefs are still held e.g., 'nondirective is not so effective with any adolescents' and 'they struggle to imagine/fantasise'. This generic statement about autistic adolescents does not reflect the spectrum nature of autism and mirrors previous findings about otherness and incorrect beliefs being held (D. Jones et al., 2021; Roudbarani et al., 2022; Kara and Demirtas, 2020); further highlighting the need for training on therapeutic working with autistic individuals.

Finally, 96% of participants believed it was beneficial to involve parents/carers in therapy. This is in agreement with previous findings from Casper et al. (2021) and findings from a large scale meta-analysis by Dippel et al. (2022) which suggest a small but significant improvement in depressive symptoms for young people when caregivers were involved in individual therapy or family therapy. In contrast, research conducted by Amirova et al. (2023) investigated the benefit of directive robot-assisted autism therapy for N=16 children aged between 5-12 years. The results found involving parents had no effect on social skill improvement. Additional research identifies that parental engagement must also be factored into consideration when considering involvement in therapeutic services (A. Murphy and Risser, 2022). Parental engagement (continuing therapeutic work at home or involvement in the sessions) was influenced by having their needs met in relation to being trusted by service providers and receiving support, guidance and information. A. Murphy and Risser's (2022) findings suggested that whilst 65% of caregivers felt trusted, only 55% felt they had enough information and only 58% felt their own needs were being met. These findings collectively identify a need for further research into parental involvement with consideration given to implementation in therapy, balancing the adolescent's needs, the age of the adolescent and therapeutic orientation, to ensure the appropriate therapeutic offer is made to young people. A further qualitative analysis was conducted to better understand this finding and inform suggestions for practice and research (see section 8.2).

8.1.3 Therapist Confidence

The results suggest 90% of participants felt confident working with autistic adolescents. Further statistical analysis found a significant relationship between the number of years qualified and the number of clients worked with on confidence; suggesting confidence in working with autistic adolescents was related to time since qualified and number of clients seen. There was no significant relationship found between level of qualification or therapeutic orientation thus suggesting these factors were not related to confidence as a practitioner.

Support for these findings comes from healthcare research also suggesting greater confidence is linked to more experience e.g., midwives (Bäck et al., 2017), palliative care nurses (Frey et al., 2020) and clinical psychologists (McMahon and Hevey, 2017). A systematic review conducted by Hecimovich and Volet (2011) into health education suggested it is practical, hands-on experience that improves confidence. In agreement with the current findings, this systematic review highlights that the more time spent working in the field (linked to time since qualifying) and the more clients worked with, leads to increased confidence.

These findings have implications for therapeutic work as therapist confidence has been suggested to hold positive outcomes for therapeutic alliance. Research by Bachelor (2013) found positive correlations between therapist confidence and clients commitment, the collaborative relationship and productive work. This is further supported in earlier research by Ackerman and Hilsenroth (2003) who found therapist confidence alongside other personal qualities to have a positive impact on therapeutic alliance. Collectively these findings highlight the importance of therapist confidence on client outcomes and identify that experience is a widely recognised and essential component in becoming a confident practitioner.

Although these results are supported, the findings are problematic for therapists working with autistic adolescents as they imply practical experience is essential. This diminishes the benefit of training and raises ethical concerns for newly qualified therapists working with this population. Newly qualified or therapists early in their careers may feel less confident working with autistic adolescents than therapists who have been qualified longer and seen more autistic clients. This has implications as perceived therapist low confidence is a suggested barrier to accessing therapy (Adams and Young, 2021; Maddox et al., 2019). It also raises concerns for the new SCoPEd framework initiated by the BACP (2020b) which originally suggested ranking of therapists based on their years of experience and subsequently a hierarchy of counselling status e.g., registered vs. senior therapist. At present, the suggested titles for therapists with different years of experience and training are being reviewed.

Altogether, the findings regarding confidence from the current study highlight that therapists with fewer years' experience may feel less confident and this may prevent autistic adolescents accessing therapy. In addition, potential changes to the status/ranking of counsellors may further impact confidence levels and as a result the impact of specific autism training needs to be further investigated. There is also a large body of research that advocates for the benefit of training on practitioner confidence. Roudbarani et al. (2022) found that confidence and knowledge of autism were linked and confidence was linked with intention to treat autistic adolescents. Further research by McMahon and Hevey (2017) suggests that although experience influenced ratings of confidence in clinical psychologists delivering psychotherapy, 44% of the N=170 participants did not feel confident, only 13% felt their training prepared them for work and greater confidence was linked with further formal training. This is interesting given 90% of the current participants felt confident working with autistic adolescents, yet 82% had not received any training during their formal qualification. Together this research suggests that further training may improve confidence, knowledge and potentially impact practitioners attitudes; subsequently improving access to therapy for autistic adolescents.

The recognition of a link between training and confidence is widely accepted and supported in studies that developed training opportunities and found positive effects on practitioner confidence when working with suicidality (Oordt et al., 2009), multilingualism (Costa and Dewaele, 2019) and intellectual disability (Hronis et al., 2018). In support of this, the BACP (2021) carried the motion to include mandatory training on neurodiversity as part of their accredited courses. The UKCP (2023) have also developed an 'Equality, Diversity and Inclusion' task force and referenced the need to include training around diversity and inclusion for course providers. This suggests the main professional bodies within the UK are identifying the importance of specific training for neurodiversity and autism; highlighting the need to further understand the contributing factors to therapists confidence, or the impact that a lack of training has when working with autistic adolescents. Despite this, neither the BACP or the UKCP has yet made further acknowledgement of how this change will be implemented which enables education providers to continue to omit autism training, potentially having dire consequences for autistic adolescents and therapists alike.

Although the links between training and experience on confidence are well-known, additional research has considered other factors that also need to be accounted for when developing practitioner confidence. A study by B. Jackson et al. (2019) utilised a narrative summary to identify that low professional status threatened the confidence of health professionals. This is further supported in research by Laker et al. (2019) who found psychiatric nurses in senior positions to feel more powerful and confident at work than nurses of lower rank. Additional research from Peng et al. (2018) found that years of experience, age and marital status also influenced confidence in professional ability with nurses. Based on these findings it may have been useful for the current study to ask a question about therapist's professional or personal status to better understand the association to confidence.

8.1.4 Therapist Competence

The results suggest 91% of therapists felt competent to work with autistic adolescents. These findings differ significantly from previous findings by Maddox et al. (2019) which suggested therapists had low competence; acting as a barrier in accessing mental health support for autistic adults. These differing findings may be explained due to the inclusion criteria as Maddox et al. (2019) did not require participants to have worked with autistic individuals in contrast to the current study which stipulated this. Despite the medium-scale of this research, the results encouragingly suggest that the included therapists do feel competent when working with autistic adolescents which is beneficial in improving access to therapeutic provision.

Of further interest is the lack of significant relationship between experience (number of years worked or number of clients worked with) or qualification level. This differs to previous systematic review findings by Rizany et al. (2018) which found that in nursing, both years of experience and qualification level predicted perceived competence. The result further highlighted the importance of training in improving competence for nurses, which questions the current study's findings as the majority of participants had not received any formal training on autism. However, the contradictory findings may be explained by the roles of nurses and counsellors differing significantly in terms of training styles and type of service provided. In contrast, smaller-scale research conducted by Brosan et al. (2007) found that years of experience or accreditation level did not predict competence for CBT therapists. The only predictor of competence was additional post-qualification training. This further supports the suggestion that therapist training is essential and beneficial. This research also suggests it may have been helpful to ascertain if participants had completed any additional training post-qualification which may have better explained the increased competency rates despite the lack of training. However, there is sparse research into predictors of competency in therapists specifically which limits the exploration of the current results and identifies a need for the creation of improved outcome measures.

In contrast to the results found for therapist confidence, the only significant relationship (with high significance: $p<.001$) to competence was therapist confidence. The direction of this relationship is not attainable due to the inability to complete parametric testing on the sample size and the measure of competence/confidence gained. Prior research aiming to understand the relationship between confidence and competence is varied with no definitive answer. Holland et al. (2012) suggest that confidence underpins competence from their concept analysis of N=31 articles investigating occupational therapists, nurses and medical professionals. Whereas prior research from organisational psychology (Bartram, 2005) stipulates competence is a multi-faceted construct and more than confidence alone. These differing findings further support the need for a specific outcome measure of therapist confidence and competence, that is informed by research with trainers and therapists alike. The current study's assessment of competence may not be sufficient to understand what competence working with autistic adolescents looks like in practice. Follow-up research using validated measures may help explore the direction of the relationship between confidence and competence.

8.1.5 Summary

The findings from Phase One Study One alongside previous research suggest that therapists who are less experienced may be less confident when working with autistic adolescents. The aforementioned prior research suggests that this might impact and reduce therapeutic accessibility for autistic adolescents requiring mental health support. There is potential for mandatory training during therapy courses to mitigate this effect and improve confidence and competence; additional research needs to be conducted. Before further exploration of the relationship between therapist confidence and competence can be conducted, research needs to better understand how this is measured to ensure validated and generalisable results. The qualitative follow-up in Study Two hopes to better understand some of the current findings with semi-structured interview and a thematic analysis.

8.2 Qualitative Results from Study Two

The aim of Phase One Study Two was to achieve greater understanding of psychotherapists and counsellors experiences of working with and perceptions of autistic adolescents. The qualitative results were also intended to build upon and support the quantitative findings from Study One. The findings from the qualitative analysis identified the following five themes from the interviews which collectively confirmed and extended the previous findings:

1. Theme One: ‘See the Person, Not your Perceptions’. Theme One reflects the importance of holding knowledge about autism, including differing communication styles, but not allowing this to determine the therapeutic process or pigeonhole the client.
2. Theme Two: ‘Collaborative Working’. Theme Two captured the different therapeutic orientations, the importance of co-creation and child-led therapy whilst also recognising the need to work with the family also as a support system.
3. Theme Three: ‘Overcoming the Stereotype’. Theme Three identified the three main challenges that therapists face when working with autistic adolescents including parents, professionals and therapists themselves. Participants were very clear in their beliefs that it was not the client that made the therapeutic work challenging, rather the system the therapist was working in.
4. Theme Four: ‘Navigating a Deluge of Diagnosis’. Theme Four considered the advantages and disadvantages of diagnosis for the clients they see and shared concern over the potential for misdiagnosis.
5. Theme Five: ‘Improving on Unpreparedness’. Theme Five recognised the significant lack of training received, the potential implications of this in practice,

participants' confidence growing with experience and suggestions for how training could be improved to better serve therapists.

8.3 Reflexivity in Research

Given the qualitative nature of Study Two, it is important to acknowledge the researchers position and how this may have influenced the research and the findings. The researcher is also a qualified therapist and lecturer who works in a nondirective way with neurodiverse adolescents. As such the researcher holds a particular passion for investigating and improving access to therapy for this client group. Whilst the data was analysed mainly by the researcher, both doctoral supervisors oversaw the analysis. Throughout the data collection and analysis, the researcher utilised personal therapy, clinical supervision and academic supervision to reflect on the process and the learning. Within this the researcher acknowledged their hopes for the results to support their personal beliefs about the usefulness of nondirective therapy and whilst this was supported, also recognised some of the findings and interviews challenged their beliefs in other ways. The process of the research in Phase One has highlighted the importance of acknowledging the researchers personal position and the differing opinions and beliefs of others' in their therapeutic work and research, which the reflexive thematic analysis positioned as a strength in the findings.

8.4 Theme One: See the Person, Not your Perceptions

Theme One outlines the importance of valuing and getting to know the young person for who they are in addition to their diagnosis, which lends itself to a relational way of working. There was a recognition of the need to hold knowledge about autism, varying presentations and development but an emphasis on not using this to create expectations or dictate the therapeutic process. This varies significantly from prior research by Vulcan (2016) and Brookman-Frazee et al. (2012b) whereby the focus remained on 'treating' clients and teaching skills.

The qualitative findings highlight the need and benefit of making adaptations to therapy that were affirming, child-led and respectful. In contrast, previous studies have cited the frustrations and difficulties of working with autistic clients with Brookman-Frazee et al. (2012b, p.370) stating: 'Participants described the slow rate of change as a key component to the challenging nature of working with these clients: "…I find that I'm doing a lot of repeating…How many times do we need to go over…you know, how to greet someone…you can tell the frustration… How long do I have to expect to go over this? Are we ever going to get this"'. This excerpt suggests participants were offering directive, skills-based therapy based on neurotypical expectations and not adapting to the client's individuality. In contrast, the current participants held very different views and frequently mentioned the use of play and creative methods enabling flexibility and adapting to the individual client. This finding alongside the systematic review (Casper et al., 2021) suggest that play therapy guidelines may be beneficial for working with autistic adolescents and requires further investigation.

There was specific consideration given to adaptations required in the room which reflected more broadly onto therapeutic services planning and policies for inclusion. Further support for these findings comes from the 'Authentistic Research Collective' (Stark et al., 2021) who are a group of autistic and neurotypical researchers in the UK and have created a report highlighting the need for adaptations to working with autistic adults and suggesting some ways therapists may wish to address them. These suggestions include physical adaptations to the space and type of therapy offered; further supporting the current findings that therapists working with autistic adolescents often make adaptations to the therapeutic process and space to improve accessibility and inclusion. Whilst the research by Stark et al. (2021) is promising, further guidance with includes young people's voice is also essential and should be a focus of further research.

Theme One also specifically mentioned the need for therapists to value and adapt to different ways of communicating with autistic adolescents. The emergent subtheme of communication is supported in prior research by Vulcan (2016) and Brookman-Frazee et al. (2012b). Both previous studies considered communication as something that is difficult and needs to be acknowledged. The current findings recognised therapists experiences of differing communication styles and how a lack of knowledge about this may be a barrier as well as provide further information as to how these differing communication styles may play out in the therapy room. Differences in communication styles are supported in research by García-Pérez et al. (2007) who found subtle differences in non-verbal communication between autistic and neurotypical adolescents. Garcia-Perez et al. (2007, p.1320) findings suggest 'one challenge facing therapeutic interventions is how to foster the levels of communicative connectedness and exchange that are essential to intersubjective relatedness'. To explore this further, Heasman and Gillespie (2019) utilised gaming to better understand intersubjectivity and communication between N=30 autistic adults. The results suggested two differences in communication: 1) an assumption of common ground which improved rapport when reciprocated but caused disruption when not and 2) 'a low demand for coordination that ameliorated many challenges associated with disruptive turns' (Heasman and Gillespie, 2019, p. 910).

Collectively these studies support the current findings that therapists should be aware of and be able to adapt to a different communication style. These findings also suggest that knowledge of autism and neurodivergent communication styles should be included in training programmes to better prepare therapists to work with this client group but focus should be maintained on valuing the individual and not only seeing the diagnosis.

8.5 Theme Two: Collaborative Working

Theme Two identified the importance of not only working with the child but also the family around them as a support system. Theme Two built upon the importance of valuing the individual as outlined in Theme One but added detail as to how collaborative working could achieve this and outlined ways of working with adolescents and their families. Although previous research had mentioned the difficulties of working with families (also discussed in Theme Three), there had been no investigation as to how this could be achieved with parents.

Theme Two recognises that nondirective therapy is and has been beneficial for participants when working with autistic adolescents; supporting the findings from the systematic review (Casper et al., 2021) and Study One. The qualitative findings add further detail to how and why nondirective therapy can be effective with a focus on relational work, play, creativity and the sessions being child-led. There was a consensus that the adolescent should feel able to direct and collaborate with the therapist on the type of therapy they received and how they used the sessions. Nondirective therapists believed therapeutic intervention could move from directive to nondirective if the client requested this. This reiterated a focus on working *with* the client which shifted the focus from 'doing' to 'being' as a therapist. The participants also highlighted concerns over a reliance on directive, behavioural methods as the main option of therapy for autistic adolescents and prescribed this to a lack of awareness and knowledge about autism which is supported in findings by Lipinski et al. (2022).

Despite the majority of participants identifying the benefit and efficacy of nondirective working there was also recognition that specific settings and time-limited offers of therapy in certain services may not allow for nondirective therapy e.g., in eating disorder or school settings. Therapists who had flexibility and agency over duration and therapeutic orientation were grateful when the setting enabled this; suggesting limitations of therapeutic services may dictate what support is offered to young people regardless of their preference. The researcher is of the opinion that this is the first research in the UK to gain therapist perceptions and experiences of working with autistic adolescents and the findings around nondirective therapy are novel and much-needed. The researcher hopes these findings will contribute to balancing the current research skew towards directive approaches and instigate further research into nondirective approaches for autistic young people.

The current research adds to the literature with practical examples of how therapists have successfully collaborated with the adolescent and their ability to dictate how parental involvement should be. Although there is limited research focusing on the importance of the child's voice within therapy, support for these findings is evidenced in several studies looking into social work and family group conferences. The American Humane Association (AHA, 2010, p.29) created guidelines for family group decision making and suggest 'Family meetings are about creating viable, workable and transparent plans for children, and therefore their role in the development and implementation of any plan is essential. This practice may challenge some cultural traditions of children being silent, or being seen but not heard. From a fundamental human rights perspective, the children's right to be heard supersedes the parental or family group's decisions about limiting their involvement or presence'. More recent research conducted by Merkel-Holguin et al. (2020, p.25) into youth experiences of family group conferences in relation to their caregivers, suggested children experienced the conferences more negatively in relation to their inclusion and participation and that the ideal of 'nothing about me without me' is still only an ideal and not a reality.

The current findings in conjunction with the aforementioned research suggest an importance of child voice within therapy and the involvement of parents. The researcher believes this is an important finding to add to a growing body of research around child-led therapy.

8.6 Theme Three: Overcoming the Stereotype

Theme Three highlighted that despite the aforementioned positive experiences of therapists, there were frequent and notable challenges to working with autistic adolescents. These barriers centred around the perceptions, experience and knowledge of others' surrounding the client and were not influenced by the client themselves. This differs to previous research findings (see section 8.1). There was collective agreement that parent's, professional's and therapist's understanding of autism was a challenge and something participants found hard to work with and tried to educate parents, professionals and themselves about. This finding is not surprising based on a recent systematic review of the fictional media representation of autism by S. Jones et al. (2023). The findings suggest the media still portrays autism in unhelpful and stereotyped ways. This is supported in further research that found lay people hold negative unconscious attitudes (D. Jones et al., 2021) and incorrect beliefs about autism (John et al., 2018).

In relation to parents perceptions, the current findings are concerning in regards to young people's autistic identity and mental health. Research conducted by Riccio et al. (2021) suggested parents of autistic teenagers who were asked to describe their child often used strength-based language however when asked to define autism, the majority used deficit-oriented language. Furthermore, research by Humphrey and Lewis (2008) found that autistic teenagers who viewed their diagnosis negatively were influenced in this by others' perceptions of them as different; having implications for self-esteem, anxiety and relationships. This suggests parents knowledge and perception of autism is key for how the child may then construct their own identity and highlights a larger societal issue around autism understanding.

Parents perceptions of therapy was also a challenge to be overcome by therapists. Some therapists experienced parents as challenging their therapeutic offer or wanting their child to be fixed or changed. Therapists also found that some parents would try to control the therapy by demanding information or asking the therapist to break confidentiality. This finding echoes prior research by Mire et al. (2017) who found that parents' perceptions of autism dictated the type of therapeutic intervention chosen, more so than child-specific or demographic factors. In their study, parents who attributed specific behaviours to the autism diagnosis were more likely to opt for intensive behavioural therapy to reduce these behaviours. Parental control over therapy was also linked to treatment choice and parents who viewed their child's diagnosis as 'chronic' were less likely to pursue certain types of intervention e.g., speech therapy. Although this study did not recognise therapeutic intervention for co-occurring mental health conditions, collectively the findings raise further concern for the impact of parents understanding and perceptions of autism on their child's wellbeing and highlight parental work and education about autism and how therapy works as an important aspect of therapeutically supporting an autistic adolescent's mental health.

The surrounding professionals understanding and perceptions of autism were also noted as difficult to work with and participants experienced an over-emphasis on the diagnosis or referrals that dictated a behavioural intervention without consideration of other options. Schools and educational screening for autism was also identified as a challenge with outdated views and a lack of knowledge underpinning educational offers or processes. Research conducted by Ravet (2018) found approximately 40% of students on a UK teacher training programme had no knowledge of autism at all and neither did approximately 20% of the tutors. The knowledge that was held was limited, basic and seemed to be derived from personal experience rather than formal education. This may better explain our findings about professionals and educators lack of knowledge.

More recent research by Ballantyne et al. (2021) suggests that UK teachers have increased knowledge of autism in comparison to teachers in China, however this knowledge seems to be linked to more experience teaching autistic students. Collectively this suggests that teachers in the UK may be advancing their understanding and knowledge of autism at a faster rate than other countries. However, the findings still highlight that more needs to be done to educate teachers about autism before they start work in classrooms in order to better support autistic students.

Finally, therapists identified their own perceptions, knowledge and understanding as barriers to therapeutic working which was linked to a lack of training (see Theme Five) or lack of resources and time. Participants discussed their early career experiences and how some services were not accessible for autistic adolescents due to a lack of adaptations (see Theme One). The findings were supported by Brookman-Frazee et al. (2012a) in reference to the system that therapists are working in as challenging and that training is required to better support therapists to navigate the clients' support systems e.g., school and other services. Brookman-Frazee et al. (2012a) also highlighted the need for training on working with parents. The current study suggests that the system and parents are both barriers for therapists to navigate; linking to a need for autism training for therapists and working with the young person's wider networks also.

Despite this, the current participants were incredibly positive about their therapeutic work. This is a stark contrast to previous studies that cited the young person or the autistic population as difficult to work with and framed this work as draining for therapists. These findings may be explained by recruitment differences. The current study had a focus on nondirective therapy, with participants who had been qualified for at least three years. Prior research (Lipinski et al., 2022; Vulcan et al., 2016) also included newly qualified and trainee therapists, social workers and psychologists and did not consider directive or nondirective orientations in the analysis. Collectively this suggests there may be an influence of experience or orientation on perceptions of therapeutic work and identifies a potential link between nondirective therapy and more positive experiences of therapists that requires further research.

8.7 Theme Four: Navigating a Deluge of Diagnoses

Theme Four captured a range of feelings about diagnosis, with participants identifying a surge of referrals for autistic adolescents and clients pursuing a diagnosis. This is supported in the increased diagnostic rates outlined in Chapter One. There were several reasons suggested as to why referrals and diagnosis were increasing, all linked to more autism awareness and specific influence of social media and COVID-19.

Participants identified some positives of an autism diagnosis for the young person as it gives more understanding about who they are and allows support to be offered. There was a recognition that other professionals with whom therapists were networking with or working with in multi-disciplinary teams were more aware of autism. This could be explained by changes in policy which are aiming to increase autism acceptance within UK society e.g., The national strategy for autistic children, young people and adults: 2021 to 2026 (DfE, 2021a).

The influence of social media was also cited as a reason for increased awareness, with adolescents accessing information and connecting with other autistic adolescents as support networks and a way to increase understanding about themselves. This is supported in research by Ahmed et al. (2018) who found that the World Autism Awareness Day campaign was successful in increasing awareness via Twitter. Over a two-month period the study found that there was a higher volume of tweets and positive messages shared; suggesting social media is a useful and easily accessible method of information sharing. In further support, research has also found online support groups on Facebook to be helpful for autistic adults (Y. Zhao et al., 2019) and that social media may improve the quality of friendships for autistic adolescents (van Schalkwyk et al., 2017).

The final association to the increased awareness and subsequent diagnosis was suggested to be COVID-19. This finding was not surprising based on the aforementioned literature review and is supported by the early research and reports that suggests autistic individuals have been disproportionately affected by the pandemic (DfE, 2021a). Phase Two aims to conduct further exploration into why this population have been so affected in order to shape future support provision.

Theme Four also captured participants worries about the increasing diagnosis rates with several practitioners concerned that autism diagnoses were being given too readily without further exploration into other potential explanations e.g., trauma or attachment difficulties. This is a novel finding and as such there is limited literature to explore further. However, Kaufman (2022) suggests that the assessment tools used for diagnosing autism that are widely accepted as the ‘gold-standard’ may in fact need further research. Kaufman’s (2022, p.1) findings suggests there are ‘biasing influences in autism assessment [and]…methodological flaws in “gold standard” autism assessment research’ and concludes ‘that it is time to rethink “gold standards” and “best practices” in the assessment of autism.’ Kaufman’s (2022) research may go some way to explaining therapists experiences around the surge in diagnosis and collectively with the current findings, identifies an important area for further investigation.

The current research also highlighted two therapists experience of autism within gender identity services which is perceived to be at a significantly higher rate than in other services. This finding is supported in research that found higher prevalence of autistic children and adolescents in gender identity services in comparison to the general population (Glidden et al., 2016). There is limited research into this area and so explanations for this link are still speculative and not agreed upon. Contradictory research suggests that increased gender variance is not specific to autism, as there are similar rates evident in other neurodiverse populations and childhood psychiatric conditions (May et al., 2017). Whereas findings from George and Stokes (2018) suggest there is a unique relationship between the formation of gender identity and autism based on their research with N=309 autistic individuals.

Further research by J. Murphy et al. (2020) investigated the impact of gender identity on mental health in autistic populations. Although the findings suggested depression and anxiety to be highest in the transgender autistic groups, the research did not find an effect of the combination more than being either transgender or autistic had on mental health alone. The contradictory and preliminary nature of these findings collectively highlights that there is a need for additional research to better understand the links between autism and gender identity, in order to inform future mental health provision.

8.8 Theme Five: Improving on Unpreparedness

The final theme captured participants experiences of training within their professional qualifications and their perceptions of what would have been useful. The findings are supported in a wealth of previous research (see Section 4.4) and adds support to the statistical findings from Study One about the lack of training and confidence growing with experience. Theme Five explores how therapists perceived this lack of training as a barrier to working with autistic adolescents and considered the negative impact on the client and on their own confidence and therapeutic experience. There has been some movement towards this within health and social care more generally with Health Education England releasing the ‘Oliver McGowan Mandatory Training on Learning Disability and Autism’ (HEE, 2020). This training requires all health and social care workers to have a basic level of autism training relevant to their role. Within the counselling and psychotherapy community, the BACP passed a motion that neurodiversity training should be included in all professional courses but further information about how to implement this and the regulation of this has not yet been received by providers (BACP, 2021).

Nearly all participants felt their training could have been better and suggested that the inclusion of autistic voices within the creation of materials or delivery was an essential place to start. This change is being reflected in wider policies and within research with a greater focus on coproduction and representation e.g., The Authentistic Research Collective (Stark et al., 2021).

8.9 Strengths and Limitations

The findings from Phase One contribute to an important research gap and provide a starting point for further enquiry into a crucial and time-sensitive topic. To the knowledge of the researcher, it is the first study conducted within the UK and the first study to consider therapist experience alongside perceptions when working with autistic adolescents; meeting an important research gap. However, the findings from Study One would have offered a more representative view of therapists perceptions and experiences if there was a larger sample gained. Due to the time constraints of this doctoral research, there was no option to extend the study which restricted the sample size. Depending on the results obtained, the original sample size of N=103 may have enabled parametric analysis to be conducted; adding increased rigour to the study. This might suggest that the inclusion criteria were too strict however ethical working and experience were necessary to meet the study’s aims and therefore removing N=8 participants was essential to ensure validity in the findings.

Also in Study One, parametric analysis and a scale measure of confidence and competence would have improved the understanding of the relationship between the two constructs as well as added to a field of research about therapists that is currently lacking. The study utilised self-report measures for time and accessibility, however the findings may be limited due to social desirability and response bias. Follow-up studies might consider utilising observation as well as self-report measures in assessing therapist confidence and competence, however a validated and reliable measure of both would first need to be created that is applicable to this client group.

In relation to Study Two, there are several limitations to using semi-structured interview methods which are pertinent to acknowledge. Whilst this method was chosen in conjunction with the quantitative survey and for its previous utility in similar research, the interview schedule may have been biased by the researchers outlook. Furthermore, responses may have been influenced by demand characteristics, as participants were aware of the researcher's background in therapy and research from the information sheet. The analysis of the qualitative data was also influenced by the researchers reflexive position and whilst every effort to reduce bias was made throughout the research, it is impossible to remove subjectivity entirely in qualitative research and instead recognised as a strength in the reflexive thematic analysis approach (Braun and Clarke, 2019).

In agreement with general statistics the current sample was mostly female, middle-aged and White-British. The findings are supported in previous research with less than 20% of therapists being under 45 years of age (Xavier, 2020), 79.1% identifying as female and 87.7% as White-British (BACP, 2022). Although the results are supported in prior data and represent the gender, age and nationality split of therapists in the UK, there may be differences that this study could not ascertain due to lack of sensitivity and skewed sample proportion.

The findings suggest no relationship between therapeutic orientation and confidence or competence which differs to previous research (Dagnan et al., 2015). However, this may be explained by the scope of the research potentially being more appealing to nondirective and integrative therapists than purely directive practitioners.

8.10 Dissemination of Findings from Phase One

The findings from both studies of Phase One will be submitted as two separate, but partnered, articles to The Counselling and Psychotherapy Research Journal. The findings from Study One were presented at the UKCP Research Conference in June 2023. The research will be shared to participants who were involved to thank them for their participation and will be distributed to colleagues and relevant networks within the counselling and psychotherapy community. The researcher also intends to apply for the Marie Curie (MCSA) Postdoctoral Research Fellowship to build upon this exploratory thesis research.

8.11 Future Research

The findings from Phase One identify a need for autism training to be further explored and included within training courses for psychotherapists and counsellors. In order to ensure this training is effective and informed, it would be pertinent to include autistic voices in the creation of materials and delivery. Consultation with the autistic community and relevant organisations such as The National Autistic Society, may help shape the content and inclusion of these courses. Follow-up research investigating the impact that the inclusion of this training has on counsellor and psychotherapist confidence and competence would be crucial, as well as research to explore how the inclusion of training impacts autistic adolescents accessibility to mental health support. Phase Two intends to capture autistic adolescents' experience of and suggestions for therapy and the findings from Phases One and Two will then shape Phase Three's investigation into perceptions and training needs for counsellors/therapists working with this population.

Additional research into defining and measuring psychotherapist and counsellor competence and confidence with this client group is essential. The creation of a validated measure may provide understanding into what factors contribute to a therapists confidence and competence, as well as understand the directionality of this relationship. This information may improve outcomes for training and continuous professional development (CPD) courses.

The findings around COVID-19, increased awareness and co-occurring mental health conditions as a reason for increased referral suggest a need for further UK-based research. It is hoped that Phase Two can build upon these findings and a greater understanding of the impact and experiences of COVID-19 on autistic adolescents can be sought.

Collectively both study's in Phase One identify that therapists believe nondirective therapy is beneficial; supporting Casper et al.'s (2021) findings and providing a stronger case for nondirective therapy to be further researched and routinely offered to this community. In conjunction with the prior systematic review (Casper et al., 2021), the findings from Phase One highlight play therapy as an approach that has been useful and provides further support to investigate the efficacy of this for supporting autistic adolescents' mental health.

The subsequent studies in this doctoral research intend to gain a better understanding of how this would be received by both adolescents and trainee therapists.

8.12 Conclusion

This research hopes to provide a starting point to the aforementioned future research suggestions by building upon the findings from Phase One. Phase Two intends to explore the effect of COVID-19 on the mental health of autistic adolescents with reference to therapeutic intervention and required support based on the suggestion from the current results that COVID19 has been influential for mental health and autism diagnoses. In addition, the perceived benefit of non-directive therapy suggested in Phase One will also be explored in Phase Two with autistic adolescents. The findings regarding the lack of training for therapists/counsellors from Phase One and the findings from the proposed Phase Two will collectively shape Phase Three to explore trainee therapists perceptions of and training needs for offering a therapeutic approach guided by play-therapy principles to autistic adolescents. It is hoped this research alongside the prior systematic review will provide more understanding to the therapeutic needs and mental health difficulties faced by autistic adolescents as well as insight into therapists experiences and guide improved training, informed by the current findings.

PHASE TWO

Chapters 9-13

Chapter Nine: An Investigation Into The Impact Of COVID-19 On The Mental Health Of Autistic Adolescents (Phase Two)

The research outlined in section 2.5 addressed the higher rate of co-occurring mental health problems with autistic adolescents (Mandy, 2019; Lai et al., 2019; Botha and Frost, 2020). The prior systematic and literature review, alongside the findings from Phase One, collectively identifies autistic adolescents' mental health as an area of concern. This is due to the limited offer of provision, the potential impact of COVID-19 and several barriers to accessing therapy including therapist knowledge and understanding. The following literature review explores and highlights current mental health concerns within this population, taking into consideration the COVID-19 pandemic, before suggesting Study Three and Study Four in Phase Two that may bridge the research gap.

9.1 The Current Mental Health Field

The research outlined in the introduction to this thesis provided a definition of mental health as including 'emotional, psychological, and social well-being' (CDC, 2023), an overview of the rates of mental health concerns (Lai et el., 2019) as well as justification for a focus on autistic adolescents due to their increased risk of co-occurring mental health problems. A study by McMaughan et al. (2023) conducted in the USA investigated reasons for hospitalisation across individuals with autism, chronic health conditions and population controls. The study utilised the '2016 Kids' Inpatient Database (KID) from the Healthcare Cost and Utilization Project' (McMaughan et al., 2023, p.1704) which includes hospital discharge data which for N=1,348,488 participants aged between 10-20 years. The primary reason for hospitalisation being any mental health condition was 46.4% for the autistic group, in comparison to 6.33% and 22.9% for chronic health and population controls respectively. The research also identified a significant cost attached to inpatient stays for autistic youth at higher rates than population controls. McMaughan et al. (2023) suggest that the results highlight the shortage of community-based mental health providers within the USA and also indicate that mental health care has not improved for autistic young people despite advances in understanding and knowledge. These findings raise significant concern for the wellbeing of autistic adolescents, as hospitalisations are often traumatising, associated with stigma (Rice et al., 2021) and an increased risk of suicidality post-discharge

(Doupnik et al., 2018). McMaughan et al. (2023) highlight an urgent need for improved community-based mental healthcare that reflects a systemic change and is guided by autistic voices.

Research has begun to consider what factors influence mental health problems within autistic young people. A study by Mukherjee and Beresford (2023, p.2) with N=30 parents of autistic adolescents aimed to explore 'what influenced their child's mental health from diagnosis to the late teenage years'. The results of the thematic analysis suggested a shift from parental concern for behavioural problems in early childhood to parental concern over emotional wellbeing in adolescence. This was presented as increased depression, obsessive behaviours alongside social withdrawal, increases in self-harming, controlling behaviours, eating disorders and suicidal thoughts or attempts. The parents suggested a range of potential explanations for this including autistic traits, socio-environmental factors, developmental changes and life events. In relation to teenage years specifically, parents believed the autistic trait of social communication difficulties led to bullying and friendship problems which influenced mental health and depressive symptoms. Academic expectations that did not accommodate for need also seemed to worsen mental health problems as well as the onset of puberty, the child's awareness and understanding of their autism diagnosis and life events, specifically bereavement or loss. The findings and recency of this research justifies and identifies an urgent and timely need for the current studies with autistic adolescents.

The research by Mukherjee and Beresford (2023) provides some important insights into factors influencing mental health in autistic adolescents from a parental perspective. The research also identified a need for further research into how best to support parents/carers in disclosing autism diagnoses and handling the increased challenges of teenage years to mitigate the impact on mental health. The findings of this research are influential in guiding policy and research objectives into parental support. Whilst this research is necessary, research by Adams et al. (2019) highlights the current bias in the research field towards capturing parent voice and focusing on parent support strategies and as such the majority of previous research has crucially missed adolescent voice and 'places parents as experts' (Mukherjee and Beresford, 2023, p.2) which unfortunately neglects the first-person perspective of autistic adolescents. This is a concern as studies have identified differences in parent vs. child perceptions of mental health (Adams et al., 2019) as well as parent-teen perceptions of online risks (Wisniewski et al., 2017), social media sharing (Lipu and Siibak, 2019) and phone usage (Davis et al., 2019). Collectively this suggests parents may not always be able to capture their child's lived experience and places further emphasis on the inclusion of adolescents in research.

In further support of this, research conducted by L. Chapman et al. (2022) interviewed N=20 autistic adolescents and identified that masking had specific links to mental health problems in a bidirectional relationship and both were influenced by social and environmental factors. This qualitative research has broadened the concept of masking within research and the wider autism community, to consider emotional and psychological roots as well as cognitive drives. The findings from the research also support the cessation of social skills training that 'encourage autistic young people towards masking and away from authenticity…[and instead there is a need for] the development of groups to support autistic young people to develop positive and authentic autistic identity' (L. Chapman et al., 2022, p.16). The research also highlighted the benefit to hearing autistic perspectives instead of others' perceptions of autistic experience and provides an example of the benefit to qualitative research within this field.

Together these studies identified significant concern for the mental health of autistic adolescents and highlight gaps in the research for further exploration around reasons for poor mental health and different therapeutic interventions. Despite the importance of the findings, most of the studies are small-scale or use parent voice. This may reflect challenges in the recruitment of autistic people but does question the generalisability of the findings to a larger population (Rødgaard et al., 2022). Furthermore, despite the recency in publication, the aforementioned studies did not consider the impact of COVID-19 on mental health. This is potentially worrying as research by Samji et al. (2022) and Golberstein et al. (2020) identify a significant and disproportionate impact on mental health for autistic young people. Collectively these findings provide justification for the current study's interest in autistic young people's mental health which takes into account the COVID-19 pandemic.

9.2 COVID-19 and the UK

Study Two of Phase One identified that therapists are seeing an increase in referrals for autistic adolescents and citing COVID-19 as a major contributor of this, due to increased awareness of autism from parents and also the impact on mental health. The global pandemic of COVID-19 wreaked havoc on economies and data from March 2023 suggests the pandemic has led to nearly seven million deaths worldwide since December 2019 (WHO, 2023a). Despite the small size of the UK population (approximately 60 million in 2021, (ONS, 2022) in comparison to other countries, the death toll is the sixth highest worldwide and the highest in Europe (WHO, 2023b). Holt and Murray (2022, p.488) identify the UK had one of the longest-lasting lockdowns globally which had 'an acute impact on children'. Holt and Murray (2022) suggest this impact took the form of a lack of education, more children living in poverty and relying on foodbanks, children from lower socio-economic backgrounds (SES) being more affected and increased domestic abuse, including child abuse throughout the lockdowns. Data provided by NSPCC (2022b) suggested calls to the NSPCC helpline about domestic violence increased and there was a 61% increase in calls to national domestic abuse charities. In addition, between 2020-2021 the number of child deaths related to suspected abuse were up 19%, there was a 12% increase in rates of serious harm by child abuse (DfE, 2022) and contacts to the NSPCC helpline about concerns for a child's welfare were up 23%.

The above research highlights young people in the UK may have experienced an increase in Adverse Childhood Experiences (ACEs) throughout COVID-19. Initially proposed by Felitti et al. (1998, p.251), the study found a 'strong dose response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults'. This resulted in the subsequent categorisation of several ACEs including forms of abuse and neglect, household substance abuse, household mental health issues, witness abuse to a family member and have been extended to include low SES, peer victimisation and peer isolation (Finkelhor et al., 2015). In contrast, McManus and Ball (2020) argue that COVID-19 itself is an ACE for some young people, dependent on their protective factors and prior adversities.

Collectively this data identifies children and young people in the UK to be at greater risk of later health issues due to COVID-19 and increased exposure to ACEs. Further research by Knowles et al. (2022) also links this impact to greater risk of poor mental health for young people which is mirrored in research on prior natural disasters (Rath et al., 2007) or in places of conflict (Dimitry, 2012) where traumatic experiences have increased.

9.3 The impact of COVID-19 on Mental Health

The literature review identified multiple studies investigating the effect of COVID-19 on the mental health of children and young people; however research in this field is preliminary due to the recency of the ongoing pandemic. A large number of studies have suggested a negative impact of school closures on mental health due to missed health care support, changing routines, increased exposure to parental stress, social isolation and risk of abuse in the home environment (Golberstein et al., 2020; Imran et al., 2020; Liu et al., 2020). However, these studies were published during the earlier stages of the pandemic and as such call for further studies that offer a more representative and indicative view of the impact on mental health.

Further early and contradictory research was conducted in China. Research by (Chen et al., 2020) reported rates of depression (18.92%) and anxiety (11.78%) for N=1036 children aged 9-18 years. This research involved online self-report on The Depression Self-Rating Scale for Children (Birleson, 1981) and Screen for Child Anxiety Related Disorders (Birmaher et al., 1997). The findings suggested incidences of both mental health problems were higher in females, and depression was more common in older participants. Additional research by S. Tang et al. (2021) found significantly greater incidences of poor mental health in a larger sample of N=4342 with 24.9% having anxiety, 19.7% were depressed and 15.2% were experiencing stress. However, both studies' conclusions were limited by the lack of comparison to pre-COVID-19 data.

Studies reporting comparison data also showed disagreement, with X. Tang et al. (2019) suggesting the depression rates in secondary aged children were lower than pre-pandemic whereas Duan et al. (2020) found greater rates of depression and anxiety for children and young people with a large sample of N=3613. These findings however may be flawed as the comparison was only made for anxiety levels and was made against research conducted by J. Zhao et al. (2012).

There are collectively significant limitations in the aforementioned research: predominantly the variability in findings, the lack of relevant comparison data and the lack of representativeness due to being conducted in China only. It may be that the time pressure to report on the impact and significance of COVID-19 whilst it was unfolding explains the shortcomings. However, it is also worth noting that mental health difficulties are highly stigmatised in China and a systematic review by Xu et al. (2018) identified mental health practitioners are often ashamed of working in mental health settings, knowledge of mental illness among the general population is poor and there is a reluctance towards personal relationships with those identified as having a mental illness. This finding suggests that data on mental health statistics from research in China should be viewed with caution; further justifying the need for research in other areas of the world on the impact of COVID-19 and mental health.

9.4 Quarantine and Mental Health

The effects of quarantine on children and young people's mental health have received more attention with research suggesting the lack of companionship can result in increased psychiatric disturbance and an experience of crisis and grief (Liu et al., 2020). Further research suggests PTSD in children and young people is higher post-pandemic (Sprang and Silman, 2013), potentially due to increased screen time and media exposure (Garfin et al., 2020). Despite these concerns none of the above studies conducted empirical investigation into the effects of quarantine on children and young people's mental health during COVID-19, thus raising concerns over validity and generalisability.

Saurabh and Ranjan (2020) addressed this research gap with empirical research conducted in India with a sample of N=121 young people aged 9-18 years. The results suggest children and young people who were quarantined experienced significantly more worry, helplessness and fear in comparison to those who were not. However, the compliance with quarantine was only 7.43% which questions the validity of the findings. Further research by Hawes et al. (2022, p.3227) on a group of N=451 young people aged 12-22 years (*M*=17.49) in New York, found that home confinement during the pandemic decreased social anxiety for some young people and 'provided a respite from social pressures'.

Altogether this research highlights a potential correlation between quarantine and mental health as well as a possible disparity between populations based on government guidance around quarantine during the pandemic and individual differences. Furthermore, a substantial research gap for valid and reliable research, with a specific focus on the UK is also identified.

9.5 Adolescents and the Pandemic

The aforementioned research focuses on broad age-ranges thus highlighting a gap for investigation into the impact of COVID-19 on specific age groups, e.g., adolescents. The Mental Health Survey of Children and Young People (NHS, 2017) identified adolescents at increased risk of mental health problems, such as depression, anxiety, mania or bipolar disorders. Research published post-pandemic has identified a link between COVID-19 and exacerbated mental health problems (Samji et al., 2022) which highlights a potential increased vulnerability to the effect of COVID-19 between the ages of 11-18 years.

Research conducted by Ravens-Sieberer (2020) and Magson et al. (2021) focused specifically on adolescents (N=1040, M=14.3 years) in Germany and Australia (N=248, M=14.4 years) respectively. Both studies utilised online surveys and the collective results suggested adolescents experienced lower quality of life, increased exhaustion, increased anxiety and depression, lower quality friendships and increased psychosomatic symptoms of headaches, sleeping problems and low mood during the pandemic. Further research in Hungary (Takács et al., 2023) suggested adolescent females to experience moderate-high hopelessness and high loneliness throughout the pandemic, putting them at increased risk of poor mental health in the future. Research in the US by Hawes et al. (2022) also found increased rates of generalised and social anxiety and that females experienced depression at higher rates than males. The findings from these studies suggest there are universal impacts of COVID-19 on young peoples' mental health.

UK-based research follows similar trends and is equally concerning. Research by Huang and Ougrin (2021) suggests referrals to Child and Adolescent Mental Health Service (CAMHS) were up 180% in November 2020 when schools and professionals returned to working. This causes significant concern as pre-pandemic CAMHS was already under strain due to a lack of funding and resources. In contrast to the research conducted in Hungary (Takács et al., 2023), K. Cooper et al. (2021) found that loneliness predicted poor mental health in adolescents aged 11-16 years in the first 11 weeks of lockdown but not at a one month follow-up. However, the respondents were from high socio-economic backgrounds and 50% were lost at follow-up which questions the generalisability and validity of these findings.

Altogether this identifies adolescence as a risk category for post-pandemic mental health problems and indicates potential individual differences in response to the pandemic. The prior research on vulnerability of autistic adolescents and possible improvements in some areas of mental health alongside a lack of research in the UK suggests an urgent need for research and interventions to support mental health focusing on autistic adolescents within the UK specifically.

9.6 Autism, Adolescence and COVID-19

There has been some early research published on the impact of COVID-19 on autistic adolescents and only N=3 in the UK specifically although the recency of the pandemic is acknowledged. Research by Vasa et al. (2021) in the USA focused on children and adolescents (M=9.1 years). The results found 59% of children and young people from a sample of N=257 experienced worsening or new psychiatric symptoms throughout the pandemic. Although worsening of mental health for autistic young people was identified, this study did not ask for child reports instead relying on parental perspectives which may not reflect the true experience of autistic adolescents. Furthermore, there was no investigation into age as a variable, and seemingly lower numbers of adolescents included.

Research by Toseeb and Asbury (2023a) conducted by in the UK found similar findings. The researchers asked N=527 parents/caregivers about theirs and their child’s mental health during the COVID-19 pandemic. The results suggest that anxiety and depression symptoms remained high throughout lockdown and when schools reopened for autistic young people, whilst anxiety levels reduced for those with other SEND. This highlights autistic young people may have been disproportionally affected by the pandemic in relation to their anxiety. In a qualitative extension of the research, Toseeb and Asbury (2023b) found some positives of COVID19 were experienced by autistic adolescents that improved their overall wellbeing. This was in relation to reduced demands, specifically school demands with parents describing home as safe and reported improved behaviour and familial relationships. The main limitation of this and previous work is that it relies on parents’ perceptions of the adolescents’ experience, reducing the validity of the findings, as prior research identified a disparity between parent and child perceptions of mental health (Adams et al., 2019).

Other research has focused on the mental health impacts of having an autistic child in the pandemic (Chan and Fung, 2021), the potential increased vulnerability of SEND individuals (Imran et al., 2020; Lee, 2020; Smile, 2020; Baweja et al., 2021) and parent perspectives of autistic adolescents' mental health (Colizzi et al., 2020). Research by Garcia et al. (2021) investigated the impact of COVID-19 on health behaviours in N=9 autistic youths aged 14-19 years in America. The findings suggest increased screen-time and decreased physical activity which raises concern for longer term health issues, including mental health concerns. However, this study was small-scale and focused on physical not mental wellbeing. Further research into the effects of this health behaviours post-pandemic is required to gain more understanding.

In contrast to the previous findings, research by Cost et al. (2021) in Canada utilised a mixture of parent and adolescent report. The results suggest that those with a mental health and autism diagnosis improved in their obsessive/compulsive behaviour during the pandemic, whilst around 50% believed their anxiety, depression and irritability were worse. A further thematic analysis by Pellicano et al. (2022) in Australia explored the impact of COVID-19 with N=16 autistic young people, N=44 autistic adults and N=84 parents of autistic children. The data proposed three main themes: 1) a release from conventional social challenges; 2) a deep sense of social loss and 3) a deterioration of mental health. Whilst there was an acknowledgement of a small benefit to COVID-19 in that online schooling 'fits my needs better' (Pellicano et al., 2022, p.921), the intensity of social loss and subsequent impact on mental health was felt by all participants. Whilst the work by Pellicano et al. (2022) identifies a sense of loss and mental health deterioration as significant, the conclusions for young people are limited by the lack of analysis of adolescent specific data. This is concerning as the aforementioned prior research identifies them as an at-risk population. Despite this, the research supports a future research focus on mental health and importantly, challenges the historic notion that autistic individuals value social interaction less than neurotypical individuals as outlined in the social motivation theory (Chevallier, 2012).

Recent research by Ozsivadjian et al. (2023) in the UK utilised open-text online surveys with N=45 caregivers of autistic adolescents, N=26 caregivers of neurotypical adolescents, N=14 neurotypical adolescents and N=18 autistic adolescents. The thematic analysis suggested that 'the autistic young people reported worsened mental health including anxiety, low mood, and worsened self-esteem with more frequency than the non-autistic young people' (Ozsivadjian et al., 2023, p.1486). Taking into consideration the data from all participants, Ozsivadjian et al. (2023) suggested that lack of routine and social contact were vital in the overall decrease of wellbeing experienced by adolescents during the COVID-19 pandemic.

In further support, additional qualitative research conducted by Hamilton et al. (2023) with N=6 autistic boys aged between 13-14 years echoed the suggestion that loss of social relationships and education were influential for autistic young people. The findings also suggested that anxiety remained high throughout the pandemic as pre-pandemic worries were replaced with COVID19-related concerns.

9.7 Factors increasing Mental Health Vulnerability

Early research into why COVID-19 may have had a disproportionate impact on autistic adolescents is ongoing, however emerging ideas suggest the loss of therapeutic services and online replacements to be influential. Pellicano et al. (2022, p.922) suggest that autistic young people 'prefer hanging out…in person' and online connections were a poor substitute and led to feelings of disconnect. Furthermore, online replacements for education were deemed inaccessible for autistic young people due to connectivity problems and the lengthy content. This resulted in behavioural problems and effects on parent-child relationships (Rakap et al., 2023). Online replacements for therapeutic services e.g., psychiatry, speech and language and psychology were also found to impact mental health. The participants in Pellicano et al.'s (2022) study reported therapeutic services stopping, becoming inaccessible or moving online (telehealth) which for all young people in the study was a negative experience. In contrast, research by Bhat (2021) found that the benefits of online therapies for autistic young people were mediated by the child's age and cognitive or language ability, as identified from a parent report of N=9639 autistic children.

Additional research by Amorim et al. (2020) found that quarantine had a significant impact on emotion management for autistic children in comparison to a neurotypical control group as reported by parents/caregivers. Within the autistic group, significantly higher mean levels of anxiety were present when routines could not be adhered to and those that were able to maintain their daily routines were better adapted to quarantine than those that could not. Parents reported staying inside, social isolation, boredom, online schooling and changes to routine as the main quarantine challenges. The impact of social isolation and quarantine is further supported in similar findings about confinement (Lopez-Serrano et al., 2021) and school closures (Kawaoka et al., 2022).

Broader research considered the impact of the home environment and the impact of parents/caregivers of young people with SEND. Research into parents of children with a neurodevelopmental disorder (such as autism) suggested parental stress was heightened during COVID-19 and this was predicted by the child's externalising behaviours which was influenced by a lack of therapeutic support (Bentenuto et al., 2021). Kawaoka et al. (2022) suggest that externalising behavioural problems indicative of anxiety in autistic young people during lockdowns, may make them more prone to abuse within the strained home environment. This is supported in research by Govindshenoy and Spencer (2007) who found children with psychological and emotional disabilities to be at higher risk of abuse than children with physical disabilities. This is further supported in research by Helton and Cross (2011) who also found children with less severe disabilities to be at greater risk of physical abuse and by McDonnell et al. (2019) who found autistic children to have a higher risk of child maltreatment than a neurotypical child.

9.8 Conclusion

In conclusion, this review has identified several studies from different countries which identify that 'the pandemic has produced a negative psychological impact in [autistic] children/teenagers' (Milea-Milea et al., 2023, p.1) greater than that of neurotypical teenagers. There are varying potential reasons why autistic adolescents are more vulnerable including quarantine, lack of social connections/routine and increased vulnerability to child maltreatment. Collectively the aforementioned studies call for greater understanding of COVID-19's impact on mental health in autistic adolescents. To address the limitations of previous findings and to meet the identified research gap, Phase Two aims to include adolescents voice and be conducted within the UK.

Chapter Ten: Phase Two Methodology

Phase Two utilised a mixed-methods approach across two studies. Study Three explored the impact of COVID-19 on the mental health of autistic adolescents via an online survey (see Appendix L), yielding quantitative data. Study Four extended the findings of Study Three via an online focus group (see Appendix M) and gathered qualitative data. The studies were descriptive and exploratory, employing a cross-sectional design and therefore had no directional hypotheses.

10.1 Aims & Objectives of Phase Two

This phase aimed to gain insight into autistic adolescents' therapeutic experience, needs and the impact of COVID-19 on their mental health. Specific objectives were:

1. Study Three: To survey adolescents with autism to gain an understanding of the impact of COVID-19 on their mental health and their therapeutic needs and experience.
2. Study Four: To conduct a focus group with 10% of autistic adolescents to better explore the findings from the survey.

10.2 Survey – Study Three

10.2.1 Rationale for methods

The survey method of data collection was chosen for similar reasons as in Study One i.e.., wide reach of participants, cost and time benefits and flexibility (Granello and Wheaton, 2004). In addition, a systematic review conducted by Flanagan et al. (2015, p.7) suggested online surveys are popular for research with adolescents due to them being 'engaged in a digital world' and providing anonymity which is good for 'sensitive topics' and 'gives voice to marginalised groups'. Limitations of online surveys were considered such as the potential for excluding those in lower socio-economic backgrounds and possible over-disclosure (Flanagan et al., 2015). The researcher mitigated the impact of this by contacting numerous organisations, including charities and schools, that could provide technology to aid participation and ensuring the questionnaire only included closed questions to reduce the risk of over-disclosure and harm to the participant. The aforementioned prior research also utilised online surveys (Chen et al., 2020; Ravens-Sieberer et al., 2020; Magson et al., 2021); suggesting them to be a reliable method of data collection for this population.

10.2.1.1 Safeguarding and Accessibility

An amendment to the original ethics application was approved on 23rd January 2023 by SHREC. The original questionnaire relied on parental consent being gained before the adolescent (11-18 years) could complete the survey. However, despite the questionnaire reaching approximately 400 people in the first month of being published (September 2022), only N=6 participants had been recruited. In contrast to the initial version, the amendment removed the need for parental consent based on Gillick Competency (CQC, 2022), adapted the questionnaire to include only closed questions and raised the age for inclusion to 13-18 years in order to increase participation. This reflects the Gillick Competency (CQC, 2022) that children above age 13 can provide consent for medical treatments if deemed competent. Whilst this research is not consenting to medical treatment, the applicability of competency in consent for research is evidenced (NSPCC, 2022a). There is no standard test for Gillick Competency, instead it relates to the child's understanding of the information they are given (NSPCC, 2022a). This research asked the child to provide consent for participation on the basis they understood the information provided and gained parental consent for participation if young people stated they required assistance in understanding the information sheet.

The researcher encouraged participants to access support from a trusted adult should they require assistance in completing the survey or did not understand the information sheet (see Appendix N). It was hoped that this would ensure the survey was accessible to all. The survey included a question at the beginning that asked participants if they were being assisted in completing the questionnaire, and if they were, what help were they receiving via a checklist of options. If participants were receiving help, then parental/carer consent was also gained and parents/carers were guided to the parent information sheet (see Appendix O). This question was included on the basis that learning difficulties (reading and writing) and autism can co-occur at higher rates than independently (Dunn et al., 2019) and to act as a measure of Gillick Competency; ensuring young people were appropriately safeguarded and the research upheld ethical values around obtaining informed consent.

Consultation with two literacy specialists was undertaken with regards to reading competence and accessibility. Both advised the information sheet was aimed at a reading age of 8-9 year olds which is younger than the lower age limit of 13 years for participation. Whilst reading competency varies between young people, the lower reading age of the information sheet ensures accessibility and enables informed consent to be provided by the young person solely. The specialists advised some formatting changes to the document and a small glossary to be added (see Appendix N) as well as a condensed video alternative information sheet (see Appendix P).

10.2.2 The Survey

The literature review also aimed to identify any previous, validated measurement tools that could be employed in this study. The vast majority of research has focused on parent perception or used qualitative interview methods with adolescents (Pellicano et al., 2022), so there was a limited pool of research to draw from. Upon further investigation N=3 studies (Ravens-Sieberer et al., 2020; Magson et al., 2021; Hawes et al., 2022) employed various batteries of tests to adolescents to explore the impact of COVID-19 on mental health. These studies were not focused on autistic adolescents, and whilst they used specific mental health measures such as '*The Strengths and Difficulties Questionnaire'* (Goodman, 1997) or the '*Screen for Child anxiety-related disorders'* (Birmaher et al., 1997) they also created their own surveys to better meet the aims of the research. Research by Cost et al. (2021) did include autistic adolescents and utilised elements of the *'CRISIS-AFAR'* ('*The CoRonavIruS Health Impact Survey (CRISIS) – Adapted for Autism and Related Neurodevelopmental Conditions'* (*AFAR*), (Vibert et al., 2023)). This measure utilises Likert-items, multiple choice and closed questions to explore the experience and impact of COVID-19 on autistic young people aged 14 upwards.

Whilst these measures all had merit, not all elements were applicable to this study and were all time-consuming due to their length. On this basis the researcher used the previously mentioned surveys to design the current research questions, with a specific focus on '*CRISIS-AFAR'* (Vibert et al., 2023). This allowed the questions to elicit data that was in line with the study's aims whilst using the measures as templates, increasing validity in the created questionnaire. The shorter questionnaire also aimed to increase recruitment as it was less time-intensive for participants and ensured the researcher would be able to analyse the data within the timeframe. The researcher's experience as a therapist with autistic young people also influenced the decision to create a short online survey based on known accessibility requirements for this population e.g., reduced time demands, familiar technology etc.

The researcher intended to assess internal validity of the survey; however, the sample size was not large enough and neither was the case-item to participant ratio to run a confirmatory factor analysis on the data (Pallant, 2020, p.190). Therefore, an internal validity analysis could not be conducted. However, the survey questions (See Appendix L) were similar and guided by previous research as outlined below, improving validity and reliability in the findings.

10.2.2.1 Demographic Questions

The questionnaire asked N=7 demographic questions relating to diagnosis, age, gender, ethnicity, location and co-occurring mental health conditions. These demographic questions were informed by previous studies which consistently asked the same questions to better understand the relationship between autism, mental health and COVID-19 (Cost et al., 2021; Ravens-Sieberer et al., 2020; Magson et al., 2021 and Hawes et al., 2022); suggesting they hold validity and applicability within this area. Furthermore, Fernandez et al. (2016) identified that the general demographic questions used in all research (age, ethnicity, gender, location etc.) are essential in exploring how diversity affects participants' experience.

10.2.2.2 The Impact of COVID-19

The current research asked N=4 questions relating to the experience and impact of COVID-19 on mental health. Using N=2 Likert-items participants were asked to rate their mental health before the pandemic and now (at the time of answering the questionnaire). Visual images of faces showing different emotions were supplied with the Likert-items to support understanding (see Appendix L). Based on the responses participants were asked two follow-up checklist questions: 1) If it has got worse do you think COVID-19 has had an impact on this? And 2) If yes, what made it worse (tick as many as you need)? These closed questions allowed for straightforward quantitative data analysis of both nominal and ordinal data. Asking about mental health pre- and post-pandemic, the use of Likert-items and the checklist options were influenced by and evident in prior research studies (Cost et al., 2021;

Ravens-Sieberer et al., 2020; Magson et al., 2021; Hawes et al., 2022) which highlighted these as valid measures for meeting the current study's aims.

10.2.2.3 Autism and Mental Health

The survey consisted of N=7 closed questions to gain insight into autistic adolescents' experience of mental health. There were N=2 questions which asked about getting support for mental health and a checklist of support options or a checklist of options why the participant was not accessing support. A further N=3 questions asked about others' understanding of autism and mental health and a final N=2 questions asked about previous experiences of counselling and the type they may have received. These questions were influenced by prior research identifying autistic adolescents as vulnerable to poor mental health post-pandemic (Milea-Milea et al., 2023) and also Phase One's findings about barriers to accessing mental health support for the client group. These questions also enabled a greater understanding about autism, mental health, the impact of COVID-19 and the interaction between these factors (outlined in the conceptual framework, see Chapter Three) that has not yet been researched within the UK or with autistic adolescents themselves.

10.2.3 Participants and Recruitment

Participants were recruited between September 2022 and March 2023 using email, social media and networking platforms such as Facebook, Instagram, Twitter and TikTok. The researcher emailed colleagues and peers inviting them to share within their networks as well as contacted local organisations, charities and schools and asked them to share via their channels. The poster, video and supplementary text was shared on relevant community pages online (see Appendix Q, P and D for recruitment poster, video and text, respectively).

Inclusion criteria of the study requested that participants must be adolescents between 13-18 years of age (in line with Gillick Competence), hold an autism diagnosis given by a doctor and be living in the UK. These criteria aimed to reduce any safeguarding risk, whilst ensuring validity in the results and fulfilling the identified research gap.

10.2.4 Analysis

The survey yielded quantitative date that was analysed using IBM SPSS software (IBM, 2021). As this research was exploratory there was no hypothesis guiding the analysis.

The statistical analysis conducted was dictated by the patterns presented in the data and focused on exploring any relationships that were present.

Two Likert-item questions were used to gather data pre-pandemic and at the time of completing the survey. There is widespread disagreement about how to analyse Likert-item responses dependent on whether the researcher views the data as ordinal or continuous. A highly cited paper published by Jamieson (2004) argued that Likert-item data is always ordinal and therefore can only be analysed by non-parametric tests. In response, Pell (2005) and Carifio and Perla (2008) outlined that there is a distinction between Likert-scales (several items measuring one construct) and Likert-items (singular questions rated on a scale) which influences the parametric vs. non-parametric analysis choice. However this was refuted by Jamieson (2005) and the debate has continued with several researchers and statisticians advising caution and providing recommendations for when different tests may be used with Likert-item data. Following the review from Norman (2010) which summarised decades of arguments and suggested either test type could be used with Likert-data, and guided by the recommendations of Harpe (2015) which outlined criteria for parametric testing of Likert-item data, the researcher employed and reported the results of a parametric paired-samples t-test. Although both types of tests were run and found a significant difference between the two time-points, parametric analysis results were reported as they are more statistically powerful (Pallant, 2020).

10.3 Methods for Study Three

10.3.1 Participants and Demographics

A total of N=44 participants completed the online survey, however only N=32 responses were included in the data analysis as N=12 participants were removed for not meeting the inclusion criteria of having an autism diagnosis. N=3 participants were under the updated age limit of 13 years but they and their parents had provided consent to involvement before the ethics amendment in January 2023 and so were retained. For demographic information see Table 10 in Chapter 11.

10.3.2 Ethics

Ethical approval for this all phases of this research was gained from the School of Healthcare Research Ethics Committee on 16th June 2022 and amendments approved on 23rd January 2023.

10.3.3 Materials

Study Three used an online survey which was developed for this research. The online survey provider used was Online Surveys (JISC, 2023) due to its availability of use to Leeds University Researchers as well as its functionality for data extraction and anonymising participants. In the original version the online survey consisted of an information sheet and informed consent forms for both parents/carers and participants (see Appendices S and R respectively) as well as a participant privacy notice (Appendix G). After the ethics amendments were approved in January 2023, the survey contained links to the privacy notice and parent/carer and child information sheets but only requested informed consent from the participant (unless it was stated that a parent/carer was providing assistance).

10.3.4 Procedure

A small pilot study (N=8) of autistic adolescents was conducted to ensure the questions were relevant and understandable. The feedback from the pilot study informed changes to the questions such as adding more detail and changing the wording e.g., providing a description of talking therapy. The inclusion of autistic adolescents in the development of the survey questions enabled the researcher to capture the voices and needs of those who the research intends to benefit. Due to time constraints of this research, a 'true' co-produced study with autistic adolescents was not possible but participation at a micro-level was achieved through the use of a pilot-study, with shared decision-making (Hart, 2008).

Due to difficulties with recruitment, the original survey (requiring parental consent) was open from 20th September 2022 until 23rd January 2023. When the ethics amendment (parental consent not required) was received the survey reopened from 25th January 2023 until 31st March 2023. Participants accessed the survey via a link provided to them online or by email. The link took participants to the information form which outlined the right to withdraw, the estimated five-minute completion time and highlighted that all questions were optional. Participants then viewed a consent form (in tick box format) and the privacy notice. All participants were required to state if a trusted adult was helping them complete the survey before continuing on to answer demographic questions.

The survey asked N=7 demographic questions and N=9 questions (including two Likert-items) about the participants experience of COVID-19 and mental health. A final question invited participants to leave their email if they wished to be involved in the follow-up Study Four.

Finally, participants were directed to a page that thanked them for their participation and were again provided with the researchers contact details. Participants were asked to make a note of their unique submission ID and reminded of the four-week window to withdraw their responses. Signposting to appropriate mental health support services was provided in order to safeguard adolescents should they have experienced any distress whilst answering the questionnaire. Participants then clicked to submit their answers.

10.4 Focus Group – Study Four

10.4.1 Rationale for Methods

Study Four utilised a focus-group method of data collection to better understand the impact of COVID-19 on autistic adolescents' mental health and their associated therapeutic needs. Brown et al. (2021, p.1) identified focus groups as an 'emerging method used among researchers working with adolescent populations especially', due to their ease of access and web-based methods of communication gaining popularity with this age-range. The swift move to online learning throughout COVID-19 provided an opportunity for children and young people to develop increased technological skills and knowledge when using online learning platforms such as Microsoft Teams (Microsoft, 2023). Microsoft Teams was chosen as the digital platform provider for the current research due to it being a popular platform for online learning during COVID-19 and the researchers' familiarity with the software. Microsoft Teams also has the ability to record and transcribe in real time; improving its utility for qualitative research. In addition, an online focus-group afforded participants the opportunity to remain anonymous (cameras off, name-change on screen) and to type their answers if they did not wish to speak. It was hoped this would increase recruitment by reducing any communication or anxiety-related barriers that autistic participants may experience to a greater extent than non-autistic participants due to their diagnosis (DSM V, 2013).

Furthermore, online focus groups have been repeatedly used for mental health research with adolescents across various countries (Coffey et al., 2022; Garrido et al., 2019; van der Westhuizen et al., 2023). Focus groups have been utilised in qualitative research alone or in mixed-methods studies with autistic adults, parents of autistic children and to a lesser extent with autistic adolescents themselves (Santomauro et al., 2017; Edgington et al., 2016; R. Cooper et al., 2021). Collectively this suggests that focus groups are a reliable and accessible method of qualitative data collection to meet the current study's aims.

The limitations of an online focus-group were considered in line with Brown et al's. (2021) recommendations. Specific consideration was given to the logistical needs of online platforms and their fallibility in regard to internet connection and the need for updates as well as accessibility issues and the difficulty in creating a controlled environment for participants when online. The researcher mitigated any technical issues by asking participants to check their access beforehand, reminding of the potential need to update Microsoft Teams and offering technical assistance on the day. Whilst holding an in-person focus group may have provided greater control over the environment (e.g., fewer distractions) and richer data to be obtained from witnessing interactions, the researcher concurs with Brown et al's. (2021, p.6) views that: 'the ideal methodology is the one that best aligns with the population of interest, minimizes participant risk, and maximizes enrolment and participation'. Based on the aforementioned research using this methodology and the researchers experience when working with autistic adolescents, an online focus group was deemed the most appropriate way to capture the current data.

10.4.2 The Questions

The literature search identified previous research utilising similar methods. Where studies were mixed-methods, the follow-up focus group questions were influenced by the findings from the earlier quantitative study as outlined by Maarouf (2019) with the explanatory sequential approach. The current research followed the same format which ensured the questions created would allow for a richer exploration of Study Three's findings (as seen in R. Cooper et al., 2021). When prior research was qualitative only, the questions were derived in line with the research aim and not predetermined by validated outcome measures e.g., van der Westhuizen et al. (2023). This is not surprising as focus groups are often used as part of an inductive, qualitative approach to data collection; enabling the researcher to understand the meaning assigned by participants and leading to a thematic exploration of the data.

The semi-structured focus group schedule comprised of N=6 questions created to gain greater insight into autistic adolescents' experience of the interaction between COVID-19, mental health and therapeutic needs (in line with the conceptual framework). The questions were guided by the findings from the systematic review, Phase One and Phase Two Study Three and asked participants N=4 questions about changes or type of therapeutic provision and support they would find helpful, N=1 question about the associated challenges of COVID-19 and N=1 question about improvements to mental health support (see Appendix M).

10.4.3 Focus Group Recruitment

The penultimate question on the online survey in Study Three asked participants to leave their email address if they would like to participate in the follow-up 30-minute online focus group. It was hoped this would increase participation and make recruitment for Phase Two Study Four easier (as it had been successful in Phase One Study One); however very few participants left contact details. Recruitment took a further four months via regular requests sent out on social media, in therapy networks and to local schools and organisations. Recruitment was time-consuming and challenging and upon speaking to parents and colleagues with autistic children, the researcher found a consensus that groups were not the most accessible way to work with this population (this will be further discussed as a limitation in Chapter 12).

Initially there were N=12 participants who consented and confirmed their availability to be involved in the focus group, despite this only N=4 attended on 1st July 2023. The researcher had sent the questions to all consenting participants beforehand in a further attempt to reduce anxiety and increase accessibility. Although unable to attend on the day due to feeling overwhelmed, anxious or a change in plans, a further N=3 emailed their typed responses to the questions; totalling N=7 participants. There are various potential explanations as to why recruitment was challenging and why participants dropped out last minute. The focus group was held on a Saturday morning as this was the time chosen by most participants however, it may be that on the morning after a week at school, participants were too tired to attend. Future studies may benefit from better understanding the barriers to participating in research for this population. Whilst the current focus group was small, prior research has identified focus groups generally have between 5-12 participants (Lazar et al., 2017) to gain a rich exploration of individual and group perspectives.

10.4.4 Analysis & Rationale

Various methods of qualitative data analysis were considered and two were accepted as aligning more closely with the data and overall research aims: Reflexive Thematic Analysis (TA, Clarke and Braun., 2018) and Interpretative Phenomenological Analysis (IPA, J.A. Smith., 2019) Although the researcher knew of TA being frequently applied to focus group data with autistic populations and had experience of this in practice, a literature search identified a growing body of research, applying IPA to focus group data (Palmer et al., 2010) and with autistic participants (MacLeod, 2019). Both types of data analysis state ‘researcher subjectivity is a fundamental resource’ (Clarke and Braun, 2021, p.41) and both aim to create themes guided by interpretation and understanding of the data. How this is achieved differs between the approaches and IPA has an additional focus on the individual accounts as well as the collective experiences (Larkin et al., 2021). This focus on individual accounts ‘encouraged attention to [participants] ‘pronoun use, pauses, laughter, functional aspects of language, repetition, tone, degree of fluency (articulate or hesitant)’’ (J. Smith et al., 2009, p.88, in Clarke and Braun, 2021, p.41). Reflexive TA in contrast may be better aligned with research that has a focus on creating practical and actionable outcomes that are derived from the shared-meanings assigned to themes.

Although both methods could work in practice for the qualitative data collected from the online focus group, during the group all participants typed their answers whilst remaining off camera and muting their microphones. This removed the option to analyse individual accounts focusing on specific contextual and linguistic information and as such Clarke and Braun (2018) reflexive approach to thematic analysis for counselling and psychotherapy research was employed as the method of data analysis.

Braun and Clarke (2021a) identify that TA is a collective term for a range of methods that can be applied to qualitative data. The reflexive TA approach is the hallmark of a ‘Big Q’ or ‘fully qualitative approach’ (Kidder and Fine, 1987; Braun and Clarke, 2021a) whereby the researcher’s knowledge, subjectivity, resources and values are essential in developing themes and creating understanding within the data. In contrast, other methods of TA e.g., applied TA, focus on coding reliability and view researcher subjectivity as bias to be reduced by cross-referencing themes and creating coding frameworks that assess inter-rater reliability.

The researcher considered their previous experience with autistic adolescents, immersion within psychotherapy research and their developed skill-set of reflexive TA and identified that aiming to remove any form of subjectivity throughout the analytic process would be impossible. Therefore, it was pertinent to choose the method that embraced these qualities and could frame them as a strength of the research, further supporting the use of reflexive TA.

A similar process to data analysis was undertaken for Study Four as in Study Two and was informed by the outlined pragmatic framework (see Chapter Three). The researcher began by reading and re-reading the focus-group transcript as well as the written feedback from N=3 participants. An inductive approach to coding was taken whereby the initial codes were derived from the data itself rather than a deductive approach of using prior theory as a guide. This approach recognises the limited theory available on the interaction between autism, mental health and therapy for autistic adolescents and met the exploratory aims of the study. When the researcher believed saturation had been achieved, subthemes were identified before the final themes were suggested (see Appendix W for coding process).

When developing the themes across the dataset, the researcher considered the guidance from Clarke and Braun (2018, p.108) which suggests ‘themes can perhaps be usefully thought of as key characters in the story we are telling about the data’ rather than descriptive summaries of the data. The researcher hoped the themes would capture the emotional content and meaning that participants were making, whilst also acknowledging that themes do not ‘spontaneously fall out or suddenly appear’ (DeSantis and Ugarriza, 2000, p.385) and are actively created and influenced by the researcher analysing the data.

As this research is part of a doctoral thesis, the analysis was supervised by and shared with two supervisors who provided feedback on process, including commenting on the codes, subthemes and themes derived.

10.5 Methods for Study Four

10.5.1 Participants and Demographics

N=4 participants completed an online focus group and a further N=3 participants sent written responses. All participants were recruited via either social media or from Study Three. N=7 participants were White-British, autistic and there was an age-range of 11-17 years (*M*=13.42, *SD*=1.90) with a gender split of N=3 males and N=4 females.

10.5.2 Materials

Study Four provided a child and an adult paper version of the information sheet again (Appendices N and U respectively) and an online consent form for young people (Appendix T) and parents/carers (Appendix V). A link was sent to participants and their parents for them to complete online via Online Surveys (JISC, 2023). The semi-structured focus group schedule consisted of six questions (see Appendix M) and was conducted via Microsoft Teams (Microsoft, 2023). Microsoft Teams was utilised as the universities preferred method of online communication and the ability to audio and video record and transcribe interviews.

10.5.3 Procedure

Participants and their parents who had provided consent for involvement in Study Four were contacted via email by the researcher. Participants were asked to complete an online poll highlighting their availability for the focus group and were resent the information sheet and focus group questions. The focus group was conducted online via Microsoft Teams and utilised the online transcription function. The focus group was recorded and transcribed in real time. Participants were advised the group would take approximately 30 minutes.

The researcher read the N=6 questions from a script. Participants had the option to respond vocally or type and they all chose to type their answers into the chatbox. The focus group lasted 35 minutes and participants were thanked for their time and reminded of the researchers contact details should they wish to withdraw. The researcher then read through the transcript alongside the recording and corrected any errors. The transcript and N=3 written responses that were received by email were then uploaded the data to the University OneDrive system for GDPR compliant storage.

Chapter Eleven: Quantitative Results for Phase Two Study Three

This section presents the results of the quantitative analysis for Phase Two Study Three. A range of tables and figures support a narrative summary of the findings.

11.1 Demographic Information

Table Nine outlines the demographic information for the N=32 autistic adolescent participants who took part in Phase Two Study Three. All participants had an autism diagnosis given by a doctor/psychiatrist and all lived in the UK. Participants could choose multiple gender options and co-occurring mental health conditions. The age range of participants was 11-17 years (*M*=14.47, *SD*=1.72). N=3 (9%) participants identified 'Other' co-occurring mental health conditions as follows (16p13.11 duplication syndrome, anorexia-nervosa and tic disorder). N=15 (47%) participants asked a trusted adult for help completing the online survey, with N=6 (40%) reading the questions, N=2 (13%) writing the answers and N=7 (47%) explaining what the words meant.

Table 9: Demographic Information for Phase Two Study Three

Demographic Information	
Age	**N**
11 years	2
12 years	1
13 years	7
14 years	7
15 years	5
16 years	5
17 years	5
Ethnicity	**N**
White-British	30
White-Other	1
Black British	1
Gender	**N**
Male	15
Female	13
Transgender	2
Non-binary	3
Co-occurring Mental Health Condition	**N = 17**

Depression	4
Anxiety	15
OCD	2
Other	3

11.2 Descriptive Statistics

The participants were asked if they were currently accessing support for their mental health. The results indicated N=14 (44%) adolescents were accessing support and N=18 (56%) were not. Participants then responded to a follow-up question asking either where they were getting support or why they were not accessing support. Participants could choose multiple options for the follow-up questions. The responses to the follow-up question are outlined in Figure Nine and Table 10 (see below).

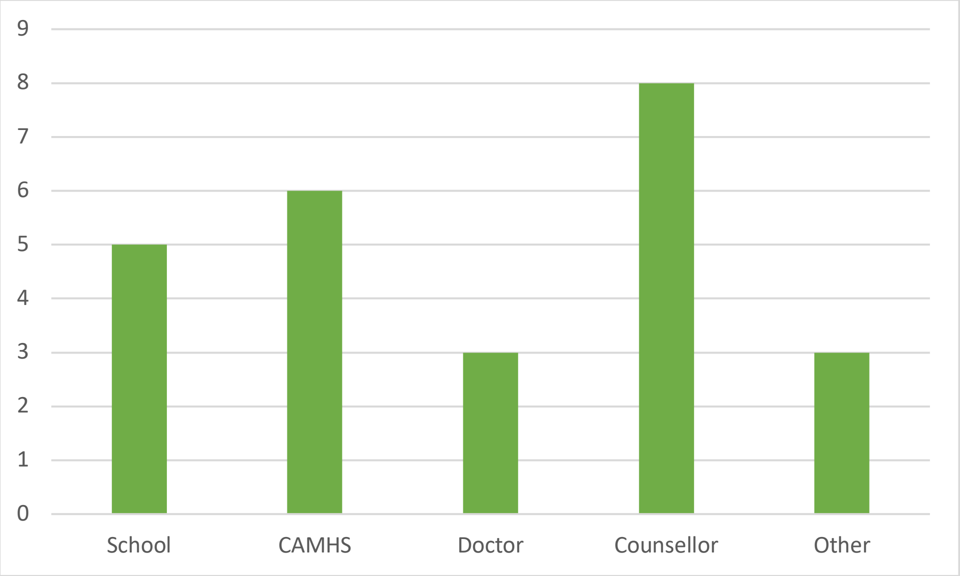


Figure 9: Where Participants Accessed Mental Health Support.

Table 10: The Reasons Participants Were Not Accessing Support.

Reason for not accessing support	**N = 18**
On a waiting list	6
Support has ended	4
Not asked for help yet	1
Other	7

Of the N=7 ‘Other’ responses participants stated: not needing support right now (N=2), not trusting mental health workers (N=1), not having access or being refused due to their autism diagnosis (N=2), trying self-care practices (N=1) and physical health issues taking priority (N=1).

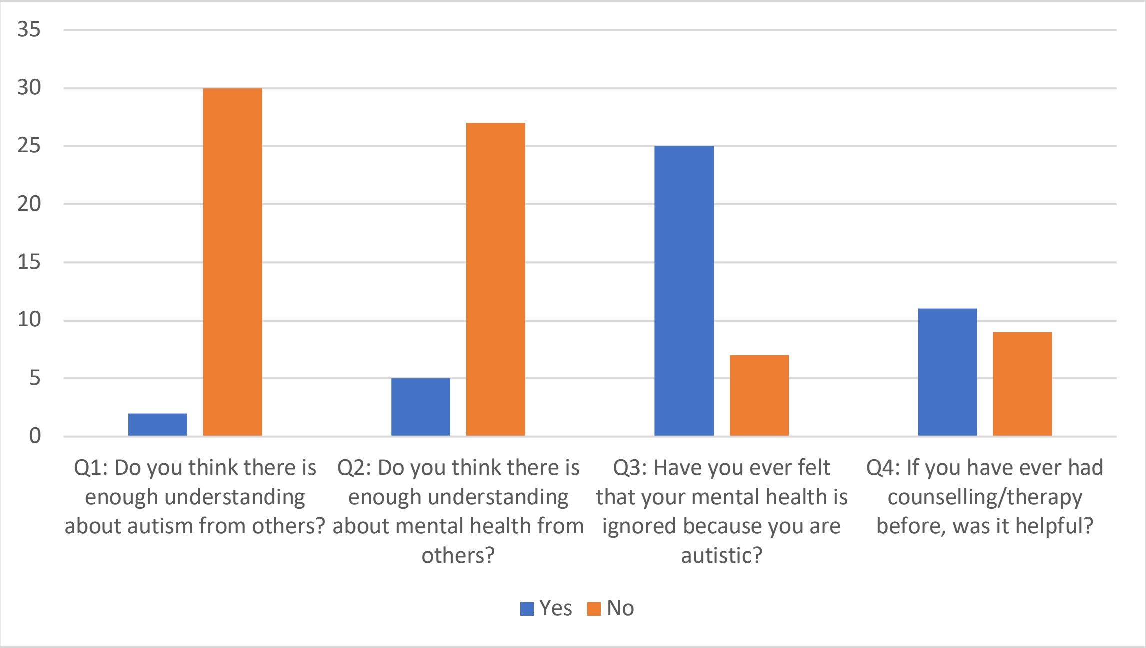


Figure 10: Participants Experience Of Autism, Mental Health And Therapy.

The participants were then asked N=4 closed questions and N=2 follow-up questions to better understand their experience of autism, mental health and therapy collectively (see Figure Ten and Table 11). For Question Four (If you have ever had counselling/therapy before was it helpful), N=12 (37.5%) participants stated they had not accessed this type of support.

Table 11: Results from Q4 Follow-up in Phase Two Study Three

If no, why not (tick all that apply)?		**If yes, what kind of counselling/therapy did you have?**	
I did not like my counsellor	N = 1	CBT	N = 6
My counsellor did not understand me	N = 5	Skills training	N = 1
My counsellor thought autism was a problem	N = 2	Art therapy	N = 2
Other	N = 4	Play Therapy	N = 2
		Talking Therapy	N = 8
		I don’t know	N = 1

Of the N=4 ‘Other answers given, participants stated problems with confidentiality, struggling to be honest and identify own feelings, receiving unhelpful advice and not being able to choose whether they wanted therapy.

Further frequency analysis between where support was offered and type of therapy accessed was undertaken, however as participants could choose multiple options a clear picture could not be gained. Of the N=6 who accessed CBT, N=2 received this in school and N=3 in CAMHS. Of the N=8 who accessed talking therapy, N=3 accessed this at CAMHS and N=2 accessed at school but also stated accessing CBT at CAMHS/School and it may be that multiple options were chosen due to confusion in terminology.

11.3 The Impact of COVID-19

Participants completed two Likert-item questions, retrospectively rating their mental health at two time-points (before and after COVID-19, see Figure 11). A paired samples t-test was conducted to investigate if there was a significant difference between the mental health ratings before and after COVID-19. There was a statistically significant decrease in overall mental health scores from before COVID-19 (*M*=3.16, *SD*=.95) to after COVID-19 (*M*=2.25, *SD*=1.14), *t(31)* = 4.18, *p*<.001 (two-tailed), *d* = .74. Based on Cohen’s (2013) guidelines this was a medium-large effect size.

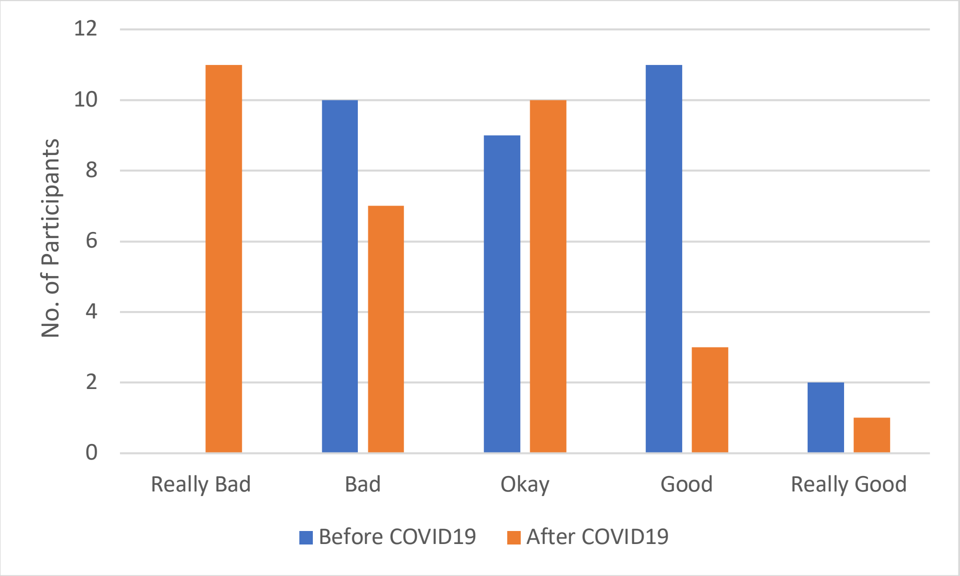


Figure 11: The Difference Between Autistic Adolescents' Mental Health Ratings Before And After COVID-19

Participants were asked N=2 follow-up questions to further understand the impact of COVID-19 on mental health. Participants were asked 'If it has got worse, do you think COVID-19 had an impact on this'? (see Figure 12 for responses). If participants responded 'yes', a further follow-up question asked them to choose what made it worse, they could choose as many options as required (see Table 12). For the N=3 other responses, participants stated feeling trapped at home, lack/change of routine and structure and difficult relationships at home. The N=3 participants who stated their mental health had not got worse identified that not going to school and having reduced pressure to do things helped their mental health.

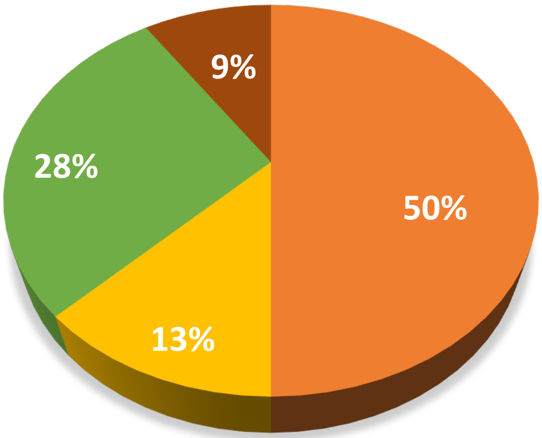


Figure 12: Participants Responses To If COVID-19 Had Impacted Their Mental Health.

Table 12: The Breakdown Of Responses To What Made Participants' Mental Health Worse During COVID-19

If yes, what made it worse? Tick as many as you need	
Not going to school	N = 7
Not seeing friends	N = 8
Being unwell	N = 2
Not seeing family	N = 8
Not going to places where I was getting support	N = 7
Other	N = 3

11.4 Further Analysis of Gender Effects

Based on prior research, further statistical analysis investigated any potential relationships in the data. Fisher's Exact Test was reported for the subsequent analysis as the cell count for some variables was <5; the assumptions for Chi-Squared tests were not met.

Statistical analysis explored whether there was any relationship between participants gender and having a diagnosed mental health condition. The results found no significant relationship (*p*=.70).

Follow-up analysis was conducted on participants who had a diagnosed mental health condition to explore if there between type of condition and gender. The results suggested there was no significant relationship (*p=.25).*

Further analysis investigated whether there was a relationship between gender on mental health scores before COVID-19 using the Kruskal-Wallis Test. This non-parametric test was used as gender was defined as a categorical variable in the survey and did not have a normal distribution. The Kruskal-Wallis test suggested no significant difference in mental health scores across the four gender categories, χ2 (3) = 1.59, *p*=.66.

There was also no significant difference found between gender groups on mental health scores after COVID-19 from a Kruskal-Wallis analysis (χ2 (3) = 6.22, *p*=.10)

11.5 Further Analysis of Age Effects

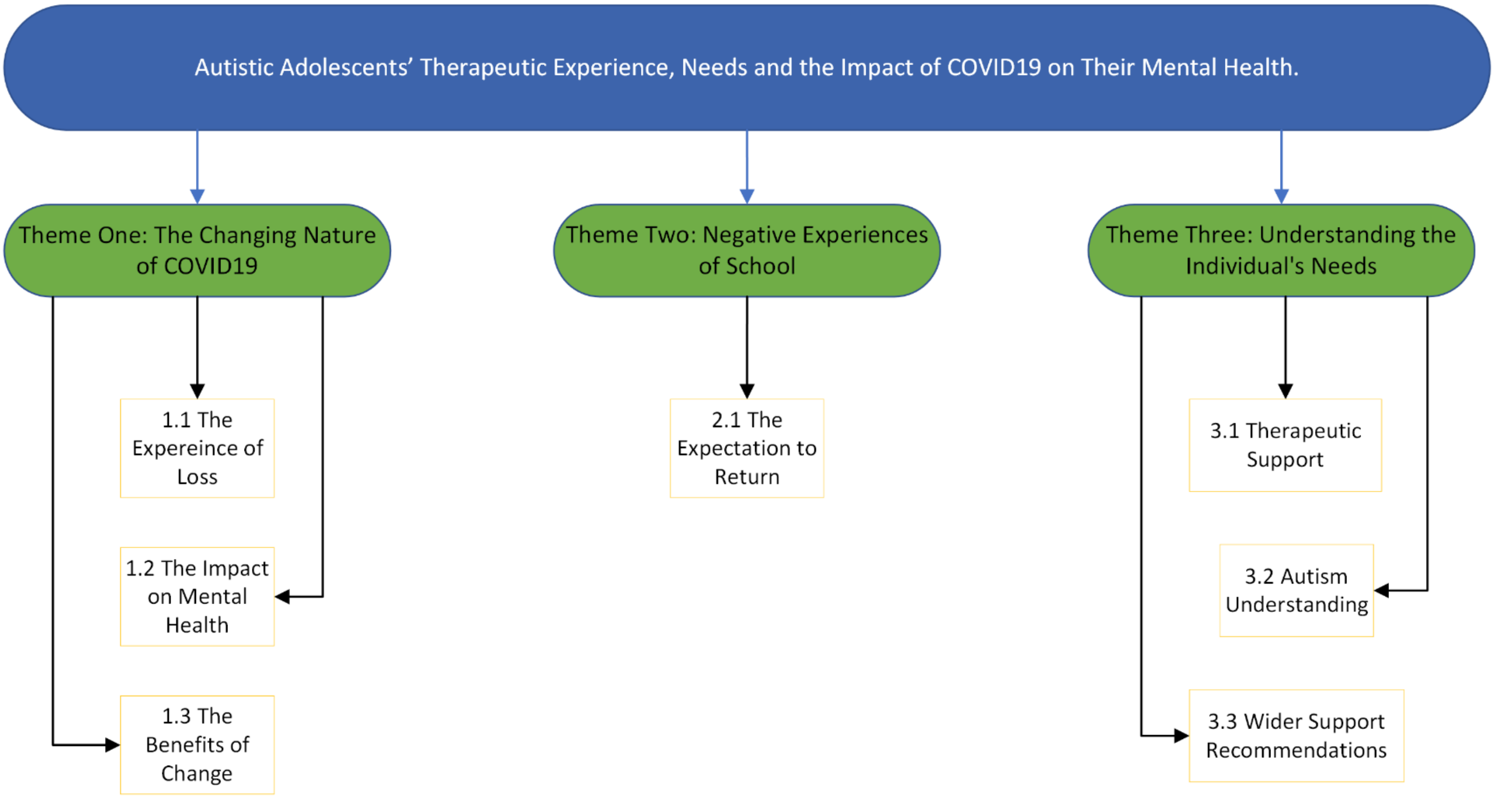
Additional statistical analysis investigated whether there was any relationship between participants' age and having a diagnosed mental health condition or type of mental health condition. The results found no significant relationship between age and a mental health diagnosis (*p*=.74) or between age and type of diagnosed condition (*p=.50).*

Further analysis investigated whether there was a relationship between age on mental health scores before COVID-19 using the Kruskal-Wallis Test. This non-parametric test was used as age was defined as a categorical variable in the survey. The Kruskal-Wallis test suggested a significant difference in mental health scores across the seven age categories, χ2 (6) = 14.01, *p*=.03. As there was a significant result found, posthoc tests were conducted showing significant differences between three age groups. The 17-year age group recorded a lower median score (Md =2) than the 15 year old age group (Md=4), *p*=.02. The 17-year age group recorded a lower median score (Md=2) than the 13 year age group (Md=4), *p*=.002. The 16-year age group recorded a lower median score (Md=2) than the 13 year age group (Md=4), *p*=.04.

There was no significant difference found between age groups on mental health scores after COVID-19 from a Kruskal-Wallis analysis, χ2 (6) = 7.70, *p*=.26.

Chapter Twelve: Qualitative Results for Phase Two Study Four

The current chapter presents the qualitative results of Phase Two Study Four. Three overarching themes were identified (see Figure 13) and narrative summaries of each theme are provided. The individual themes and sub-themes are presented below with supporting quotes from participants.



12.1 Theme One: The Changing Nature of COVID-19

Participants discussed various impacts of the COVID-19 pandemic. There was a consistent mention of all the changes COVID-19 brought which had both positive and negative results. Participants mentioned *'all the change was hard because the rules kept changing'* (Participant One) and that *'I didn't like the we are in lockdown, now we are not in lockdown, now we are back in lockdown, now we are not in lockdown again'* (Participant Four). Participants also mentioned struggling with changes that brought about an impact on schooling. This included not liking home schooling (Participant Seven) and *'technical issues in online learning was never a fun thing'* (Participant Six). One participant also experienced an impact on their transition from primary to secondary school as *'my first full year back after the pandemic was starting in Year 7 at a new school and I hadn't had an induction day* *so I found it even more stressful'* (Participant Two). These changes brought about three impacts, categorised as subthemes and outlined below: 1) The Experience of Loss; 2) The Impact on Mental Health and 3) The Benefits of Change

12.1.1 Subtheme One: The Experience of Loss

There was an experience of loss outlined by some participants as a result of the changes they experienced. These losses seemed to be linked to a *'lack of routine'* (Participant One) or *'no school routine'* (Participant Five). As well as finding *'the isolation was the hardest part'* (Participant One). Participants identified a sense of loss for normality and socialising. Participant Two *'missed seeing people and being able to go out and do normal activities'* and Participant Five struggled with *'not being able to go out anywhere'.*

12.1.2 Subtheme Two: The Impact on Mental Health

The associated changes and experience of loss resulted in participants characterising lockdown as challenging. N=2 participants mentioned things being *'really hard'* (Participant Four) or identifying aspects of COVID-19 as *'the hardest part'* (Participant One) or *'the hardest thing to deal with'* (Participant Four). Other participants noted an impact on their mental health as they *'didn't like the anxiety of the pandemic'* (Participant Two) and feeling *'worried if I would be able to eat again…I was worried about my family dying'* (Participant Five). There was also specific mention of *'the uncertainty it brang'* (Participant Two) or alluding to struggling with the uncertainty (Participant One and Participant Four).

12.1.3 Subtheme Three: The Benefits of Change

Despite the negative impacts of COVID-19, N=4 participants also specifically mentioned the benefits they experienced as a result of the changes COVID-19 enforced. N=3 participants *'liked being at home'* (Participant Four) because it was *'less stressful'* (Participant Three) or *'because I sometimes struggle with school'* (Participant Two). Participant Six felt they *'mostly enjoyed lockdown and Covid. The lack of interaction came as a kind of relief to me and I was sad when school started again'.*

12.2 Theme Two: Negative Experiences of School

Despite not asking any school-related questions in the focus group, participants repeatedly brought up school and discussed their negative experiences. These related to *'struggling to share with my teacher if I am struggling…I bring my anger home if things go* *wrong at school'* (Participant Five), negative experiences of school counselling sessions (Participant 3), school affecting their mental health (Participant Four), schools not providing enough support (Participant Two) and finding a relief in home during lockdown (Participants Two, Three, Four and Six). However Participant Five did mention the lack of school routine was a challenge for them. There was specific mention of struggling with the return to school post-COVID-19. This is outlined in Subtheme One: The Expectation to Return.

12.2.1 Subtheme One: The Expectation to Return

Returning to school and their previous routines was mentioned specifically by N=4 participants as a real challenge. Participant Four stated *'I didn't like the expectation that we would all just cope with being back in school. That we would all be fine'.* Other participants found it '*harder to return to school' (*Participant Three), felt stressed without transition support (Participant Two) and felt *'sad when school started again'* (Participant Six). Participant Four noted this expectation as *'really hard and I wasn't coping. This was the hardest thing to deal with'.*

12.3 Theme Three: Understanding the Individual's Needs

Theme Three encompasses a range of experiences, needs and recommendations for support that young people identified. This theme is characterised by the need for autistic adolescents to be *'accepted for who you are and feel like you have a space to be yourself'* (Participant Two) and is split into three subthemes: 1) Therapeutic Support; 2) Autism Understanding and 3) Wider Support Recommendations.

12.3.1 Subtheme One: Therapeutic Support

There was consistent mention of any therapy being individualised and tailored to the young person who was accessing support because *'all autistics are different'* (Participant Six) and '*depending on the person, different types of therapy will be more useful and comfortable'* (Participant Two). This was characterised by the varied responses to questions about therapy preference with participants offering personal experience based on their individual needs e.g., *'prefer directive therapy – less pressure and I am not always sure what to say first'* (Participant Seven) and *'in my experience I have found nondirective therapy is easier to engage in because I have PDA Autism'* (Participant One). Participants also discussed and agreed upon a need for *'a combination of both approaches'* (Participant Four) depending on the client and also *'what is right on the day'* (Participant Four).

These responses suggested a need for flexibility from the therapist that enabled the client to *'say what is bugging me at the time'* (Participant Three) and also opportunities for the client to *'be in control'* (Participant Four) of therapy. Whilst also identifying when clients might feel *'better when encouraged'* (Participant Five) or need the therapist to *'use a technique sometimes because that helps me open up'* (Participant Four). There was a collective feeling that *'it honestly depends on the child…[therapy] may need adjustments according to the child's preferences'* (Participant Six). Participant Six also identified concerns over just offering one approach *'directive therapy would seem like a lesson, in nondirective it would be too loose'.*

The participants shared experiences where therapy has been challenging for them. Participant One mentioned *'sometimes I am not been in the right headspace for certain topics'* and Participant Two identified *'some autistic people might find nondirective therapy challenging because they might not fully know their feelings'* or '*I struggle to get my feelings out'* (Participant Five) or '*know what to say'* (Participant Four).

This led onto discussion about what is and is not helpful when accessing therapy for mental health support. N=1 participant found they *'don't like it when the therapist just talks at me. Or when I had to do loads of worksheets with them'* (Participant Four). Other participants identified ways therapy could be tailored to them that would be helpful. This included taking time getting to know the young person individually and participants mentioned finding a common ground with *'a common interest to me'* (Participant Three) and *'ask me about my cats'* (Participant Four). There was also mention of getting to know the young person which involved having knowledge of autism, the therapist being *'understanding of the ways you think'* (Participant Two) and being *'someone who can understand my perspective of things'* (Participant Four). Knowing the young person and tailoring therapy also extended to language, with Participant Four stating *'don't ask me how I am, because I will probably just say I'm fine…a better question might be how is your energy level today? How has your week been so far on a 1-10 scale?'*

After looking at some guidelines for nondirective therapy there was a collective positive response that *'they all sound good'* (Participant Four). The adolescents identified the aspects of the guidelines they thought were most helpful and there was repeated mention of *'listening more, sometimes you just need to talk to someone'* (Participant Three). The participants linked the nondirective guidelines with it being *'especially important to be accepted for who you are and feel like you have a space for yourself, especially if some people do not accept you as an autistic person in the outside world'* (Participant Two) because *'I don't always want to be told what to do to change'* (Participant Three). Generally the guidelines were linked to enabling flexibility in the therapy room. Participant Four felt the flexibility of the guidelines could enable provision of *'a range of resources that I can self-select…but not for these things to be forced, just as options'.* There was also a specific mention of the need to give *'you time and space to open up'* (Participant Three) because it '*takes time to work through things'* (Participant One) and *'takes me a while to warm up to people…I hate rushing'* (Participant Five).

12.3.2 Subtheme Two: Autism Understanding

Throughout the focus group there was repeated mention of a need for improved autism understanding and awareness of the individual presentation of autism in adolescents, this was also relevant for therapeutic support too. Participant One mentioned the interaction between autism and mental health specifically with a need for *'better understanding of how autistic people think because all the mental health support tends to be aimed towards neurotypical ways of thinking, especially CBT'.* This also suggested a disparity in support offers experienced by autistic adolescents, which was further supported by *'more support for those who haven't got an EHCP'* (Participant Five). Other participants noted a need for '*knowledge of the way autism presents'* (Participant Four) and a need for *'understanding what ASD is to me'* (Participant Seven). Participant Four specifically identified a need for *'more training for counsellors on neurodiversity, especially about masking'.*

12.3.3 Subtheme Three: Wider Support Recommendations

Collectively participants mentioned a need for there to be more support offered, more time available for support and to *'have meetings or groups regularly'* (Participant Five). There was mention of wanting *'to be seen quicker'* (Participant Seven) and have help *'earlier'* (Participant One) and *'sooner'* (Participant Four). There was also mention of more knowledge of '*the support they have because some people might not know'* (Participant Two).

Participants recommended places and areas of support they thought would be helpful. There was specific mention of more support at school (Participant Two and Participant Five) and school counsellors offering *'more time to those struggling to communicate'* (Participant Three). N=6 participants felt their parents would benefit from some support as well. This focused on *'more [autism] awareness'* (Participant Four) and awareness of *'autism and mental health'* (Participant Three). One participant identified that *'my parents already knew quite a lot about autism since I was young so that's not been an issue. However, I find it hard to discuss how I feel so they probably don't know everything about how it [autism] effects specifically me'* (Participant Two).

In contrast, there was a belief held by some that a lack of parental knowledge and support had delayed them accessing diagnosis and support too. When talking about her Mum, Participant One identified *'if she could have understood what was going on and how to help earlier, that would have been easier'.* Participant Four shared the same sentiment with '*if my parents knew about autism better, I would maybe have had access to support sooner and I could have had a diagnosis much sooner'.*

This led onto further recommendations about types of parent support. Participant Four suggested parent support groups may be helpful for parents *'to have connections with other parents with autistic children'* and more personally there was a suggestion of strategies for parents to find *'ways to stop arguments and calm me down faster'* (Participant Seven).

Chapter Thirteen: Phase Two Discussion (Studies Three and Four)

The following chapter discusses the quantitative (Study Three) and qualitative (Study Four) results from Phase Two. This Phase aimed to understand autistic adolescents' experience of COVID-19, mental health and therapy using a mixed-methods approach. Both Studies in Phase Two are discussed independently before suggesting how the findings collectively add to the broader research field. Suggestions are made for future research linking to Phase Three and improvements based on limitations are identified. Consideration is given to practical implications of the findings.

13.1 Quantitative Results from Study Three

The results from the quantitative study provide a meaningful insight into autistic adolescents' experience of COVID-19, mental health and therapy. The main findings confirm previous work identifying autistic adolescents as experiencing co-occurring mental health problems at a higher rate than their neurotypical peers, with a specific focus on anxiety (Vasa et al., 2021; Toseeb and Asbury, 2023a; Cost et al., 2021). The results also indicate a negative impact of COVID-19 on mental health across all ages and genders of this population and suggest several barriers to therapy or negative therapeutic experiences, specifically stating a lack of autism understanding which may further explain the current poor state of mental health.

13.1.1 Mental Health

In relation to mental health, 53% of participants stated they held a co-occurring mental health diagnosis. This finding is supported in the prior research identifying mental health and autism as co-occurring at higher rates than in neurotypical populations (Koenig and Levine, 2011; Lai et al., 2019; McMaughan et al., 2023), and is recognised in the most recent DSM V (2013). Within these results N=15 participants (47%) stated they had a diagnosis of anxiety. This finding is supported in previous research which outlines children and adolescents with autism can experience co-occurring anxiety at rates between 42-79% (R. Kent and Simonoff, 2017). This is significantly higher than young people generally, with the ONS (2017) identifying anxiety rates at 21% across this age group. The large-scale systematic review by Lai et al. (2019) across all ages of autistic individuals identified anxiety to be the most commonly diagnosed mental health condition alongside autism, supporting the current findings. Lai et al’s (2019) findings also suggested being an autistic female was associated with increased diagnosis of depressive disorders (anxiety/depression). This is supported in previous research by Hull et al. (2017); however the current research found no gender differences in having a mental health diagnosis or type of diagnosis given which is supported in research by Vasa et al. (2013). The collective contradictory data on influence of gender on anxiety in autistic young people may be explained by the difference in methods used to collect data or the sample size, however the results from the current research specifically may also be influenced by the impact of COVID-19 on mental health (which will be discussed below in Section 13.1.2).

Lai et al. (2019) and Vasa et al. (2013) suggested an impact of age on anxiety diagnosis with autistic individuals, finding that as age increased so did the likelihood of co-occurring anxiety in a linear relationship. This contradicts the current findings, however both prior studies compared broad age groups, e.g., child vs. adolescent vs. adult. The current study found no impact of age on having a mental health diagnosis or on the type of diagnosis given but was looking at a much smaller age range of 11-17 years. It may be that this age-range or the sample size is too small to detect any significant difference. However, further significant statistical analysis did suggest that older adolescents (16-17 year olds) perceived their mental health to be worse pre-COVID-19 than younger adolescents. Further exploration into specific age-differences within adolescence is required to create a bigger picture of mental health difficulties for this population. This research may help to tailor therapeutic support for this vulnerable age-group.

Despite the varying findings, the increased rates of anxiety in autistic young people is concerning based on the associated negative impact on quality of life and general health (Ng-Cordell et al., 2022; Adams et al., 2019). Research into why anxiety rates are elevated in autistic populations is still exploratory. Findings by Jenkinson et al. (2020) suggest a significant relationship between anxiety and intolerance for uncertainty in autistic populations; highlighting interventions aimed to support the management of uncertainty may help reduce anxiety. A systematic review by McVey (2019) summarised various neurobiological studies into anxiety and autism. The findings suggest autistic individuals with hyperactive amygdalas tend to be linked to co-occurring anxiety disorders whereas autistic individuals with hypoactive amygdalas tend to be linked to autism diagnoses independently. However, the data is contradictory and as such further neurobiological studies need to be undertaken to ascertain if functional or structural differences within the brain could account for increased rates of anxiety. Whilst the neurological link between autism and anxiety is not yet understood, the far-reaching negative impact of anxiety on autistic young people is accepted within the literature and identifies a specific need for therapeutic interventions aimed at supporting mental health for these adolescents.

The study also found that participants generally felt there was a lack of understanding about mental health from others (N=27, 84%). This is supported in research by Bradbury (2020) which suggested young people aged 16-18 years held more stigmatised attitudes towards mental health than adults age 40+ years. These results may be especially important in explaining the findings of the current study as the sample only included young people. Further research found low levels of mental health knowledge amongst English adults (Evans-Lacko et al., 2013), UK university students (Gorczynski et al., 2020) and some samples of UK nurses (McInnes et al., 2022). Some research has identified positive changes in general knowledge and attitudes towards mental health, such as that by Makita et al. (2021) which analysed Twitter discourse during Mental Health Awareness Week. The results suggested a generally positive discourse although stigma towards mental health challenges was still present. Further research by Sampogna et al. (2017) found that social media campaigns have been effective in reducing stigma towards mental health and highlight a potential platform for improvements to be made. Collectively the current and prior findings highlight a need for improved awareness about mental health within the UK and a possible benefit of online platforms in achieving this.

In addition to not feeling that mental health was understood by others, N=25 autistic adolescents (71%) felt their mental health had been ignored due to their autism diagnosis. It may be that the higher co-occurrence of mental health problems alongside autism diagnoses is resulting in mental health challenges being viewed as a presentation of autism rather than something to address specifically. It is possible this has been exacerbated with the DSM V (2013) recognition of mental health difficulties as co-occurring conditions. Indeed, one participant in the study wrote this as a reason for not currently accessing mental health support. This has consequences for young people who are trying to incorporate their diagnosis into their identity (as seen with the move to identity first language, (L. Kenny et al., 2016)) and are trying to seek support for their mental health separately. The neurodiversity movement pioneers a view of difference and not disorder. This allows neurodivergent young people to develop a positive sense of self, seeing autism as who they are and recognising their strengths. This is especially important as autism is a lifelong condition. In contrast, mental health problems are not always pervasive and can be improved or ceased. Viewing mental health problems as a presentation of autism introduces further barriers to seeking support and suggests the individual cannot change their mental health status, which is inherently incorrect. Research conducted by K. Cooper et al. (2023) identified a link between positive autism identity and psychological wellbeing in young people aged 15-22 years (*M*=17.6) within the UK. Together these findings highlight the importance of providing timely and appropriate mental health support to autistic adolescents which may contribute to improved mental wellbeing and autism identity.

13.1.2 The Impact of COVID-19

Similar to the preliminary data published regarding mental health trends pre- and post-COVID-19, the results from the survey identified that autistic adolescents' self-reported mental health was significantly worse after the pandemic. This finding is mirrored in previous research by Chen et al. (2020), Ravens-Sieberer et al. (2020), Magson et al. (2021), Ozsivadjian et al. (2023) and Toseeb and Asbury (2023a). However, the current study differs by gaining adolescent voice specifically, instead of relying solely on parent/carer report or using parent/carer report to further explain the findings from autistic adolescents; suggesting strength and reliability in the current findings. Additional analysis explored any potential impacts of gender or age on these scores. There was no significant impact of gender on self-reported pre-and-post COVID-19 mental health scores. Despite the prior literature suggesting gender differences in mental health diagnoses, the literature on self-reported mental health supports the current study's findings. Research by Arwert and Sizoo (2020) found no gender effects on suicidality and a study by S. Jackson et al. (2018) found no gender effects on mental health scores, both from samples of autistic adults. In contrast, research with N=28,000 neurotypical adolescents found that females had poorer mental health than their male counterparts (Deighton et al., 2019). These finding are interesting as they suggest there may be something unique to autism and mental health that is not influenced by gender, which is seen in non-autistic populations. Additional and larger-scale research using self-report would enable more conclusive findings to be drawn.

To add to prior research, potential reasons for why COVID-19 resulted in poorer mental health were investigated. Participants identified not going to school, not seeing friends and family and not being able to access support services as the main reasons for worsening mental health. This adds support to previous research which speculated that school closures, loss of social activities/relationships, quarantine and lack of therapeutic support as potential reasons (Pellicano et al., 2022; Amorim et al., 2020; Kawaoka et al., 2022; Ozsivadjian et al., 2023). Collectively these early findings identify loss of routine, people, places or support to be the most influential factor in worsening mental health for autistic adolescents. This is supported by Fitzgerald et al. (2021) who raised concerns over the wellbeing of children and young people based on COVID-19 events being characterised by trauma, loss and grief.

Prior research into experiences of loss in neurodiverse populations may also support and explain the current survey's findings. Research by Gilrane-McGarry and Taggart (2007) found that those with intellectual disabilities may use challenging behaviour as a communication tool, which was often not related by others to their experience of loss and incorrectly attributed to their diagnosis. The result of this was a lack of appropriate support services and even when offered (e.g., bereavement counselling), it was not readily available or frequent. Gilrane-McGarry and Taggart (2007) did identify that when talking or art therapy with a bereavement counsellor was offered, the participants found it to be a helpful and positive experience in processing their feelings and improving wellbeing. Research by K. Hume et al. (2016) with bereaved autistic young people suggests that the change of routine that comes with loss can be particularly distressing to some autistic individuals who experience rigid thinking. Furthermore, those who struggle with social communication may be unable to express their feelings and therefore access the community of support that is readily seen forming in neurotypical populations at times of loss. Findings from K. Hume et al. (2016) highlighted the importance of keeping routines, considering language use, offering different formats to express emotion and offering calming strategies. Sadly, K. Hume et al. (2016) also suggested the use of teaching coping skills using CBT strategies and reinforcement to autistic children. This recommendation goes against findings from L.

Chapman et al. (2022) which suggest skills training programmes for autistic populations are harmful for mental health and further contributes to the ableism within autistic literature whilst ignoring the spectrum nature of autism. An example of this ableism in this literature is evidenced with a case-study of a 15 year-old autistic girl using a CBT style intervention to help process her grief that was unsuccessful. The researcher (Zakreski, 2017) attributed the lack of success to the clients' autism impeding therapy rather than considering the therapeutic intervention as not appropriate and considering a therapy that may be tailored and led by the young person.

The research by K. Hume et al. (2016) did also not consider the potential benefits of therapy for autistic young people whereas the lived experience explored in Buckingham (2019, p.23) identified feeling 'grateful for someone to talk to' when she was referred to a bereavement counsellor. Further case-study research by Prabha (2013) found directive play therapy to helpful for an 11 year old autistic child in understanding the death of her father. Another qualitative study by Johnson (2016) found that play therapy and bibliotherapy in the form of videogames was helpful for N=4 autistic teenagers between the ages of 12-16 years and that grief tends be experienced in similar ways to neurotypical populations but can go on for extended periods of time.

It is noted that there is a distinct lack of research into therapy around loss and grief for autistic adolescents and what has been conducted is small-scale, contradictory and at times ableist. The findings from the current and recent studies suggesting loss as a contributing factor to poor mental health post-COVID-19, identify an urgent need for further research into therapeutic support. Framing young people's experience of COVID-19 in this way suggests therapeutic support should be tailored to the individuals' experience of loss and providing a space for the processing of trauma and grief.

Research into the effectiveness of grief therapy or bereavement counselling generally has been criticised as having poor validity and showing little effectiveness (Waller et al., 2016; Currier et al., 2007). Despite this, additional research has found person-centred, nondirective therapy to be beneficial for grieving clients. In summarising relevant literature Larson (2013, p.322) suggests that 'a compelling case can be made for a person-centred approach as the foundation for grief counselling in view of its focus on the therapeutic relationship, provision of common factors and its fit with the needs of grieving clients'. This is further supported in research by Klasen et al. (2017), Simonsen and Cooper (2015) and Payne et al. (2002). These studies all identify empathy, the therapeutic relationship and client-led therapy as essential.

For some autistic young people, client-led (nondirective) talking therapy may enable them to discuss topics of importance to them at their own processing speed and within a co-created safe relationship. Moving to this type of therapy as a therapeutic offer has potential to be beneficial in supporting young people through the losses COVID-19 dealt and subsequently improving their mental health. These findings (in conjunction with findings from Phase One and the systematic review (Casper et al., 2021)) highlight a significant and urgent need for research with this therapy in the hope of improving the poor mental health, specifically anxiety that is currently experienced by autistic adolescents in the UK.

13.1.3 Mental Health Support

Of the N=32 participants only N=14 (44%) were currently accessing mental health support, with others stating they were waiting (N=6, 33%) or their support had ended (N=4, 22%). N=2 (11%) participants cited difficulty accessing mental health support as a reason with N=1 (5%) stating their mental health had been attributed to their diagnosis. These findings are concerning when read in combination with the finding that mental health deteriorated for this group of autistic young people post-COVID-19. The findings are however not surprising given the report from the Mental Health Commission (2023) which suggests CAMHS are under-staffed, under-funded and have increased waiting times since COVID-19. The report also found disparities between localities in terms of service provision; suggesting inequality based on where clients were living.

The participants who were accessing support listed school, CAMHS, doctors and a therapist/counsellor as service providers. Participants also stated what support they were receiving (e.g., CBT, talking-therapy, play-therapy). However, participants could choose multiple options and so these findings may not represent an accurate picture of support (i.e., they may have chosen therapist and CAMHS/School and only be accessing one therapeutic offer or have misunderstood CBT and talking-therapy to be the same). This suggests a limitation of the current research and identifies a need for further clarity to better understand where young people are accessing support. Further research may benefit from identifying the split between accessing private therapy or NHS/School provision as well as the type of therapy most commonly accessed or offered, when asking young people about their experiences.

N=20 (62.5%) of participants had accessed therapy before but only around half of these had found it useful, with the most commonly cited reason being that '*my counsellor didn't understand me'.* This may be explained and supported by findings from Phase One which suggested that counsellors had not received training on working with autistic populations. With regards to autism specifically, the autistic adolescents' perceptions of lack of understanding from others is supported in data e.g., Lipinski et al. (2021) and D. Jones et al (2021), which highlighted that a lack of understanding of autism in the general population and within therapeutic communities. This further identifies a need for improved training and awareness of autism and in combination with the aforementioned findings, suggests future research and training should be guided by autistic voices, move away from a deficit-based view and focus on supporting the mental health of autistic adolescents post-COVID-19. Exploration of the current mental health difficulties as influenced by losses experienced through COVID-19 would also be worthwhile and research into the potential of nondirective therapies may have merit.

13.2 Summary of Quantitative Findings

The quantitative results both supported previous findings and identified gaps in the research for further investigation. The results support previous research that identifies autistic populations as more vulnerable to co-occurring mental health problems. Specifically, the current study concludes that autistic adolescents experience anxiety at higher rates than neurotypical adolescents and that mental health is worse post-pandemic across 11–18-year-olds and all genders. The findings suggest an urgent need for more and timely mental health support provided by practitioners who hold a knowledge of autism. Reasons as to why mental health is worse after COVID-19 suggest an experience of loss and uncertainty as major contributors, which requires further investigation. The follow-up Study Four aimed to further explore and understand the impact of COVID-19 on mental health and therapeutic needs of autistic adolescents in the UK.

13.3 Qualitative Results from Study Four

Study Four aimed to better understand the impact of COVID-19 on the mental health and therapeutic needs of autistic adolescents. There were three emerging themes from data analysis as follows:

1. Theme One: The Changing Nature of COVID-19. Theme One captures a range of experiences and impacts of the COVID-19 pandemic which related to its rapidly changing nature. There were evident experiences of loss which resulted in worsening mental health but also significant benefits identified for autistic young people.
2. Theme Two: Negative Experiences of School. Theme Two identified a common negative experience of school and school support which extended to struggling with expectations to return to school post-pandemic.
3. Theme Three: Wider Support Recommendations. Theme Three captures the voices and wishes of autistic young people in relation to their therapeutic and wider support needs. This was characterised by prior experiences of therapy and support systems and led to recommendations for improvements.

13.4 Reflexivity

The qualitative nature of Study Four requires the researcher’s reflexivity to be accounted for due to the subjective nature of thematic analysis. Similarly to Study Two, the researcher utilised academic and clinical supervision throughout the research process. Both doctoral supervisors oversaw the thematic analysis and agreed upon overarching themes and the conclusions drawn from the findings. However, the researcher’s position as a therapist and academic is important to acknowledge as an influential factor in the analytic process. The researcher recognised their frustrations with recruitment as linked to a desire to capture autistic adolescents’ experiences and fill a research gap, as they see first-hand the challenges this population face. The researcher identified from Study Two that findings can be unpredictable and may not always align with previously held beliefs that nondirective therapy is always the best option for neurodivergent clients. It was important in Study Four to approach data collection with flexibility and openness whilst still maintaining the researcher’s personal values of improving therapeutic experiences for autistic adolescents.

13.5 Theme One: The Changing Nature of COVID-19

The qualitative analysis captured the impact of COVID-19 as changing in nature which had various consequences. There was a collective feeling that COVID-19 was challenging for autistic adolescents and resulted in feelings of loss that negatively impacted upon their mental health. Despite this, COVID-19 also resulted in positive changes that were often experienced as a relief and parts of the pandemic lifestyle were enjoyed by the young people.

The experience of loss adds further support to the findings from the survey in Phase Two Study Three. The qualitative analysis supports and extends the suggestion that COVID-19 was experienced as and characterised by loss of routine, support and social activities for autistic young people which had a significant impact on their mental health. The notion of COVID-19 as a loss has been discussed in prior literature (Fitzgerald et al., 2021) and the impact of these losses on mental health is supported by Pellicano et al. (2022), Amorim et al. (2020) and Kawaoka et al. (2022). Collectively these findings may explain the disproportionate impact of COVID-19 on autistic populations and identifies an urgent need for further research to better understand their unique experiences.

In representing autistic teenagers' experiences of COVID-19 through loss, suggestions can be made for future support and therapeutic interventions. The previous literature search identified mixed conclusions regarding the efficacy of loss/bereavement/grief counselling in the general population but nondirective talking therapy had been effective in research by Klasen et al. (2017), Simonsen and Cooper (2015) and Payne et al. (2002) . These mixed findings alongside the current research identifies an opportunity and urgent need for further studies to investigate the potential benefit of nondirective therapy in supporting autistic young people through the loss experienced as a result of COVID-19.

The current findings and future research has potential to create a buffer against a longer-term impact of COVID-19. Losses (including parental separation, incarceration, death, neglect and peer isolation) are suggested to be ACEs that result in poor physical and mental health outcomes (Finkelhor et al., 2015). McManus and Ball (2020) suggested COVID-19 itself may be an ACE for some young people depending on their protective factors. It is worth noting that the longer-term impact of COVID-19 cannot yet be identified and the research presently is recent and speculative. However, the current findings in addition to previous work suggests a time-sensitive need for therapeutic support and provides an opportunity to intervene before the effects extend into adulthood.

The identification of loss as a major source of worsening mental health also further supports and explains the findings from Study Three, that the mental health of autistic adolescents is worse post-pandemic. The qualitative analysis extended the quantitative findings in highlighting the links between increased anxiety and uncertainty due to regular changes in regulations and the removal of routines and support. J. Smith (2021) identified that within the UK, COVID-19 was characterised by uncertainty and fear due to rapid and conflicting changes in Government response, differing lockdown measures across the four nations and delayed decisions that cost unnecessary lives. As such 'the UK thus ended 2020 divided, impoverished and more unequal than it had begun' (J. Smith 2021, p.73) which raised significant fear across the general population.

Previous research identified uncertainty to be a major contributor of anxiety for autistic populations (Jenkinson et al., 2020). Additional research by Boulter et al. (2014) utilised child and parent self-report measures of anxiety and intolerance for uncertainty against a neurotypical control group. The results indicated a causal relationship between intolerance of uncertainty and anxiety in both groups, but found it was more pronounced in the autistic group. Boulter et al. (2014, p.1399) suggests the findings 'counteract a 'one size fits all' approach to treatment and allow the development of tailor-made interventions based on individualised formulations. The first step in this process is the identification of an appropriate model of anxiety which is relevant to individuals with ASD'.

The findings from Study Four support Boulter et al.'s (2014) suggestions about tailoring intervention and suggest that for some autistic young people the uncertainty of the COVID-19 pandemic was intolerable and created significant anxiety, which has had long-lasting impact on their mental health. Combined with the findings about experiences of loss, there is an immediate need for tailored therapeutic support that respects the individual's experience of the pandemic and understands the growing mental health needs of this vulnerable group.

The changing nature of COVID-19 whilst bringing about loss and anxiety also offered a sense of relief for some participants in Study Four. This relief and appreciation of change was mainly linked to the removal of school and feeling happier at home. There has been limited research investigating the positive impact of COVID-19 on autistic populations as many researchers focused on physical and mental health impacts of the pandemic and the impact on parents of autistic children. Despite this, early research has found some benefits for autistic young people and their families which support the current findings. Research by Asbury et al. (2021) found that for some children who found school challenging, lockdown was experienced as a form of respite and G. Rogers et al. (2021) suggested that mothers of children with intellectual disabilities perceived their child to be more relaxed due to decreased demands. Research conducted in Spain by Mumbardó-Adam et al. (2021) with parents of autistic children (M=7.3 years) identified increased participation in family routines and better communication with parents during lockdown.

Whilst this paints a more positive picture of the pandemic experience for autistic adolescents, it also raises concern as to why they needed to seek refuge from their daily life in the form of a global healthcare crisis. The findings collectively suggest important lessons could be learnt from COVID-19 that will positively impact the quality of life for autistic teenagers. These will likely involve a closer look at the demands placed upon them, tailoring support and intervention to the individual and a specific focus on education (further supported in Theme Two).

13.6 Theme Two: Negative Experiences of School

Despite the focus group asking no questions directly relating to school, the topic was consistently raised by participants with a focus on negative experiences within school and enjoying not having to attend during the pandemic. There is mixed findings in the literature in relation to school experiences and satisfaction for autistic young people. Research with autistic adults found their experience of school to be generally poor with reference to bullying and discrimination as well as lack of support and understanding (Parsons, 2015). This had longer term impacts with a significant association between poor school experience and perceived current life satisfaction. Participants also ‘felt disenfranchised compared to others in terms of the qualifications they obtained, the choices they had upon leaving school and the information they received to enable them to decide what to do next’ (Parsons, 2015, p.416). This also supports the current findings relating to disparity of support offers experienced by autistic adolescents (further discussed in Theme Three). Recently published research by Ozsivadjian et al. (2023) captured caregivers of autistic young people and autistic adolescents' experiences of school as overwhelming from a sensory perspective, socially difficult and lacking in appropriate support. The COVID-19 pandemic had brought some relief from these school-related issues and further support the current study's findings.

Additional school-related research conducted by L. Chapman et al. (2022) focused on experiences of masking in autistic adolescents. The findings suggest experiences of bullying and victimisation in school had led to some participants having to move schools, affecting their mental health and using masking as a protective mechanism from further bullying. Additional research by Renty and Roeyers (2006) found parental satisfaction in education support for their autistic child was lower when children attended mainstream schools, in comparison to autism-specific settings in Belgium. There was specific reference to a need for consistent staffing, reciprocal communication, staff enthusiasm and the child's individual needs to be understood and supported, for high satisfaction to be obtained. The results from these studies may further explain the current findings as the majority of autistic young people in the UK are educated in mainstream settings (Bond and Hebron, 2016) and may therefore not be provided with appropriate and individualised support.

The inclusion of autistic children in mainstream settings is intended to benefit both the child and their peers with increased opportunities to socialise and improved educational opportunities (Goodall, 2019). However, the DfE (2010) published data that identified SEND young people as significantly more likely to be excluded from schools due to behavioural difficulties than neurotypical children. This raises concerns for the current mainstream educational provision within the UK for autistic adolescents and may explain the findings in the current study.

Some research has identified ways in which schools can support autistic young people by adapting their provision or by developing specific provision with mainstream settings. Research by Bond and Hebron (2016) looked at successful resource provisions located within mainstream settings and found links with wider communities, multi-agency working, training and continued professional development and communication between all parties to be essential. A further study by Hebron (2017) emphasised the potential of transitions between primary and secondary to be positive if they are planned appropriately. This included considering individualised plans, inclusion of the young person and their family and autism awareness training for staff. Despite this research, the current findings suggest that something is lacking for autistic young people in UK schools and further research gathering autistic voices is essential to drive positive change.

Linked to Theme One and the changing nature of COVID-19, participants voiced a real struggle with the expectation they would just return to school and be able to cope. Participants did not mention any strategies or positive experiences of this return to school which may suggest either a limitation of the study in not asking specific questions, or a lack of support offered for returning to school.

During the COVID-19 pandemic within the UK, it was noted that some young people were struggling significantly and government guidance (DfE, 2021b) enabled schools to independently make a decision about who could attend the school site during the pandemic (children of keyworkers and those with SEND). This decision was often influenced by the staffing capacity and school site measures in keeping students safe and as such was often unpredictable; bringing more uncertainty to families. The participants in the study did not mention accessing school in-person during the pandemic, instead the focus remained on the return to school and so it is unclear if the students in the focus group were referring to the general return to school when they reopened in June 2020 and March 2021.

Given the negative experiences shared by many participants and the aforementioned research that school can be challenging for young autistic people, it is unsurprising there was a reluctancy to return. The specific mention of expectations to return and being able to cope with school again, suggest support around this transition would have been beneficial. Whilst it is important to acknowledge the urgency of schools to reopen due to concerns over academic attainment, specifically for autistic young people (Genova et al., 2021), the findings suggest attainment superseded wellbeing and the expectation to return was overwhelming and without support.

13.7 Theme Three: Understanding the Individual's Needs

Theme Three captured the varying responses of the participants in relation to their support needs and highlighted the importance of tailored support both therapeutically and more generally with parents and schools. There was specific emphasis placed on autism understanding through an individual lens. The findings add further depth and support to both Phase One and the findings from Study Three.

Persistent mention of tailoring therapy to the individual was evident throughout the focus group, with participants describing varying support needs and requesting flexibility, understanding, being listened too, acceptance and having enough time as essential aspects. Participants recognised their therapeutic needs could change based on how they were feeling and so advocated for the therapist to be able to work with them, not only ever offering one type of therapy or making assumptions/expectations over what they would need. These findings add further support and explanation to the findings from Study Three which found only half of participants who had accessed therapy had found it useful and cited reasons such as '*my therapist doesn't understand me'.*

It is noteworthy that these findings mirror the results from Phase One Study Two whereby therapists working with autistic adolescents also recognise the need to see the individual, tailor therapy, remove expectations and be flexible. This lends support to Study Four and suggests the need for future research investigating this tailored therapeutic intervention and the benefits for autistic individuals based on the spectrum nature of their diagnosis and respect for their autonomy in therapy.

Theme Three also captured the need to get to know the individual, irrespective of assumptions about their diagnosis and participants identified crucial aspects of therapeutic relationships that would enable this to happen. Collectively, the findings suggest a focus on the therapeutic relationship as essential and suggest this component of therapy is non-negotiable for autistic young people. Placing the focus on the therapeutic relationship provides an opportunity to consider alternate types of therapy such as nondirective therapy or relational ways of working. The therapeutic relationship has long been accepted as essential with Goldfried (2007, p.250) stating: 'Rogers emphasized the therapeutic value of a good therapy relationship. Over the years, clinical experience and empirical research has affirmed his thesis, such that most approaches to therapy now acknowledge what Rogers emphasized a half century ago'. However varying approaches to therapy place different amounts of emphasis on the relationship, with behavioural approaches typically underestimating the value of the relationship (Follette et al., 1996) or viewing therapist techniques as more important in bringing about change (Lejuez et al., 2005).

Based on the prior systematic review and Phase One findings recommending play therapy principles as a potential framework for nondirective ways of working, the participants in the current research responded to the play therapy guidelines as proposed by Axline (1969). Participant response was overwhelmingly positive, and a consensus was formed that they would be useful in therapy because they prioritised things that felt meaningful to them e.g., not being rushed, being accepted, being listened to. It is essential that future research investigates the efficacy of these guidelines for therapy with autistic adolescents to better support young people’s mental health in a way that is significant to them.

Similarly to the trends in the literature, participants felt there was a need for more autism understanding, awareness and training. These findings further support the quantitative data in Study Three that found participants thought there was a lack of understanding from others about autism and their mental health had been ignored because they were autistic. The findings also support the acknowledgment in Phase One of a current lack of training for therapists on neurodiversity. This related to the idea of individualising support for autistic young people, based on an understanding of the differing ways autism presents and the negative impact of others’ assumptions. There was also a perceived disparity in support offered which is echoed in the literature about disparity in diagnosis based on race, perceived need and socio-economic status (Wiggins et al., 2020).

Despite the increased awareness of autism globally (Zeidan et al., 2022), autistic adolescents in the UK are struggling more than ever and still feel misunderstood and let down by the support systems in place. It is crucial the findings of the current study are used to provide a platform for autistic voices in shaping future research and training for therapists and support providers.

The participants had a collective feeling that more mental health support should be available and repeatedly mentioned time in relation to waitlists, accessing, regularity or duration of support. These findings support the quantitative findings from Study Three that participants were either on a waitlist or their support had ended; collectively mirroring the findings from the Mental Health Commission (2023) report that waitlists are high and there is a lack of available services post-pandemic. The findings are mirrored in research by Batchelor et al. (2020) with N=376 UK university students also identified a call for reducing waiting times, more regular support, longer sessions and more support offered generally. Similarly, research with female veterans found beneficial mental health support prioritised giving more sessions and time to get to know the client instead of time-limited therapy (Campbell et al., 2023). Furthermore, Phase One identified therapists felt grateful for some organisation's policies and the flexibility of private practice as it allowed them to work in longer-term ways with clients. Therapists in Phase One recognised longer-term work was sometimes essential in order to build a therapeutic relationship with some autistic clients.

The waitlists and early cessation of support are a concern as early intervention for mental health problems in young people are widely accepted to result in favourable longer-term outcomes in adulthood (Honeyman, 2007). Long waiting lists and lack of support are likely to exacerbate mental health problems and increase the risk of suicide, antisocial behaviour and substance abuse (Honeyman, 2007) in this vulnerable population.

In relation to time and duration of services, participants disliked being rushed and having their support ended for them. There was an acknowledgement that more time may be needed as it might take longer to feel comfortable with someone new and to communicate with them. This finding may be explained as some autistic individuals experience alexithymia whereby understanding and communicating emotions is difficult (Kinnaird et al., 2019) and working with feelings is an essential component of therapy. The findings suggest that time-limited therapy may not be appropriate for all autistic young people based on possible challenges communicating emotions, a need for time to build safe relationships and that a choice should be given that enables them to feel in control of their mental health care.

Theme Three also captures participant recommendations of more support for parents and in school. Despite the literature being dominated by research into parent support and school interventions, participants still felt things could be improved which suggests the research findings are either not being implemented or the support suggested is not what autistic young people find helpful. The support centred around more awareness for parents and schools especially, which may have resulted in earlier support and diagnosis. This is supported in research by Crane et al. (2018) who found that parents of children who were going through the diagnostic process had limited understanding of autism and parents and autistic adults felt health professionals and teachers had limited understanding and awareness too. It may be that continuing to improve autism awareness in the general public and the inclusion of autism/neurodiversity in training courses for teachers, therapists and health professionals could mitigate this experience for autistic young people. The benefit of this may be earlier access to diagnosis and support, as well as earlier identification of co-occurring mental health problems; resulting in improved quality of life for autistic adolescents.

13.8 Strengths and Limitations

Despite the strengths of Study Three e.g., the relatively even-split among 13-17 year olds, there was only N=3 (9%) 11 and 12 year olds. This is likely to be explained by the ethics amendments that upped the age-limit for participation to 13 years in line with Gillick Competency. Whilst this was necessary to improve recruitment, this resulted in a sample skewed towards older adolescents and interpretation of these results towards younger adolescents should be approached with caution.

The sample in Study Three is also heavily skewed towards British and particularly White-British participants. The Office for National Statistics (ONS, 2022) found approximately 81.7% of the UK population to be from White ethnic groups and, of these 74.4% were White-British. The sample in the survey reflects higher rates than the UK general population; suggesting the sample may not be representative. Further research by Roman-Urrestarazu et al. (2022) suggests diagnosis rates for autism to be higher in Black or unclassified ethnicity groups from large-scale retrospective research, which was not mirrored in this sample. However this may be explained as Roman-Urrestarazu et al. (2022) also found that young people who spoke a non-English language or were from lower SES experienced more barriers in accessing autism diagnoses. This might explain the near non-existence of other ethnic groups in this sample as the inclusion criteria stated participants had to already hold an autism diagnosis.

Within Study Three there was a near even split between male/female participants. This differs from prior research that suggests boys are 4 times more likely to be diagnosed with autism than girls (Schuck et al., 2019) and therefore the representativeness of the sample may be questioned. However there are varying explanations as to why the diagnosis rates vary amongst genders such as increased masking of autism in girls meaning fewer or later diagnoses (Hull et al., 2017) and the autism diagnostic criteria historically being biased towards the male phenotype (Kreiser and White, 2014). Therefore, research on actual gender differences in autism is ongoing and inconclusive.

There were significant recruitment challenges which resulted in Study Three being open longer than anticipated and changes to the study protocol being required. Autistic adolescents were on this occasion particularly difficult to reach, which may explain the prior over-reliance on parent report in the literature. Although there is a growing-body of research that includes autistic adults as stakeholders and co-producers (Warner et al., 2019; Benevides et al., 2020), the researcher knows of only N=3 studies in the UK that capture autistic adolescents' voice (L. Chapman et al., 2022; Ozsivadjian et al., 2023; Hamilton et al., 2023) and research with autistic adolescents in other countries is very limited. The benefits of involving young patients/populations is being advocated for in recent research (Sharp and Walker, 2023) and as such it is imperative that a protocol for including their voice in research is investigated in order to continue meeting the research gap identified as a justification for this study.

Despite the pilot study aiming to assess the appropriateness and clarity of the questions asked in Study Three and Four, the researcher recognised that one of the questions asked in Study Three could have been interpreted as biased in their wording. The question asked: 'Are you getting support for your mental health? With the provided options of 'Yes' or 'No', yet omitted an option to state that mental health support was not needed. This potentially reflects the researchers viewpoint about mental health needs in autistic young people and suggests further reflexivity may have been helpful to identify this before the study had commenced.

A final potential limitation of Study Three is that N=15 (47%) participants answered *'yes'* when asked if anyone was helping them answer the questions, which may suggest the questions were not suitable for young people. Another concern is that adult responses may have biased the results. In order to mitigate this, the questionnaire instructed helpers to capture the exact words spoken by the adolescent which added to the ethical rigour of the research. Every effort to create a questionnaire that was accessible to autistic young people was made including the inclusion of adolescents in a pilot study and seeking consultation from a literacy specialist about age and ability appropriate wording. However, the N=15 participants who required support indicate there may be a population of autistic young people whom online surveys involving reading and writing is not accessible. There is a plethora of research that identifies autistic individuals as being more likely to also have a learning difficulty (LD). Data specifically within the UK (NHS, 2021) suggests co-occurrence rates of 28.6% for autism and LD, with individuals who have a LD being 21 times more likely to also be diagnosed with autism. The current study did not ask for information regarding LD status and so conclusions between these factors cannot be drawn. Despite this, the findings may go some way towards explaining the reliance on parental report when researching autistic adolescents that is prevalent in this field.

The researcher hoped to gain more participants for the focus group in Study Four and facilitate an open discussion to generate rich and detailed data. However, recruitment was slow and feedback suggested groups were anxiety-inducing. To mitigate this feeling, the participants who did attend chose to type their answers instead of holding a group conversation. This is a limitation of Study Four as the focus group may have gained more information had discussions have been held. Despite this, the study highlights the importance of tailoring interventions to young people and the findings identify that focus groups may not be accessible to this population. Further research should focus on better understanding the needs of autistic young people in research and co-creating studies that remove barriers to participation.

Collectively the findings from Phase Two suggest a need for future research to identify ways to improve participation and capturing of adolescent voice for a specific population of autistic young people. However, also highlights that for a significant portion of autistic adolescents, participating in research without a parent/carer is possible and continued efforts from researchers to achieve this should be made, to ensure their voices are heard.

13.9 Dissemination of Findings from Phase Two

The researcher intends to submit the findings of Phase Two from Study’s Three and Four separately to The Journal of Health Psychology and present the findings at the BACP

Children and Young People's Research Conference in 2024. The findings will also be distributed through peer and research networks to autism specific groups, counselling and psychotherapy networks and the University of Leeds Counselling and Psychotherapy Research Conference.

13.10 Future Research

The collective findings from Phase Two provide an appropriate and strong starting point from which future research with larger samples and differing demographics could begin. These studies would create a more representative picture of autistic young people's experience of mental health and therapy in the UK. Future studies should include young people in the creation of research designs to ensure the aims of the research are appropriate and the data collection methods are accessible.

Future research considering autistic adolescents experience of COVID-19 as a loss requires further investigation. The findings from this proposed study may expand the current study and better explain why this population of young people have been disproportionately affected by the pandemic. Collectively these results could shape therapeutic intervention that recognises the individuality of each autistic person and respects their therapeutic wishes. It is possible that the nondirective play therapy guidelines could provide a starting point for this research based on the current findings.

Study Four highlighted school as a challenge for the majority of participants. It was noteworthy that this theme emerged despite the researcher not anticipating this or asking about education specifically. The findings suggest autistic adolescents are struggling at school and further research to better understand the barriers to education and what adaptations are needed is necessary. It is important that any research gathers autistic adolescents' voice in shaping changes as there is already a large body of research into autism and education, yet the findings identify much more needs to be done.

In conjunction with Phase One, Phase Two also identifies an urgent need for improved autism awareness and training both in the general population and within therapeutic communities. Given the current poor mental health and negative therapeutic encounters experienced by the majority of participants in the study, training for therapists is identified as a priority. The current findings will shape the development of Phase Three to explore the training needs of therapists and the potential of nondirective play therapy guidelines as a training tool.

Of further interest N=5 participants identified as either transgender or non-binary, equating to 15.6% of the total sample size. This percentage is considerably higher than the statistic gained from the 2021 Census within the UK (ONS, 2021) which found 0.5% of participants identifying themselves as a gender different to the one assigned at birth. A higher rate of gender-diversity in autistic populations has been consistently found in research (Corbett et al., 2023; Hisle-Gorman et al., 2019; May et al., 2017) at around 4-7 times higher than control groups; suggesting an urgent priority for further research.

Recent research by Strang et al. (2021) compared data from N=27 transgender autistic, N=27 cisgender autistic and n=26 transgender neurotypical young people between the ages of 13-21 years (*M*=17.24). The results suggested 'ASD-gender diversity co-occurrence as associated with greater mental health burden overall than either ASD or gender diversity alone' (Strang et al., 2021, p.222). Collectively the gender-split in the current sample supports research that gender diversity is higher in autistic populations and raises significant concerns for a sub-population of autistic adolescents in regards to mental health challenges. Based on these findings and the researcher's experience in supporting the mental health of neurodiverse young people who identify as gender-diverse, an urgent need for further investigation into appropriate and individualised mental health support is identified. It may be that a larger sample would have found a similar percentage to prior research as all prior studies had larger sample sizes. However, there were also varying differences in methods e.g., reliance on parent-report or rates of gender diversity were gained from gender identity services, rather than the self-report method in the current study. The increased rates of gender diversity in this sample also provide support for the findings from practitioners in Phase One Study Two around increased rates of autistic young people in gender services. Collectively this suggests large-scale research with a gender-diverse group of autistic adolescents is required to better understand mental health needs.

13.11 Conclusion

Study Four extends the findings from Study Three and captures autistic adolescents' voice which is regularly missed in the literature. Phase Two collectively supports previous findings that co-occurring mental health problems are experienced at higher rates in autistic populations and COVID-19 has exacerbated this for adolescents specifically. The results from both study's attempt to understand this change and suggest that COVID-19 was characterised by loss and uncertainty which has implications for the type and duration of therapy offered. Phase Two expands these findings to consider nondirective therapy guidelines as potentially beneficial in supporting autistic young people's mental health. To add to the findings of Phase One that therapists are not trained on autism, autistic adolescents experience a limited understanding of autism in most aspects of their life and calls for further training and awareness for parents, therapists and schools were made. The findings conclude that further research investigating the efficacy of nondirective therapy in supporting autistic adolescents experience of loss, uncertainty and subsequent anxiety is necessary. In order to achieve this, research into therapist's training needs for offering nondirective therapy is crucial and as such the findings and suggestions around improved training, greater awareness and non-directive therapy gained from Phase Two will shape Phase Three's research with trainee therapists.

PHASE THREE

Chapters 14-17

Chapter Fourteen: Exploring Trainee Therapists Perceptions of and Associated Training Needs for Offering a Nondirective Therapeutic Approach Guided by Play Therapy Principles to Autistic Adolescents (Phase Three)

The findings from the prior studies (see Studies One to Four) presented in this thesis highlight a significant need for improved awareness and training on autism for therapists, justify the focus on autistic adolescents based on mental health statistics, and suggest the potential benefit of nondirective therapy for autistic adolescents' mental health post-pandemic. The following literature review explores the current training offer for therapists within the UK and highlights gaps in the research for further investigation. Chapter Fourteen concludes with the proposal of Phase Three Study Five which intends to build upon these findings and understand the perceptions of and training requirements trainee therapists have in order to offer a nondirective therapeutic approach for autistic adolescents.

14.1 Therapy Training in the UK

The two main professional bodies that accredit therapeutic training courses within the UK are the British Association for Counselling and Psychotherapy (BACP) and the United Kingdom Council for Psychotherapy (UKCP). Collectively the BACP and UKCP accredit approximately 160 training courses and organisations. The BACP (2023) outline a three-stage process to becoming qualified that involves an introductory course (usually 12 weeks), a certificate in counselling skills (usually a year part-time) and core practitioner training at a minimum diploma level (usually two years part-time). In contrast, the UKCP (2017) outline a minimum of four years training with an approved provider at Master's level. An accredited course ensures a minimum standard of skill and competency is gained, therapists work within an ethical framework and a pre-determined, research-driven curriculum has been followed. Accredited training often involves learning knowledge of theory, gaining competence in therapeutic skills and having some knowledge of research (BACP, 2023). Throughout an accredited course, trainees have to complete between 100 hours (BACP, 2023) or 450 hours UKCP (2019b) of placement, have regular supervision and attend their own personal therapy.

Despite the rules on accreditation, there is still significant variation in the content and length of training courses e.g., some courses qualify you as a CBT practitioner only or only enable you to work with children. In addition, each educational institute can dictate the completion requirements for trainees e.g., the researcher completed their training at the University of Leeds which requires 70 hours of personal therapy whereas training at Leeds Beckett University only requires 20 hours of personal therapy. This raises concern about maintaining standards of practice within the profession.

14.1.1 Non-regulation of Therapists

In addition, within the UK counselling and psychotherapy is an unregulated profession and so whilst there are professional bodies which offer ethical frameworks to adhere to, there is no standardised format of training or regulation over the use of the title ‘counsellor’ or ‘psychotherapist’. Worryingly, a review conducted by Priebe and Wright (2006, p.21) found a ‘lack of strict and statutory accreditation rules’ in the UK when compared to other European countries, Canada and Alaska. It is worth noting that there has been no updated research on this since 2006; potentially reflecting the neglect of this ethical issue and highlighting a need for updated research to better understand the implications of this finding. However, a report by the BBC (2021) suggested continued ethical issues with the lack of regulation of counsellors were still present within the UK and this was resulting in the exploitation of vulnerable people.

In contrast, counsellors in America are strictly regulated and have to obtain licenses to work in specific states and adhere to legal requirements. This has significant ethical implications within the UK, as the lack of laws and regulation enable anyone to use the titles and offer therapeutic services without receiving any accredited training. Individuals accessing counselling are usually vulnerable and struggling with their mental health which raises concern over the risk of potential harm that could be caused by an inadequately trained professional.

The two main professional bodies in the UK aim to mitigate these ethical concerns by accrediting specific courses in the hope that this increases confidence and maintains standards in practice. However, this relies on the general public holding an awareness of these professional bodies when searching for a therapist and therefore is not 100% effective in preventing harm. Both professional bodies have called on the UK Government to regulate the profession but this has been denied (BACP, 2020a) and as such there continues to be a plethora of unmonitored training courses and practitioners offering services that meet no professional standards.

14.1.2 Types of training

The differences in training lead to different experiences and knowledge held by trainees which impacts their subsequent abilities post-qualification and also their personal lives and sense of self. A literature review conducted by Daldorph and Hill (2022) found counselling training impacts trainees' emotional intelligence (A. Pearson and Weinberg, 2017) and their personal relationships (Pascual-Leone et al., 2013).

Whilst the BACP and UKCP have a loose curriculum for educational providers, how this is implemented varies between institutions and until 2021 there was no inclusion of specific teaching on neurodiversity. This teaching only became mandatory following the BACP (2021) annual general meeting where this motion was passed. Pre-2021, providers could choose whether to include training on working with neurodiversity and trainees could complete their whole courses without having any formal learning. Despite the motion being passed in 2021, there has yet been no guidance as to how to include this for providers and this is not officially checked by the BACP until institutions complete re-accreditation of their training programmes after five years of original accreditation. This has serious implications given the current estimated rate of neurodiverse individuals worldwide is 15% (Hutson and Hutson, 2023) and therefore therapists are likely to work with neurodiverse individuals in their career.

The previous systematic review (Casper et al., 2021, see Chapter Two) identified that the majority of research into therapeutic services for autistic individuals was biased towards directive therapies and behavioural research, specifically CBT, skills or parent training. The systematic review identified that this persistent focus on directive therapies meant that autistic adolescents were 'ignored, marginalised and medicalised in the therapy room due to a lack of individualised and tailored interventions that respect the spectrum nature of their diagnosis' (Casper et al., 2021., p.310). As research informs practice it is likely that the previous training (if offered) was informed by this research bias. Research conducted by Roudbarani et al. (2022) found the majority of therapists in their large sample of N=611 practitioners offered either CBT or directive therapeutic interventions. Further research by

Bottema-Beutel et al. (2018) discussed the links between social skills training, reduced authenticity and increased stigma for autistic individuals. This raises concern for continuing to train therapists in only these interventions. In addition, the findings from Phase One Study Two (see Chapter Seven) captured therapists' experience of the non-affirming or outdated theories that underpinned the minimal training some received. Others mentioned seeking further training post-qualification, in the form of continued professional development (CPD).

14.1.3 Continued Professional Development

An important part of therapeutic practice is CPD and both BACP and UKCP stipulate CPD as mandatory. CPD ensures practitioners are maintaining best practice and are up to date with research developments in their area of interest. This is monitored by the BACP with random audits of practitioners whereas the UKCP monitor CPD activity every five years when practitioners apply for re-accreditation. Until training courses were required to teach about neurodiversity, CPD had been the only way for therapists to gain knowledge in this area. The findings from Phase One Study Two alongside other research (Dougan, 2023) highlight issues with CPD courses as non-affirming or not co-created with neurodiverse individuals. The impact of this can be detrimental for clients' wellbeing and calls for 'participatory research that involves autistic people and their parents or caregivers in the design of interventions' (Lai et al., 2020, p.445).

14.2 Impact of a Lack of Training

A lack of training when working with neurodiverse young people can have a significant negative impact on the therapist's confidence and ethical practice (Maddox et al., 2019) as well as on the clients themselves (L. Chapman et al., 2022).

14.2.1 The Impact on Therapists

The findings from Phase One Study One supported recent research that identified that a lack of knowledge about autism impacted therapists' confidence and willingness to work with autistic individuals (Maddox et al., 2019; Lipinski et al., 2022). The qualitative Study Two in Phase One identified that therapists felt underprepared and lacked confidence to work with neurodiverse populations at the start of their careers. This raises concern over ethical practice as both the BACP (2018) and the UKCP (2019a) ethical frameworks highlight the importance of working within the practitioner’s competency level. This may be difficult to achieve without any formal training and will subsequently impact upon clients’ experience and the accessibility of therapy.

14.2.2 The Impact on Clients

A lack of autism understanding and adaptations for autistic individuals has been linked to poor mental health and low self-esteem (L. Chapman et al., 2022). The findings from Phase Two identified autistic adolescents had experienced a lack of autism understanding from others and believed their mental health had been ignored due to their autism diagnosis (see Chapter 11); potentially because their mental health problems had been misattributed as a presentation of autism. Participants in Phase Two also identified negative therapeutic experiences when their counsellor thought autism was the problem or they were not understood.

In addition, prior research has identified a lack of autism understanding from practitioners as a significant barrier to accessing mental health support (Adams and Young, 2021). This has serious negative implications given Phase Two Study Three also identified COVID-19 had significantly worsened mental health for autistic young people and as such access to appropriate therapeutic support is urgent. The findings from Phase Two Study Four also captured autistic adolescent voice in relation to the need for more autism training for therapists, and for there to be a range of support options that were not behavioural/directive or aimed at neurotypical populations.

14.3 The Need for a Spectrum of Therapies

The systematic review findings, alongside prior research and the results from both Phases One and Two highlight an urgent need for a range of therapeutic interventions to be offered to autistic adolescents in order to support their mental health. The revisions to the DSM V (2013) criteria (see Chapter One) recognise autism as a spectrum condition and the NHS (2023) states that ‘Autism is highly variable – the word ‘spectrum’ refers to how autism is experienced differently by different people. Autism is considered a spectrum because it’s different for every autistic person – some autistic people might need more support than others to live the lives they want to lead’. Altogether this suggests a move away from ‘continuing to over-prescribe behavioural interventions [as this] may be wasting resources and having a negative impact, for example disengagement or exacerbated mental health problems' (Casper et al., 2021, p.310).

It is widely acknowledged in therapy research that different orientations, modalities and therapists will suit individual needs. Research by Suzuki et al. (2021, p.142) found 'generalized micro-cultural differences within the United States, in which a culture in the Northeast [were] more attuned to propriety…in contrast to a more relaxed mode of living in the West' which influenced the type of therapy individual's accessed.

By acknowledging the autism spectrum and accepting that every autistic individual differs to another and therefore has different support needs, the researcher suggests a wider range of therapeutic interventions must be available. This increased offer would enable the tailoring and individualisation of therapeutic support that has been identified as necessary in the findings from both Phases One and Two. In addition, it would also embrace the intersectionality of autism and other elements of identity e.g., culture, race and class, which must be considered when offering therapeutic support (Dougan, 2023) and potentially provide a holistic therapeutic offer that supports the whole individual rather than targetted behaviours.

14.3.1 The Potential of Nondirective Therapies

The previous systematic review (Casper et al., 2021) identified that nondirective interventions were widely under-researched in favour of directive interventions for autistic adolescents. Despite this, nondirective therapy was found to be beneficial across a range of wellbeing domains and 'promoted holistic acceptance of the adolescent, encouraged self-acceptance, and improved mental health' (Casper at al., 2021, p.307). The findings also identified four commonalities across the included nondirective interventions that underpinned the approaches and reflected the core conditions of person-centred therapy (C. Rogers, 1957). It was also interesting that Play Therapy (Axline, 1969) accounted for 25% of the included nondirective interventions with autistic adolescents as the guidelines developed for play therapy were built upon C. Rogers (1957) core-conditions.

These findings identified the play therapy guidelines as worthy of research as a nondirective therapeutic approach for supporting autistic adolescents' mental health and influenced the development of this thesis proposal (see Chapter Two for more detail on the systematic review and play therapy guidelines).

14.4 Play Therapy Guidelines

The majority of research into autism and therapy focuses on directive interventions influenced by the history of autism and the ability to quantify and scientifically validate directive interventions. The definition of autism as outlined in the DSM V (2013) suggests two main difficulties (repetitive/restricted behaviours and social communication); implying play may be difficult for autistic individuals to engage in. This is supported in contested research by Chevallier (2012, p.5) who argues the ‘preference for collaborative activities is diminished in ASD’ due to ‘diminished social motivation’.

As such previous research has focused on teaching play skills (Goldingay et al., 2020; C. Kent et al., 2020; Doernberg et al., 2021; Pratiwi et al., 2020) with limited research on nondirective play therapy and its benefits for autistic individuals. Mastrangelo (2009, p.26) argues ‘the definition of play reveals that choice, freedom, and child-driven intentions are necessary components. This definition easily lends itself to support developmental models of play in which the adult is viewed as a facilitator rather than on models in which the focus is on predetermined structured activities or on a concentrated subset of skills’. This implies that behavioural and directive techniques using or teaching play may neglect the meaning of play for a child and that interventions should be child-led.

14.4.1 Research on Nondirective Play Therapy

There is some research detailing positive outcomes of nondirective play therapy with younger autistic children (Parker and O'Brien, 2011; Hancock, 2020; Salter, 2016; Josefi and Ryan, 2004; Schottelkorb et al., 2020). Schottelkorb et al. (2020, p.64) states: ‘the process of child-centred play therapy allows children with ASD to experience safety in a relationship, express affective arousal and dysregulation, and practice self-regulatory skills and varying forms of self-expression’.

Although this prior research is promising, most is relatively small-scale, conducted outside the UK, and ignores the potential role of play therapy with autistic adolescents. The prior systematic review identified N=3 (25%) studies that utilised either nondirective therapy (Lu et al., 2010) or a mixture of nondirective play and directive therapies (Müller and Donley, 2019; M. Kenny and Winick, 2000) with positive outcomes for autistic adolescents. This suggests there may be benefit in exploring the potential of nondirective play therapy with this client group.

14.4.2 Nondirective Play Therapy Guidelines

The aforementioned systematic review drew parallels between nondirective therapies offered to autistic adolescents and the nondirective play therapy guidelines proposed by Axline (1969, see Chapter Two). This research focus is also supported in recent, small-scale research by Maciejewska (2022) who investigated interactions between N=2 nondirective play therapists and N=2 autistic adolescents in Poland. The results indicated language use maintained the focus on the client and allowed the co-construction of the therapeutic intervention between client and counsellor; expanding the knowledge of how nondirective therapy looks in practice with this population.

The results from Phase One supported the use of nondirective therapy with autistic adolescents and highlighted the need for more and improved training for therapists when working with neurodiverse populations. The qualitative findings from Phase One identified the need for therapy to be individualised, tailored and collaborative; further supporting research into play therapy guidelines as a potential therapeutic approach.

These findings from Phase One informed the development of Phase Two which identified an urgent need for a range of therapeutic offers due to the experience of loss and uncertainty that characterised the impact of COVID-19 on autistic adolescents' mental health. The qualitative results from Phase Two captured autistic adolescents' wishes for therapy to be individually tailored and a consensus that play therapy guidelines could enable this flexibility and relational way of working. Similar to the findings from Phase One, Phase Two also indicated a need for improved autism and mental health awareness from professionals and therapists in the form of training.

14.5 Conclusion

In conclusion, this review has identified an urgent need for therapists to receive increased and improved autism training as part of their formal qualifications as well as highlighted the potential role of play therapy guidelines (Axline, 1969) in informing therapeutic approaches for autistic adolescents. Based on this and the findings from Phases One and Two, Phase Three Study Five aims to meet this research gap and gain trainee therapists’ perceptions of and identify the training needs associated with offering nondirective therapy to autistic adolescents guided by play therapy principles (Axline, 1969).

Chapter Fifteen: Phase Three Methodology

Phase Three encompassed Study Five which utilised a qualitative approach of a focus group with trainee therapists. Using an interview protocol (see Appendix X), Study Five explored trainee therapists' perceptions of and training needs for offering a nondirective therapeutic approach guided by play therapy principles to autistic adolescents. The study was descriptive and exploratory and therefore had no directional hypothesis.

15.1 Aims and Objectives of Phase Three

Study Five aimed to gain trainee therapists' perceptions of and identify the training needs associated with offering nondirective therapy to autistic adolescents guided by play therapy principles (Axline, 1969). The objective was:

1. Study Five: To conduct an online focus group with trainee therapists which gathered their perceptions and training requirements to offer a therapeutic approach guided by play therapy principles.

15.2 Focus Group – Study Five

15.2.1 Rationale

Study Five employed a focus-group method of data collection to better understand how trainee therapists perceived using play therapy guidelines as a model for therapeutic intervention and to understand the associated training needs of working in this way. Focus groups are frequently used in research with trainee therapists of varying orientations when reflecting on their learning (Blease et al., 2020; Bax et al., 2022; Lennie, 2007; Tribe, 2020) Consideration was given to the potential for individual interviews in contrast to focus groups as a method of qualitative data collection. Individual interviews have been shown to produce more items for data analysis in comparison to focus-groups however focus-groups tend to elicit more personal and sensitive data than individual interviews (Guest et al., 2017). As this study was interested in personal perceptions and training needs of individual therapists, a focus-group was chosen as 'this method is particularly well-suited to obtaining a variety of diverse perspectives…understanding, experiences and opinions' (Blease et al., 2020, p.2). For this reason, qualitative data collection eliciting richer data that elicited perceptions and understanding from participants was also favoured over quantitative data.

The current study utilised an online focus-group via the platform Microsoft Teams (Microsoft, 2023). Microsoft Teams has the ability to record and transcribe in real time, improving its utility for qualitative research. Research by Daniels et al. (2019, p.2) highlighted that ‘technological advancements now available to researchers can remove restrictions imposed by geographical barriers. This makes it possible for focus groups to comprise participants deemed most appropriate to address the research question and thereby enhance the rigor of a qualitative study’. It was hoped that an online focus-group would improve accessibility and participation in the research due to the flexibility of timings that was afforded. Furthermore, Microsoft Teams (Microsoft, 2023) enables live video streams which have been identified as mimicking of face-face focus groups with regards to the interaction data that is provided (Flynn et al., 2018). Collectively this suggests that online focus groups are an accessible method of qualitative data collection with trainee therapists and meet the current study’s aims.

Similar to Phase Two Study Four’s focus-group with autistic adolescents, the limitations of an online focus-group were considered in line with Brown et al’s., (2021) recommendations e.g., logistical requirements, technological difficulties, controlled environments and accessibility issues. As the participants in the current study were all trainee therapists attending the University of Leeds, they already held significant experience in accessing online platforms which mitigated the impact of using IT software and a need to be IT literate. The researcher offered technical support to participants beforehand to further remove any technological barriers and reminded them about the need for a confidential and a quiet space in which to participate. Although holding an in-person focus group may have enabled stricter control over the research conditions and additional data to be obtained from physical interactions, the recruitment pool of trainee therapists at the University of Leeds would not have enabled an in-person group to be offered based on geographical locations and availability.

Based on the previous research using this methodology, the philosophical framework and the researcher’s access to participants, as well as a lack of prior research addressing the current research aims, an online focus group was therefore chosen as the most accessible way to generate primary data.

15.2.2 The Focus Group Questions

The literature review identified prior research utilising focus-groups with trainee therapists which influenced the format of the interview schedule. Research by Gill et al. (2008, p.291) states that focus group questions should be specific and 'consist of several key questions that help to define the areas to be explored, but also allows the interviewer or interviewee to diverge in order to pursue an idea or response in more detail'. The focus group questions were influenced by the results from Phases One and Two; following the explanatory sequential approach (Maarouf, 2019). Similar to previous studies with trainee therapists, the interview schedule was short, specific and devised from the research aims due to the exploratory nature of the primary research; enabling thematic exploration of the data.

The semi-structured focus group schedule comprised of N=5 questions to elicit data about perceptions and training needs (see Appendix X). The questions asked participants N=4 questions about their perceptions of offering nondirective therapy using play therapy guidelines and N=1 question about their training needs to work in this way.

15.2.3 Focus Group Recruitment

The researcher is also a lecturer at the University of Leeds on the MA Psychotherapy and Counselling Programme which has 3 cohorts of students enrolled every academic year. It was hoped this would enable access to trainee therapists who may wish to participate therefore easing recruitment challenges. Recruitment was carried out in June 2023 with an email invitation sent to all enrolled students across the three cohorts on the MA programme. Participants were reassured that their involvement was voluntary and had no bearing on their studies (see Appendix Y) in an attempt to reduce social desirability bias or a sense of coercion.

Initially there were N=11 participants who consented to participate. The interview schedule was sent to participants beforehand to aid accessibility and inclusion. A poll was circulated to find a suitable time and date, which N=9 students responded to. Thursday 29th June 2023 at 11am was the most popular time for the participants and so was chosen for the focus group. Despite this only N=7 participants joined on the day and dropout was due to unexpected work or childcare commitments.

The researcher acknowledges Study Five was easier to recruit for based on access to participants. Furthermore, the focus group being online enabled participants across three cohorts to be involved which would not have been possible with an in-person group due to time constraints of teaching. In addition, N=1 participant was visually impaired and accessing the online focus group and the sharing of the interview schedule ensured inclusivity in the research. The current focus group size is in line with Gill et al's. (2008, p.293) recommendation that 'the optimum size for a focus group is six to eight participants'.

15.2.4 Analysis

The aforementioned research (Blease et al., 2020; Bax et al., 2022 and Lennie, 2007) informed the methods of qualitative data analysis that were considered. However, there was not one favourited method of analysis as the research aims were varied. Blease et al. (2020, p.3) utilised thematic analysis because 'focus groups encompassed questions on participants' knowledge, understanding, and attitudes' and was well-suited to gaining rich qualitative data. In contrast Bax et al. (2022) utilised a framework approach which 'starts deductively from pre-set aims and objectives' (Pope et al., 2000, p.116). Finally, Lennie (2007, p.10) employed grounded theory as 'grounded theory analysis allowed for the data to be segmented and quantified into the meaning units and overall themes that occurred most commonly'.

Research by D. Pearson and Vossler (2016, p.17) stated that 'it would be a mistake to assume that there is one 'right' or 'proper' way to do focus group research' and all analysis should be driven by the aims and philosophical framework of the study. In consideration of Study Five's aims and the pragmatic philosophical framework guiding the study, grounded theory or a framework approach were not deemed compatible. As such the researcher decided upon reflexive thematic analysis (Clarke and Braun, 2018). This approach (similarly to Phases One and Two) acknowledges the unique role and subjectivity of the researcher in developing an understanding of the data which is important to position as a strength of the analysis. Reflexive thematic analysis enabled the researchers dual positions and skills as a researcher, lecturer and therapist to be accounted for within the analysis.

A similar process to data analysis was undertaken (see Appendix Z1 for coding procedure) for Phase Three as in the prior two Phases and was guided by the outlined pragmatic framework (Chapter Three). The researcher began by repeated reading of the focus-group transcript. An inductive approach was taken whereby the initial codes were derived from the data in line with the exploratory aim of the research. When the researcher believed saturation had been achieved, subthemes were identified before the final themes were suggested. This followed a reflexive process as outline by Byrne (2022, p.1393) as 'themes are produced by organising codes around a relative core commonality'.

As this study is part of a doctoral thesis, the analysis was supervised, shared and fedback upon by two supervisors. It was acknowledged that 'there should be no expectation that codes or themes interpreted by one researcher may be reproduced by another' (Byrne, 2022, p.1393) but that there was benefit in sharing the analysis to achieve greater understanding of the data in a collaborative way. Both academic supervisors believed data saturation to be achieved and that the themes developed captured the meaning of the data.

15.3 Methods for Study Five

15.3.1 Participants and demographics

N=7 participants attended an online focus group. All participants were recruited via email communication from the researcher to trainee therapists at the University of Leeds (see Appendix D). There was an age-range of 26-45 years (*M*=37, *SD*=7.23) with a gender split of N=1 male and N=6 females. The inclusion criteria outlined that participants had to be trainee therapists. All participants were recruited from the University of Leeds and had completed an introduction to autism lecture. As such there was an understanding that a basic level of knowledge about autism, co-occurring mental health problems and the role of therapy was held by the participants.

15.3.2 Materials

Phase Three provided an information sheet (Appendix Y) an online consent form (Appendix Z) and a copy of the focus group questions (see Appendix X). The information and questions were emailed to the participants and a link was sent for them to provide informed consent online via Online Surveys (JISC, 2023). The semi-structured focus group schedule consisted of N=5 questions (see Appendix X) and the Play Therapy guidelines (Axline, 1969, see Section 16.1).

The focus group was conducted via Microsoft Teams (Microsoft, 2023). Microsoft Teams was utilised as the universities preferred method of online communication and the ability to audio and video record and transcribe as well as the researcher and participants' familiarity with the platform.

15.3.3 Procedure

Participants who had provided consent for involvement in Phase Three were contacted via email by the researcher and asked to complete a poll of availability. The participants were then resent the information sheet and focus group questions as a reminder. When a date had been agreed, the researcher sent a link to the online focus group on Microsoft Teams (Microsoft, 2023). The focus group was recorded and transcribed in real time. Participants were advised the group would take approximately 30-60 minutes.

The researcher shared her screen which showed the Play Therapy guidelines (Axline, 1969) and the N=5 questions. The researcher read the questions from this script and read each guideline in turn. Participants answered each question orally. The focus group lasted 45 minutes before participants were thanked for their time and reminded of their right to withdraw.

The researcher then read through the transcript alongside the recording and corrected any errors. The transcript was then uploaded to the University OneDrive system for GDPR compliant storage.

Chapter Sixteen – Phase Three Results (Study Five)

This chapter presents the qualitative results of Phase Three Study Five (for demographic information see section 15.3.1). Two themes emerged from the reflexive thematic analysis and are outlined in Figure 14. The individual themes and sub-themes are presented below with supporting quotes from participants. A narrative summary of how each theme related to the nondirective play therapy guidelines (Axline, 1969) is also included (please see section 16.1 for a reminder of Axline's (1969) guidelines).

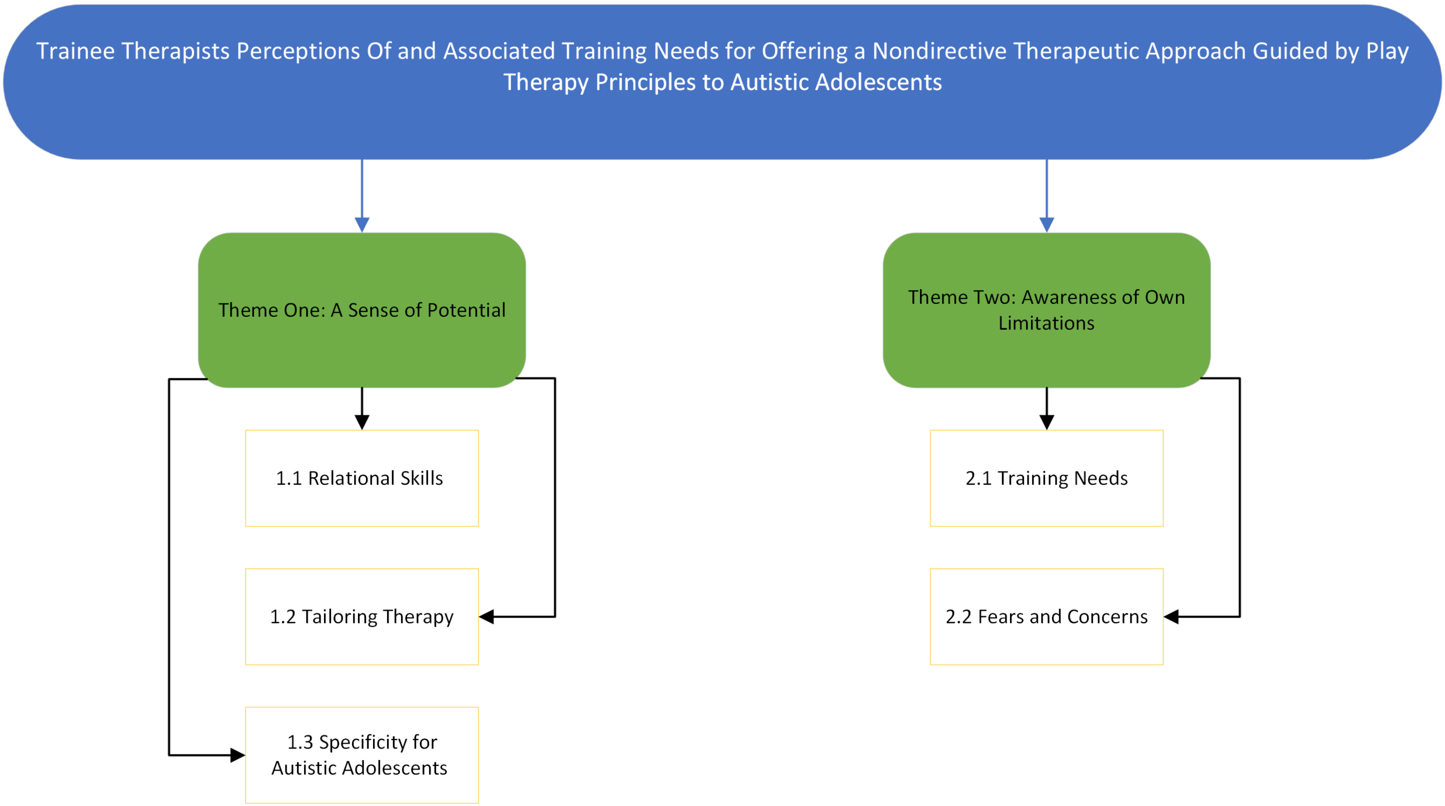


Figure 14: Thematic Map from Phase Three Study Five

16.1 Play Therapy Guidelines (Axline, 1969)

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child's exactly as he is
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognise the feelings the child is expressing and reflects those back to him in such a manner that he gains insight into his behaviour

5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and the institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognised as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.

16.2 Theme One: A Sense of Potential

Theme One captures the sense of potential that trainee therapists believed the guidelines could hold. There was a collective positive response to the guidelines content, using the guidelines in practice and receiving training on them as part of their qualification. This theme was split into three subthemes which are outlined in further detail below: 1) Relational Skills; 2) Tailoring Therapy and 3) Specificity for Autistic Adolescents.

16.2.1 Subtheme One: Relational Skills

The participants felt that the relational skills they had learnt or were learning as part of their formal qualifications were the foundations for these guidelines to build upon and an essential part of offering this therapeutic intervention. Participant One identified that *'it's like the training we already get'* and Participant Five felt it was *'similar to what we get at the moment'.* The participants also acknowledged the limitations they may face that would prevent them offering the relational skills and working in line with the guidelines, this will be discussed further in section 16.2.2.

There was specific mention of relational skills and theory that formed part of working therapeutically in this way, with Participant One identifying '*a person that has autism is a client, just like anybody else is a client and it's like non-judgement and you know all those things that go with the normal therapy relationship that we get in training anyway'.* This was also encompassed with the recognition that *'feelings of safety'*, *'strong, secure base'* and being able to *'trust the therapist'* (Participant Three) were essential for this therapeutic work. Furthermore, was the belief that the relationship should be co-created with a striving for shared power and equality between parties because '*as part of the relationship, this is not about me telling you what to do'* (Participant One). Participant Three further identified the need for the relationship to allow for *a 'conversation around how they can say when they're feeling misinterpreted'* and Participant Seven highlighted the need to *'be really clear that yeah, it's their right to challenge and to kind of say no'.*

In relation to the guidelines, participants explored how the relational skills they hold could support them to offer certain elements. The use of mirroring and attunement felt important when supporting expression of emotions with autistic clients (Guideline Six). Participant Two shared her experience of *'you kind of mirror what they're doing, but it's not like words. It's all just like movements. But I think if you can tune into like, even if they're just tapping or something and you can tune into that, that's really important to them and can be them expressing something'.* Being able to *'reflect back, the same kind of emotions and intensity to show that yes, it's acceptable'* (Participant Six) was also an important foundational relational skill to offer the guidelines. Finally, participants commented that *'maybe therapists attempt to fix someone with autism and it's about that respect, like they're not coming to be fixed'* (Participant One) and felt the need to be *'accepting of everybody anyway and what the bring'* (Participant Two).

16.2.2 Subtheme Two: Tailoring Therapy

The participants collectively felt that a nondirective approach informed by the play therapy guidelines would enable a way of working that allowed therapy to be tailored to the individual. This was linked to working in a relational way which '*gives them a sense of like you're following them rather than trying to lead something'* (Participant Two) and '*meeting them where they are in that moment'* (Participant Seven).

There was specific mention of adaptations to therapy for the client if trainee therapists had a *'general knowledge'* of autism that was underpinned by a belief that *'each individual is very, very different'* (Participant Two). With the knowledge of autism alongside the guidelines, participants felt adaptations that accounted for '*sensory and non-verbal needs in terms of communication'* (Participant Four) could be implemented and therapists could learn *'a different language that you need to discover with them'* (Participant Four). This may take different forms such as reduced expectations around eye-contact, *'being* *really comfortable with things like stimming'* (Participant One) and '*being happy to go with what the young person wants to get out of it and what they're feeling comfortable with, so things like they can sit where they want, they can play with whatever they want…and if they want to sit with a fidget spinner for the whole session, that's fine'* (Participant Five).

Participants also felt '*it's important to understand that every type of therapy won't fit everyone'* and to consider the move between *'directive and nondirective'* (Participant Three) because *'a lot of people with autism like structure. So it might be like how do they want, listen to them and how do they want to structure it'* (Participant Two). There was a sense that the guidelines would enable this flexibility and adaptive practice.

In addition to specific adaptations and tailoring of therapy, there was repeated mention of contracting in relation to the guidelines and how this could also be adapted for working with autistic adolescents. In particular, participants felt Guideline Eight (only establishes those limitations necessary to anchor the therapy to the world of reality and to make the child aware of his/her responsibility in the relationship (Axline, 1969)) could be covered in the contract explicitly by discussing *'clear boundaries that you have to still stick to, so we only have 50 minutes, that sort of thing'* (Participant Five). When considering Guideline Six (not direct the child's actions or conversations (Axline, 1969)), Participant Seven shared that *'I think explicitly explaining that maybe in the contracting…that this is not about me telling you what to do'* and also highlighting *'the young persons' right to challenge'.*

Participants also felt that Guideline Seven (not hurry the therapy along (Axline, 1969)) would enable tailoring of the therapy process to the individual client because *'it can take a while to build a relationship. I think for somebody with autism it can take several sessions for them to be like right, I feel safe'* (Participant Two) and the therapist *'not having a pre-set agenda is going to help show that they're not, you know, behind'* (Participant Five). Collectively, there was a sense that the guidelines could be added to, in order to highlight the need for tailoring therapy because *'autism is a very large spectrum'* and *'completely different in every way'* so *'this process will look different with each person'* (Participant Four).

16.2.3 Subtheme Three: Specificity for Autistic Adolescents

A strong tie into the sense of potential felt for the guidelines was linked to their perceived benefit for autistic adolescents specifically. The guidelines were described as *‘a kind philosophy’ (*Participant Six) that felt *‘feasible and seems like a really respectful approach’* (Participant Four). This was influenced by the links with the relational skills and ability to tailor therapy (outlined above) *‘because autism isn’t an issue to be fixed. They’re coming with their anxiety or depression or whatever it is they’re bringing. It’s like that respect for what they’re bringing rather than who they are’* (Participant One).

On the whole, participants perceived that the guidelines offered *‘an accepting presence’* (Participant Three) and created *‘the space to be who they are’* (Participant Two). It was recognised that this is important for adolescents generally as *‘a lot of the time as a teenager, you’re very much told how you should be and what you should be doing and where you should be and how you have to be all the time’* (Participant Two). In relation to autistic adolescents specifically it was noted *‘some individuals might be stigmatised, bullied or treat differently’* (Participant Three) and that some schools do not allow autistic expression e.g., stimming and so *‘that even with just 10 sessions that might just give them a little bit of like, actually I can be like this and I can be who I am and I don’t have to be ashamed of it’* (Participant Two). There was a suggestion that working in this way may allow the young person to accept and ‘*talk about that experience’* of being ‘*pissed off that you know, you’re treated differently in the outside world’* (Participant Five).

When discussing the guidelines, specific elements were highlighted as potentially beneficial for autistic adolescents. In relation to Guideline Three (establish a feeling of permission in the relationship so the child feels free to express his or her feelings completely (Axline, 1969)) participants felt this may help autistic individuals who mask because of *‘people pleasing and changing themselves for the other’* (Participant Three). When discussing Guideline Six (not leading but following child (Axline, 1969)) there was a sense that this could be a *‘new positive experience’* because *‘maybe in letting them lead that can mitigate the feeling that they need to be something else or change their behaviours or change who they are’* (Participant Three). Finally, Guideline Seven (not hurrying the therapy along (Axline, 1969)) might be beneficial *‘to help show that they’re not behind’* (Participant

Five). Collectively it was felt that this could encourage client authenticity, acceptance of themselves as they are and improve the mental health of this population.

16.3 Theme Two: Awareness of Own Limitations

Theme Two encompassed the trainees' thoughts and perceptions of working in this way in relation to themselves and their needs. Whilst the overarching message was that *'the benefits outweigh the cons'* (Participant Four) the trainees outlined areas for consideration which formed the subthemes: 1) Training Needs and 2) Fears and Concerns.

16.3.1 Subtheme One: Training Needs

The participants identified several training needs that they would have in order to offer a therapeutic approach informed by the guidelines. Having teaching on autism included in formal training was felt to be necessary by all the trainees. Suggestions as to how this looked included the training being *'incorporated a bit more'* (Participant Three) throughout the course and learning *'stuff based in research that's actually true'* (Participant One). There was a strong sense that teaching materials should be influenced by autistic voice and suggestions that trainees would like to *'hear lived experiences of young people who are autistic in counselling'* and autistic *'therapists and how that's impacted upon their approach to therapy'* (Participant Seven).

There was specific mention of learning about and being *'more aware of'* (Participant Five) different types of communication, sensory profiles and presentations of autism whilst *'acknowledging those unique individual characteristics'* (Participant Four). Trainees also felt that *'some training around common misconceptions'* was essential *'because there's a lot of stereotypes from what you see in the media'* (Participant One).

When using the guidelines to inform therapeutic work, participants felt they would need more clarity in training on starting therapy which might include a *'framework to establish where you begin'* (Participant Four) and some guidance on explaining *'the contractual stuff…or what the therapy relationship is'* (Participant Three) to the client. Participants also felt more clarity was needed for Guideline Eight: 'only establishes those limitations necessary to anchor therapy to the world of reality' (Axline, 1969). The participants felt they didn't *'really understand eight'* (Participant Three), in particular the *'world of reality'* (Participant Three) which led to a discussion that this likely inferred practical restrictions in the therapy room e.g., safeguarding, confidentiality and *'respect the time you've got'* (Participant Five).

This linked to participants feeling that there should be *'more of an emphasis on the difference of working with young people compared to working with adults'* (Participant Five) during training programmes. Participant Four suggested a focus on *'the emotional and social needs of an adolescent'* and an awareness that they *'might need some privacy around some things and be more reluctant to share. So just really honouring the boundaries of how sensitive topics can be at that age'.* In addition, participants felt that placements with young people were essential (if the trainee wanted to work in that way after qualifying) *'because it is so so different, regardless of autism, like contracting is so so different to contracting with adult clients. And I think you don't really get your head around stuff like that without doing it'* (Participant Five).

To build upon the suggestions for training, participants felt that *'the way you were assessed for recordings and stuff like that, would maybe need to change'* (Participant Five), if training courses were to incorporate these guidelines into teaching. There was also a sense that *'the university would need to take a lead on coordinating with placements'* (Participant Five) to ensure the placement was in support of the therapist's approach.

Finally, participants called for training to help navigate certain fears and concerns they hold around working in this way (see Subtheme Two below). Participants felt the training should include '*how to manage the time-limited nature of some* settings' (Participant Six), how to adapt outcome measures and how to communicate this to placements. Participant Five also felt trainers needed to give an *'acknowledgement that it is a harder part of it'* (working with adolescents) because '*there's so much they don't have control over by definition of being a child or a young person'* (Participant Five).

16.3.2 Subtheme Two: Fears and Concerns

The final aspect of being aware of own limitations relates to the fears and concerns trainee therapists voiced about working in this way. There was a recurring theme that '*it's difficult if…you don't have the luxury of time'* (Participant Three) and fears over how therapists could work in this way when *'my placement is limited to 10 sessions'* which can *'feel quite stressful' (*Participant Six). This linked back to the use of outcome measures that is often required by placement providers and concerns that '*bringing out a CORE form and* *that's like leading to an expectation that it's not a gradual process and you should have improved by last time'* (Participant One). Participant Four felt this might *'disrupt that nondirective process with a client'* and create feelings *'in conflict because you know that it doesn't match the way that the placement is asking you to track the clients progress'.* Participant Six had experience of this with a placement and shared that '*my supervisor helped me work out a way that I could meet the [placement's] needs without damaging my client'.*

Participant One also shared that a lack of '*experience and knowledge of autistic teens is the barrier for most of us'* and that therapists would need to be aware of their own perceptions and feelings when working in this way. Participant Four highlighted the necessity of '*the therapist becoming aware of frustrations that it's not moving faster and kind of learning…in supervision'.* This included *'not having an agenda'* (Participant Three) and *'reasonable expectations'* to ensure *'therapist frustration doesn't get in the way'* (Participant Four).

Finally, participants considered the limitations of therapy more generally and whether *'it might be more harmful than good'* (Participant Two). This led onto a discussion about ableism and that '*the idea is wonderful, but the reality is a bit crap…because if they're not gonna have that accepting presence elsewhere then it could be argued that we're setting them up to fail'* because *'the reality is very different to that'* (Participant Five). Participant Five shared that '*from my experience its harder to go from an environment where you do feel empowered and able to do everything. So I don't feel disabled in my own home but say if I go to try and get a job it feels like everything is held up against you'.* It was felt that this approach *'maybe needs to go wider than an approach to therapy'* (Participant Five) in reference to education and advocacy as well. Furthermore, this could be something for trainees to be mindful of and open to *'talking about that experience…that it's okay to be pissed off that you know you're treated differently in the outside world'* (Participant Five).

Chapter Seventeen: Phase Three Discussion (Study Five)

The following chapter discusses the qualitative results from Phase Three Study Five. The results are presented alongside suggestions of how the findings fill a research gap, extend upon Phases One and Two and identify future research opportunities. Limitations of the study and practical implications of the findings are also considered.

Study Five aimed to gain trainee therapists' perceptions of and identify the training needs associated with offering nondirective therapy to autistic adolescents guided by play therapy principles (Axline, 1969). There were two emergent themes identified as follows:

1. Theme One: A Sense of Potential: Theme One captured the perceived benefit that a nondirective therapeutic intervention guided by play therapy principles could hold for autistic adolescents. This sense of potential was linked to the use of relational skills as a foundation, enabling therapy to be tailored to the young person and its specific application for autistic clients.
2. Theme Two: Awareness of Own Limitations: Theme Two identified trainee therapists' thoughts and feelings in relation to them offering this therapeutic intervention. Theme Two captured the specific training needs and adaptations required to current training programmes as well as personal fears and concerns that therapists held about working in this way.

17.1 Reflexivity

The qualitative methodology of Study Five supports the inclusion of the researcher's reflexivity and subjectivity within data analysis. A similar process to that outlined in Studies Two and Four was followed and the researcher accessed clinical and academic supervision throughout the analytic process. Both doctoral supervisors oversaw and agreed upon the overarching themes and the conclusions drawn from the findings. In Study Five the researcher's position as a therapist, lecturer and researcher was influential and important to consider as an ongoing reflection point throughout the study development. The researcher was more aware of their role as a lecturer and the potential power imbalance this may have struck when conducting research with their own students and actively sought to mitigate this with guidance from the ethics council. The researcher was also aware of their hopes for the research to extend the findings from previous phases and the frustrations around recruitment and time pressures for completing the doctoral research. As such it was important for the researcher to approach Study Five with neutrality and receptiveness to whatever findings were gained. The researcher attempted to do this by viewing Study Five as research in its own right and separate to the previous studies for the course of data collection and analysis, whilst still acknowledging their intentions and the philosophical framework that drove the research.

17.2 Theme One: A Sense of Potential

Theme One captured the sense of potential that participants felt a nondirective therapeutic intervention guided by play therapy principles held for autistic adolescents. There was a feeling of inherent benefit, respect and kindness that was associated when supporting young autistic clients in this way that links to an affirming way of practice. In support of the benefits of affirming therapy, research by Pantazakos and Vanaken (2023, p.1) outlined that 'approaches focused on reducing autistic 'symptoms' are unlikely to solve the problem, as autistic mental health is positively correlated with autism acceptance and perceived quality of support provided…the development and dissemination of neurodiversity-affirming clinical interventions is key for addressing the autism mental health crisis'.

The findings from Study Five suggest that trainee therapists believe the relational skills they have been taught or are currently learning could provide the foundation from which to offer the proposed therapeutic intervention. This is supported on the basis of the nondirective play therapy principles (Axline, 1969) being 'grounded in the philosophy of relational humanism' (Ray, 2019, p.68). Relational humanism is 'the belief that the self-actualizing tendency within a person is activated more fully through connection with others' (Ray, 2019, p.76) and this encompasses the acceptance, respect, trust, authenticity and lack of agenda that the trainees outlined as relational skills that supported this therapeutic intervention.

Offering a therapeutic intervention that is built on these relational skills has been repeatedly shown to be effective for supporting client wellbeing since C. Rogers (1957) first proposed his person-centred theory. For neurodivergent young people, the use of relational skills and prioritising the therapeutic relationship moves away from the concept of a 'neurodivergent deficit' (R. Chapman and Botha, 2023, p.313) proposed by medical models of disability. An affirming therapeutic intervention rejects the idea of 'normalisation' and suggests that 'Clinicians should, to the extent that this is possible, depending on communication difficulties, follow the guidance of the neurodivergent individuals regarding what they are in the therapeutic space for, and why' (R. Chapman and Botha, 2023, p.314). The findings from Study Five suggest trainee therapists believe the proposed therapeutic intervention could enable practitioners to work in this affirming way.

This directly opposes common practices such as Applied Behavioural Analysis (ABA) which 'focuses on the normalization at the expense of autistic thriving and well-being, often addressing behaviours which autistic people themselves find non-problematic' (R. Chapman, and Botha, 2023, p.314). Further research by R. Chapman and Bovell (2022) supported the development of affirming therapeutic practices based on preliminary research that ABA can lead to trauma and mental health difficulties for neurodivergent individuals. This is due to an increased need for masking, teaching a neurotypical way of being as superior and viewing autism as something to 'treat' which impacts on individuals sense of worth and self-esteem (Bottema-Beutel et al., 2018). Altogether this highlights an urgency for alternative therapeutic interventions to be offered that are affirming, utilise a relational way of working and aim to support the mental health of autistic adolescents'.

In further support of this, the findings from Phase Two Study Four highlighted autistic adolescents' wishes for therapists to offer understanding, acceptance and time (see Section 13.7.1) which mirror the relational way of working that trainees felt could underpin this nondirective approach. The current findings suggest the proposed therapeutic intervention may provide guidelines for therapeutic work that would meet this need; effectively supporting autistic adolescents' mental health.

In viewing the relational skills as the foundations of this approach, it implies that the guidelines may be implemented by any therapist/trainee therapist who has learnt a relational way of working. This improves the accessibility of this approach to a wide range of therapists dependant on their orientation. In support of this, the therapeutic orientation data gained from Phase One (Study One) identified 69% of participating therapists were person-centred/relational; suggesting that this approach could be widely undertaken and offered. However further research mapping the current therapeutic orientation split of qualified therapists in the UK and also of training courses would be required before conclusions could be drawn.

Finally, the previous findings from Phase One Study Two identified that newly qualified therapists may not feel confident to work with autistic adolescents as confidence seemed to be gained from experience and this posed a barrier to accessing therapy for clients. The current findings suggest that trainees on relational courses may feel more confident to work with autistic young people if the relational skills are framed as the building blocks of the proposed guidelines. Whilst it is important to acknowledge relational skills alone are not sufficient (see Section 17.3), the findings suggest a starting point from which training courses and future research could mitigate this lack of confidence and improve therapeutic access for autistic teenagers.

The participants in Study Five believed that the play therapy guidelines had potential for tailoring therapy to the individual client with the amendment of Guideline Eight (see Section 16.1) and an additional guideline stipulating the individuality of this approach. There was also specific reference to allowing the adolescent to lead the therapeutic process. This was mirrored in the findings from Phase Two Study Four that highlighted autistic adolescents viewed the guidelines positively as it enabled them to use therapy in a way that prioritised what was important to them. Allowing the child to lead and tailoring therapy to the individual 'sends a powerful message to the child that the counselor believes in the child and trusts the deepest instincts of the child' (Ray, 2019, p.77).

Proctor (2018) suggests tailoring therapy to the individual offers a dynamic that encourages 'power-from-within' and 'power-with'. These dynamics support an inner strength that is characterised by a sense of agency and value within the client and a belief that they will be listened to and have equal contribution, respectively. This approach varies significantly from a 'power-over' intervention whereby there are hierarchical systems in which those with perceived authority/power make decisions for others. Proctor (2008, p.240) explains power-over in relation to 'the therapist is believed to be in a better position to decide what the client needs than is the client'. In addition, Proctor (2008, p.242) raises concern over the CBT approach whereby 'the goal of therapy to encourage the client's 'power-within' is not consistent with the means of the therapist's 'power-over' the client'. The potential for CBT therapists to have 'power-over' clients raises concerns for the development of autonomy and authenticity which is essential for self-esteem and positive mental wellbeing (L. Chapman et al., 2022). This is perhaps more necessary for autistic adolescents based on the systemic and societal barriers they face.

The idea of 'power-with' and 'power-from-within' also support a move away from treating autism. Trainees in Study Five felt the ability to use the guidelines to tailor therapy created a safe space where autistic adolescents are *'not coming to be fixed'* (Participant One). This finding was echoed in results from both Phases One and Two; lending further support to an affirming therapeutic approach. The intervention offers the flexibility to accept the client and get to know the individual. The benefits of this are supported in research by Cage et al. (2018, p.482) who suggests 'mental health difficulties in autistic individuals can be protected against by improving autism acceptance' and are actively being called for from the autistic community (Autistica, 2021).

The tailoring of therapy informed by the guidelines also involved an acknowledgement of adaptations such as sensory amendments to the physical space, awareness of different communication styles (including non-verbal language) and the need for time to get to know the young person. Tailoring therapy in this way moves away from the deficit-based approach that the problem lies with the autistic individual and instead posits difficulties as 'relational rather than intrinsic to neurodivergent people' (R. Chapman and Botha, 2023, p.313). In this way, therapy has the potential to reduce the stigma associated with poor mental health for autistic young people (Makita et al., 2021; Bottema-Beutel et al., 2018) and provide a supportive and inclusive space. R. Chapman and Botha (2023, p.313) further highlight that a 'successful clinical relationship should be built upon an accessible environment (including as access needs shift), a collaborative relational experience, and epistemic humility that acknowledges the limitations of non-insider knowledge'. In this way tailoring therapy and adapting therapeutic spaces could contribute to 'cultivating ecological niches to help enable neurodivergent individuals and groups—that is, making space for everyone regardless of how they experience life'. (Singer, 1999 in R. Chapman and Botha, 2023, p.313).

Furthermore, the current findings lend support to the results from Phase One that collaboration and co-creation are beneficial when working with autistic adolescents. The current findings extend previous knowledge by proposing practical therapeutic guidelines that have potential to shape a collaborative relationship. Further research is required to understand how this might look in practice and assess the efficacy and benefit of working in this way.

Finally, trainee therapists felt the guidelines enabled them to tailor therapy, but this was reliant on taking time to get to know the young person. This is supported in both Phases One and Two with a consistent mention of time and not rushing the therapeutic process as important for both qualified therapists and autistic adolescents. However, concerns were raised around the practicality of this in placements and time-limited therapy settings (see section 17.3.2 for further discussion.

In addition to the aforementioned findings, trainee therapists felt the play therapy guidelines as a basis for a therapeutic intervention with autistic adolescents held specific benefit for this population. This encompassed the belief that autistic adolescents experience ableism, stigma and a lack of understanding outside the therapy room. This is supported in the findings from Phase Two Study Three whereby adolescents felt they were misunderstood or their mental health was ignored due to being autistic.

The participants in the current study mentioned the benefit of creating a safe environment that reduced the need for autistic adolescents to mask or change themselves. This has potential benefit as research by Botha and Frost (2020) identified that concealment/masking predicted poor mental health in N=111 autistic adults. In addition, research by Bradley et al. (2021) found the same results from a larger sample of N=277 autistic adults and extended the findings to consider that a lack of awareness and societal understanding was the biggest contributor to masking. Therefore suggesting, that there would be inherent benefit in having a space where this was not essential and clients could be themselves and create a positive autistic identity that may act as a protective factor for mental health (K. Cooper et al., 2017).

The provision of this accepting and safe therapeutic space may not only be beneficial due to a lack of other spaces available to autistic adolescents, but also due to their adolescent status. Trainees recognised the lack of control that adolescents have over several aspects of their life and how beneficial this space may be given the child-led nature outlined by the play therapy guidelines. Similarly to the findings from Phase Two Study Four, research by Lavik et al. (2018) identified that adolescents value a therapeutic relationship that is based on equality, trust and connection and this has links to positive therapeutic outcomes. Further supportive research by Pearce and Sewell (2014, p.30) ‘found that the ‘presence’ strived for in a person-centred approach can often be unique in the young person’s world, where some adults may either have been absent or may have related on their own terms and were therefore not able to step into and honour the young person’s world as they see it'.

Collectively the findings from Study Five (and Studies One to Four) suggest that a therapeutic approach guided by play therapy principles may provide an accepting and safe space for autistic adolescents to experience a different type of relationship, develop a positive sense of autistic identity and protect against mental health difficulties. This has significant implications based on the current poor mental health state of autistic adolescents in the UK, identified from Phase Two. Further research that is co-created by autistic stakeholders and investigates how this therapeutic approach may look in practice as well as the efficacy of this support, is both urgent and necessary based on the current findings.

17.3 Theme Two: Awareness of Own Limitations

Theme Two captured an additional and alternate perspective to what was identified from Theme One. Whilst the underlying feeling was that *‘the benefits outweigh the cons’* (Participant Four), trainee therapists recognised there were limitations to their practice that may prevent them from offering this therapeutic approach.

Theme Two identified a large array of training needs that participants felt were essential in order to work in this way. Participants highlighted that the guidelines could be added to in order to emphasise to trainees and practitioners that ‘*this process will look different for each person’* (Participant Four). In this way the guidelines would be adaptable to individuals, enable therapy to be tailored and respect the spectrum nature of autism.

In relation to the formal training course content, participants identified that training about autism, common misconceptions and the spectrum nature were essential and should be embedded throughout the course. This finding is supported from Phase One and Two in which therapists identified a need for good quality, research-based and autistic co-created learning and adolescents called for therapists (and other professionals) to better understand them. In Study Five there was specific mention of autism awareness that included different presentations, communication styles and sensory awareness but also a wish for this to be informed by autistic-voice and be research-based. Participants felt that media often displayed misconceptions that led to biases and stigma. This finding is supported in research (Mittmann et al., 2023) that suggests typical media sources such as newspapers and TV portray autism in a stereotypical and negative way which increases the stigma experienced by autistic individuals. In contrast Mittmann et al. (2023, p.7) also found that 'social media tends to portray autistic individuals more positively, this pat tern may be explained by the fact that social media platforms are more likely to feature content created by autistic individuals themselves'. This is further supported in research by Bury et al. (2022, p.1) who found that 'learning about autism from conventional sources (e.g., professionals, parents) was associated with more internalised stigma, lower endorsement of special abilities and autism identity, whereas online blogs and social media showed the opposite pattern as well as more accurate knowledge of autism'.

Collectively the findings suggest there is a need for training courses to include knowledge about autism that is based in research but also highlights the impact of the type of knowledge shared. The implications of Study Five place pressure on training providers to include theory and learning on autism from a strengths-based perspective that supports the individuals' uniqueness and promotes a positive autistic identity.

In addition, participants felt that offering this type of therapeutic approach would have implications for placement opportunities whilst training. As outlined in Chapter 14, trainee therapists have to complete a minimum of 100 hours placement before qualifying, as part of their formal course. Trainees in Study Five identified that placements would need to be aware of this approach and buy-in to this way of working. This would likely have implications for time-limited placements (discussed in Section 17.3.2) as well as ways of contracting and using outcome measures to monitor progress.

The concern around outcome measures is supported in research by Proctor and Cahill (2021, p.169) who utilised outcome measures with an autistic client and concluded 'outcome measures are not suitable for clients with a diagnosis of ASD or perhaps some clients with this diagnosis, and indeed, their unsuitability means that their use constitutes ableism'. This finding is further supported in research by Brugha et al. (2015) who conducted a systematic review of outcome measures and found a distinct lack of standardised measures or measures that had been adapted for evaluating outcomes with autistic adults. Altogether these findings suggest a need for further research into how appropriate validated outcome measures are for autistic populations and furthermore whether outcome measures are applicable to an approach guided by play therapy principles. This will likely have implications for placement and therapeutic organisations who rely on documenting therapeutic progression for funding purposes and suggests a much wider systemic change to training providers, policy and supporting autistic adolescents therapeutically may be needed.

Trainees also commented on the adaptations for contracting which tied into adapting practice to working with adolescents. There was a sense that working with children and young people is distinct to adults and further training should be provided on adapting practice to these groups as well as autistic clients specifically. There was a general concern as to the lack of regulations around working with young people and the consequent lack of training provided on a standard course in relation to adolescent/child development, different relational needs and implications for the therapy room. Although there are specific training courses in the UK aimed at working with children and young people, the lack of regulation in the profession doesn’t require any therapist to complete specific training. Both the BACP and UKCP highlight the need for therapists to hold specific competencies when working with this age group but currently there is no legal requirement to do this.

This is concerning based on the differences in working across age groups as identified by M. Cooper et al. (2013, p.277) who suggests that ‘children and young people engage, process and communicate in the therapeutic relationship in ways that can relate to their particular developmental stage’. These findings further highlight that if providers are to offer training on this approach to therapeutic working, additional guidance about working with adolescents as well as knowledge about autism is essential.

Participants in Study Five also shared their reflections on working in this way and their worries relating to the approach. The need for time was a consistent theme throughout, with participants querying the benefit of the approach if certain placements or organisations offered time-limited therapy e.g., 6-12 sessions. This finding is mirrored in Phase One whereby some therapists recognised the flexibility they had in private practice and viewed time as a luxury. Other therapists in Phase One felt that a nondirective approach to therapy was not always possible based on their setting which further supports the current findings. The importance of time was also picked up in Phase Two Study Four with adolescents requesting more time in therapy, a wish to be understood without being rushed and to be able to direct the therapy towards things that were meaningful for them. This potential concern is supported in research by Renger et al. (2020) who found that nondirective therapists who (due to funding pressures) were required to restrict their therapy offer to 6-8 sessions felt there was not enough time and found themselves relying on directive approaches.

This highlights a potential limitation with the proposed therapeutic approach in that it may not be applicable to time-limited settings. This was also linked to a fear from trainees that in a time-limited setting, offering this approach may not be enough and '*could it be argued that we're setting them up to fail*' (Participant Five). Trainees reflected that this was linked to their frustrations that '*you can have an accepting presence in the therapy where in reality is that you know the individual might be stigmatised outside the therapy*' (Participant Three). This suggests the participants are aware of the ableism their clients may face and this limits how much they could help them. As the discussion progressed, participants in Study Five felt that their concerns about working in this way in time-limited settings related more to their agenda and concerns over outcomes than what was helpful for the client.

It is possible this finding can be explained as feelings of increased responsibility by the therapist due to their awareness of ableism in society and the impact of this on client wellbeing. This is supported in research which considers therapists feeling responsible for their clients at times of crisis or distress e.g., suicide attempts (Levkovich and Vigdor, 2021) and in qualitative research by Whitfield (2011) with N=6 therapists. The results suggested that despite therapists believing they were responsible to their clients instead of for them, at times of significant distress, therapists did take on responsibility for their clients and the outcome of therapy. This is an important consideration point for offering a therapeutic approach guided by the play therapy principles and raises the importance of supervision and support for therapists during practice and training. The trainee therapists in Study Five did share experiences of using supervision as a support network and to help them adapt their practice for neurodivergent clients. Furthermore, the concern for clients experiencing stigma outside of the therapy room despite feeling accepted within the therapy space is not specific to autistic clients only. Clients from other marginalised groups e.g., transgender clients (Lewis et al., 2023), clients from ethnic minority groups (Kapadia, 2023) or clients experiencing abuse (Saboury Yazdy et al., 2022) are also likely to face challenges outside of therapy but this does not diminish the potential benefit of therapy on mental health.

The issue of time and how effective this approach may be in a time-limited manner is important when considering practical implications. There is a plethora of research supporting the effectiveness of short-term therapy and the cost-effectiveness of this (Maljanen et al., 2012; Abbass and Katzman, 2013; Hedman et al., 2012) The prior systematic review (Casper et al., 2021) identified a significantly larger research pool for short-term therapeutic interventions which informs therapeutic provision. However, the effectiveness of short-term interventions is commonly based upon comparisons with waitlist control groups and follow-ups at one year. In contrast, a study conducted by Maljanen et al. (2016) comparing outcomes of short and long-term therapy at both one and five year follow-ups suggested that whilst the costs were higher for long-term therapy the outcomes for clients were greater at the five year follow-up. This may suggest that longer-term therapeutic interventions are more cost and time-effective in the long run if clients are not returning to therapy due to maintained improvement in wellbeing.

Furthermore, the research considering the effectiveness of short-term therapies for autistic clients (mainly CBT) is mixed, with no conclusive answer that CBT is actually beneficial, especially when used to support affective disorders e.g., depression, anxiety and OCD. A systematic review of N=17 studies conducted by Weston et al. (2016) found no significant effect of CBT for affective disorders across all ages of autistic participants based on self-report measures. Collectively the aforementioned research and results from the current study suggest that there is much wider change on both a policy and societal level that needs to be implemented. These changes should account for the overall cost and time-effectiveness of short vs. long-term therapy for autistic adolescents which may impact on organisation's therapeutic provision.

17.4 Strengths and Limitations

The use of reflexive thematic analysis (Braun and Clarke, 2019) is a strength of the current research as it enabled rich, detailed data to be gained from which emerging themes were identified and implications for practice and research could be drawn. Reflexive thematic analysis also positions the subjectivity and reflexivity of the researcher as a strength and recognises the influence on the findings gained. To ensure quality in the thematic analysis the researcher followed guidelines and appraised the analysis based on Braun and Clarke (2021b) suggestions and through discussion with academic supervisors. The exploratory nature of this primary research required an inductive approach to data analysis which fit with the chosen methodology and aligned with the philosophical framework outlined in Chapter Three. Finally, Study Five meets an important research gap and the findings extend the prior studies' conclusions, about the potential benefit of a nondirective therapeutic approach informed by play therapy guidelines.

The main limitation is the potential lack of representation of trainee therapists' views based on the participants being recruited from the University of Leeds only. The participants included were all being trained in a relational model of therapy which may limit the generalisability of these findings to other therapeutic orientations. Whilst this participant pool ensured the research was completed in a timely manner as part of this doctoral thesis, the findings would be strengthened by including a range of trainees from different courses and different therapeutic orientations. It may be that trainee therapists on courses at other institutions hold different views towards the proposed therapeutic intervention. This would have important practical implications and should be considered in future studies of accessibility or efficacy of this therapeutic intervention.

A further limitation could be that the participants' views may have been influenced by social desirability bias based on their connection to the researcher as students and their knowledge of the researchers' interests in this field. However, every aim to reduce this was made using guidance from the School of Healthcare Research Ethics Committee and clear statements were made about participation being voluntary and separate to their studies in the information sheet (see Appendix Y).

The focus group was conducted online which enabled increased participation due to the flexibility of time and lack of location demands. This is supported in research by

Zwaanswijk and van Dulmen (2014) who found that adult participants perceived online focus groups to be advantageous due to the convenience of time and participating from home. Despite this, there may have been greater depth of information shared if the focus group had been conducted in person as it may have been 'easier to have a discussion with the whole group when there is personal contact with others' (Zwaanswijk and van Dulmen, 2014, p.1). However, the participants were already acquainted with each other and the researcher through their studies, so it is hoped that personal contact was already established. The online focus group in Study Five also used audio-visual technology so the participants could see and hear each other in real time. There is a growing body of evidence that suggests this produces the same richness of data (Abrams et al., 2015) and quantity and quality (Underhill and Olmsted, 2003) in comparison to face-face groups; highlighting the strengths of this approach to data collection.

17.5 Dissemination of the Findings from Phase Three

The researcher intends to submit the findings of Phase Three to the Journal of Counselling and Psychotherapy Research based on the relevance this journal holds for both trainee and qualified therapists. The researcher also hopes to present this work at both the UKCP and BACP Research Conference in 2024. The findings will also be shared to peer and research groups including autism organisations, counselling and psychotherapy networks and the University of Leeds Counselling and Psychotherapy Research Conference.

17.6 Future Research

Phase Three identifies several opportunities for future research based on the findings. As the trainee therapists believed the suggested therapeutic approach to hold benefit for autistic adolescents, a further study informed by the thematic analysis findings to assess the efficacy of the proposed approach is worthwhile. This study should be co-created with therapists and autistic clients to ensure the research is meaningful for the population it seeks to benefit. There are numerous advantages of including service-users in research design such as 'identifying potential issues that may not have occurred to the researcher' (Gordon et al., 2018, p.2) and recognising 'the value of ''expertise by experience'' is a potentially validating and affirming notion for service users' (Telford and Faulkner, 2004, p.552). The findings of this future research may enable a greater understanding about therapeutic interventions for autistic adolescents which have the potential to influence wider policy change and therapeutic services.

Another essential future study should consider implementing the findings from Phase Three into a revised training offer for trainee therapists and evaluating this change. Phase Three identified several areas in which adaptations to the current training offer would need to be made in order for trainee therapists to feel confident to work in this way e.g., learning materials, placement considerations and the use of outcome measures with clients. Further research should investigate how this could best be attained through consultation with education providers, trainee and qualified therapists and the autistic community. The findings from this proposed study may inform educational offers of training for therapists that are neurodiversity affirming and develop confidence within practitioners to work with this population. This is beneficial based on the findings from Phases One and Two and in the longer-term could improve access to therapy for a currently marginalised group of young people.

Finally, replicating the current study with a larger sample of trainee therapists from different educational establishments would enable conclusions to be drawn as to the accessibility of this approach for therapists. This research may increase the understanding of the use of relational skills as the foundation of this nondirective therapeutic approach, guided by play therapy principles. The results from this research may inform future training content and provision, in a way that improves therapeutic access and outcomes.

17.7 Conclusion

In conclusion, Phase Three both supports and extends prior research and the results from Phases One and Two. Phase Three identifies that a therapeutic approach informed by the play therapy guidelines could be a viable way of working with autistic adolescents based on the use of relational skills as a foundation, the ability to tailor therapy to the individual and the perceived benefit of encouraging autistic clients to be their authentic selves on mental health. In order for trainees to feel confident to work in this way, several adaptations to training courses were suggested which informs suggestions of future research. The findings from Phase Three meet an important research gap in the literature around therapeutic approaches for supporting autistic adolescents’ mental health which holds significant benefit based on the findings from Phases One and Two. Consideration as to how the collective findings of this research can inform future investigation and practice is outlined in Chapter 18, which provides an overall conclusion to the research as a whole.

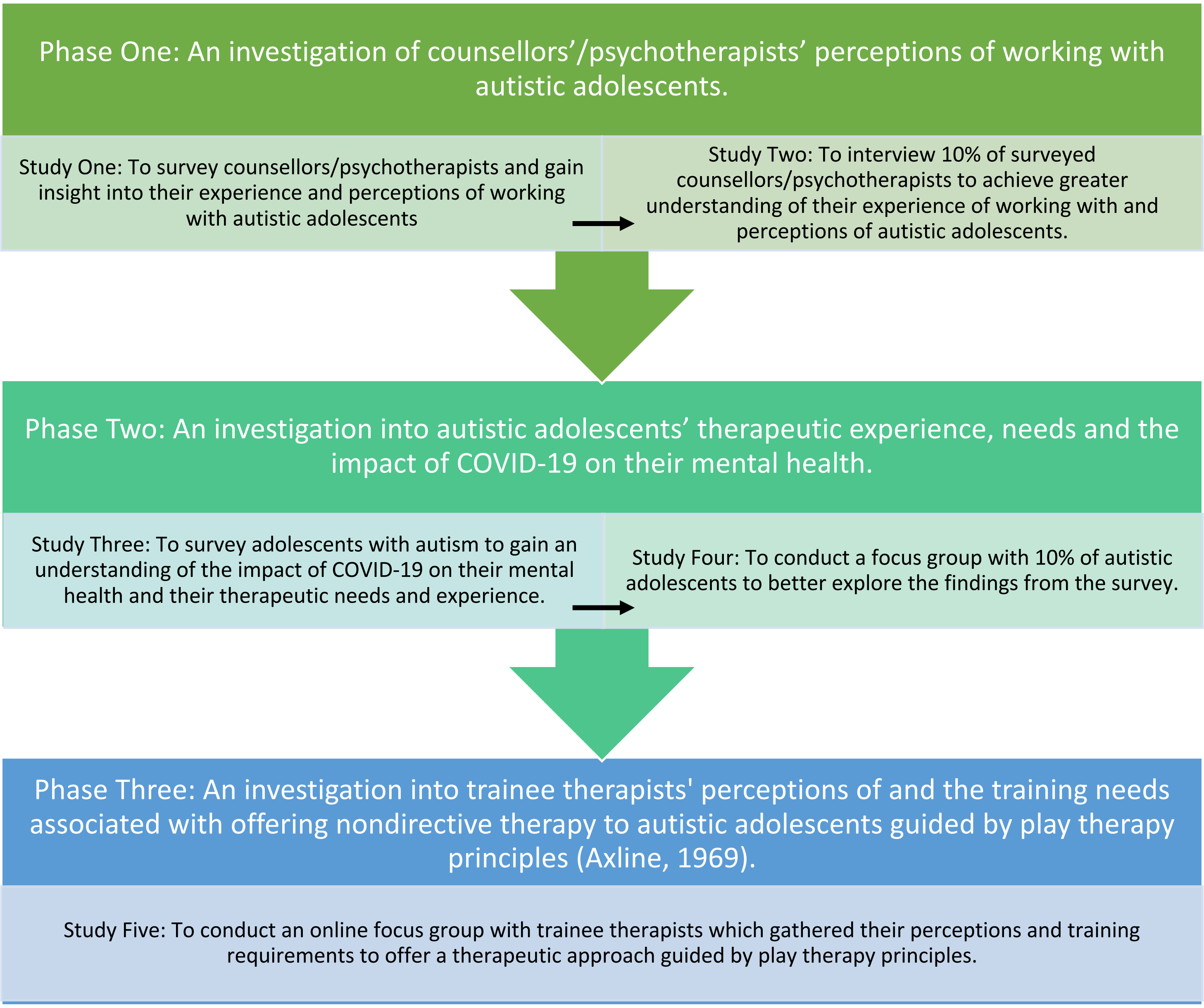
CONCLUSION

Chapter 18

Chapter Eighteen: Final Conclusion

***'You have a responsibility to make inclusion a daily thought, so we can get rid of the word 'inclusion.'* – (Theodore Melfi, unknown).**

The purpose of this final chapter is to provide an overview of the research findings and collate them to meet the final research objective (see Figure 15 for a reminder of the research process). The contribution to academic knowledge, clinical implications and future research opportunities will be discussed alongside the collective strengths and limitations of this thesis.



Phase One: An investigation of counsellors'/psychotherapists' perceptions of working with autistic adolescents.

Study One: To survey counsellors/psychotherapists and gain insight into their experience and perceptions of working with autistic adolescents

Study Two: To interview 10% of surveyed counsellors/psychotherapists to achieve greater understanding of their experience of working with and perceptions of autistic adolescents.

Phase Two: An investigation into autistic adolescents' therapeutic experience, needs and the impact of COVID-19 on their mental health.

Study Three: To survey adolescents with autism to gain an understanding of the impact of COVID-19 on their mental health and their therapeutic needs and experience.

Study Four: To conduct a focus group with 10% of autistic adolescents to better explore the findings from the survey.

Phase Three: An investigation into trainee therapists' perceptions of and the training needs associated with offering nondirective therapy to autistic adolescents guided by play therapy principles (Axline, 1969).

Study Five: To conduct an online focus group with trainee therapists which gathered their perceptions and training requirements to offer a therapeutic approach guided by play therapy principles.

Figure 15: An Outline of the Research Process

18.1 The Research Aims and Objectives

Overall Research Question: How applicable are play therapy principles to nondirective therapeutic working to support autistic adolescents’ mental health?

Phase One Research Question: How do counsellors and psychotherapists experience and perceive nondirective working with autistic adolescents?

Phase Two Research Question: How has COVID-19 impacted autistic adolescents mental health within the UK?

Phase Three Research Question: What are trainee counsellors and psychotherapists perceptions of and training needs for offering a nondirective therapeutic approach guided by play therapy principles to autistic adolescents?

Aim: To investigate the use of nondirective therapy based on play therapy principles with autistic adolescents experiencing mental health difficulties.

Objectives:

1. To conduct a literature review of current research based on the findings of the previous systematic review and use to inform the proposed research design
2. To survey and interview counsellors/psychotherapists and gain insight into their experience and perceptions of working with autistic adolescents (Phase One).
3. To survey and hold a focus group with autistic adolescents to gain insight into the impact of COVID-19 on their mental health (Phase Two).
4. To conduct a focus group with trainee therapists to understand the training requirements for working in a nondirective way with autistic adolescents (Phase Three).
5. To utilise all the data from the research to re-develop guidance for nondirective therapy with autistic adolescents experiencing mental health difficulties.

18.2 Overview of All Findings and Contribution to Academic Knowledge

In response to the original research question, the overall findings from this research suggest that a nondirective therapeutic approach guided by play therapy principles is applicable to working with autistic adolescents experiencing mental health difficulties.

Collectively the findings show benefit of a nondirective approach from therapists and potential in this approach from autistic adolescents' and trainee therapists' perspectives. A summary of the findings is outlined below.

18.2.1 The Benefit of Nondirective Therapy guided by Play Therapy Principles

Across all Phases of the intervention there was perceived benefit to offering a therapeutic approach guided by play therapy principles. In Phase One, the participants discussed using play therapy and utilising elements of the guidelines in their nondirective work. The participants shared experience of how effective this had been in supporting autistic adolescents' mental health and also how they had found working in this way positive and enjoyable. In Phase Two autistic adolescents felt that this approach would be beneficial for them and meet their current therapeutic needs by enabling them to share what was meaningful. Participants shared that the Play Therapy guidelines (Axline, 1969) placed a focus on the therapeutic relationship which would enable them to feel accepted and be listened to without being rushed. The approach also offered an opportunity to experience therapy in a more positive way than previously experienced. Finally, the trainee therapists in Phase Three believed the approach to be respectful and helpful for autistic adolescents specifically, as well as accessible to them due to the transferrable relational skills that underpinned the approach. These findings suggested that the proposed approach may increase confidence levels of newly qualified therapists, if they received this teaching during their formal training. Across all Phases there was a belief that a nondirective way of working with autistic adolescents enabled therapy to be tailored to the individual, by the individual and provide a holistic offer of support which would have a positive impact on mental health and wellbeing.

Despite this there were some concerns raised about offering this approach which suggested a need for consideration of training adaptations, applicability in time-limited settings, how to involve parents/carers or professionals and how to ascertain the effectiveness of therapy given the current concerns around outcome measures. It is hoped that future research can better understand these concerns and develop clinical applications from the findings.

18.2.2 The Training Needs of Therapists

There was a collective mention of training in varying levels of depth within all the five studies. Phase One identified that there is a significant lack of training about neurodiversity and autism throughout formal training qualifications. This had implications for therapists' confidence and competence when they were newly qualified. Over time their competence and confidence (linked to experience) had grown, however this raises ethical concerns about working within competency limits and also suggests a potential barrier to accessing therapy for autistic adolescents. Participants believed that training on autism should be mandatory and shaped by autistic voice e.g., created or delivered by an autistic individual. The findings from Phase Two identified that participants had felt misunderstood or had their mental health wrongly attributed to their autism diagnosis based on a lack of awareness around mental health and a lack of autism understanding from therapists and mental health professionals. There was specific mention of training for therapists and educators as well as general improved autism awareness and support for parents, which they felt would have significantly improved their diagnostic experience and current mental health. Finally, whilst participants in Phase Three had received an introduction to autism through their course, they felt it could be better integrated, more informative and should always be taught from an affirming position. There was also specific mention of adapting practice, and training on working with the proposed therapeutic guidelines that would be essential. Participants felt that more emphasis should be placed on the difference between therapeutic working with adults and adolescents during their training which raised concerns around the lack of regulations within the UK.

These suggestions were extended to consider not only the training content but also the adaptations to training courses that would encourage inclusive and affirming practice e.g., changes to the use of outcome measures, utilising supervision to support in adapting the therapy process and changes to placement requirements. Educational establishments and training providers may be able to incorporate these changes into equality, diversity and inclusion policies and use this to inform future training offers. Collectively there was a belief that there needs to be wider change at a policy and societal level as well as much more awareness and education around autism for all to tackle ableism and promote inclusion.

18.2.3 The Impact of COVID-19 on The Mental Health of Autistic Adolescents

The literature review and the findings from each Phase supported the concern for autistic adolescent's mental health. Participants in Phase One mentioned the impact of COVID-19 on their autistic clients due to changes in routine and a lack of appropriate support services. There was also concern raised over the lack of nondirective and affirming therapeutic provision and the impact this had on mental health. The results from Phase Two highlighted a worsening of mental health since the pandemic and proposed experiencing the pandemic as a loss was a significant contributor of this. Feelings of loss and uncertainty were significant contributors to anxiety, alongside a lack of awareness from others and challenging school environments. The return to education post-COVID-19 had been challenging for all participants and participants called for improved school support and increased offers of tailored mental health support that were not time-limited. The result from Phase Two also supported prior research findings about increased gender diversity within the autistic population (Corbett et al., 2023; George and Stokes, 2018; Glidden et al., 2016) which has further implications around mental health support needs and status.

The findings from Phase Three suggested participants were aware of the mental health concerns faced by autistic young people and shared their beliefs that the proposed therapeutic approach may be of benefit based on the mental health concerns and stigma faced by autistic adolescents. The findings alongside previous research highlight an urgent need for further research and adaptations to policy and practice to ensure autistic adolescents' mental health is a priority. This is likely to have implications for future access of services, quality of life, general wellbeing and has the potential to decrease the high suicidality known in this population (Mukherjee and Beresford, 2023; McMaughan et al., 2023).

18.3 Clinical Implications of the Research

The clinical implications of this research are numerous and varied with applications to different populations such as therapists, trainees, education providers and autistic individuals. The findings identified an urgent need for improved therapeutic support, autism understanding, and awareness of mental health challenges faced by this population. This is supported in early research (Amorim et al., 2020; Pellicano et al., 2022; Hamilton et al., 2023; Toseeb and Asbury, 2023b) that COVID-19 has disproportionately affected autistic populations and suggests alternative and affirming mental health support should be a high priority for policymakers and health organisations.

Second, the need for training around autism specifically for therapists but also increased autism awareness with professionals and parents/carers was identified. This suggests that whilst there is progress in the understanding of autism within the UK (Ballantyne et al., 2021), there is still more that needs to be done to create an inclusive society. This has benefits for mental health and developing positive autistic identities (R. Chapman and Botha, 2023) which in turn may reduce longer-term reliance on additional support required (e.g., therapy or education); having potential cost, time and health benefits on a societal level.

The final objective of this research was to re-develop guidance for nondirective therapy with autistic adolescents. Based on the positive findings that a nondirective approach guided by play therapy principles holds benefit for autistic adolescents mental health, the researcher proposes adapted and enhanced guidance (based on Axline, 1969) as follows (changes in bold):

1. The therapist must develop a warm, friendly relationship with the **young person**, in which good rapport is established as soon as possible.
2. The therapist accepts the **young person** exactly as **they** are
3. The therapist establishes a feeling of permissiveness in the relationship so that the **young person** feels free to express **their** feelings completely.
4. The therapist is alert to recognise the feelings the **young person** is expressing and reflects those back to **them** in such a manner that **they** gain insight into **their** behaviour
5. The therapist maintains a deep respect for the **young person's** ability to solve **their** own problems if given an opportunity to do so. The responsibility to make choices and the institute change is the **young persons.**
6. The therapist does not attempt to direct the **young person's** actions or conversation in any manner. The **young person** leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognised as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the **practicalities of the real word** and to make the **young person** aware of **their** responsibility in the relationship **e.g., contracting, safeguarding, timing of session, safety etc.**
9. **The therapist recognises the individuality of each young person and as such recognises the therapeutic approach will be tailored to each client**

This framework is similar to Axline's (1969) original guidance but based on the findings of this research, the researcher has amended some of the wording and added an extra guideline. In respect to the known increased rates of gender diversity within the autistic community outlined in Phase One, Phase Two and prior literature (Corbett et al., 2023; George and Stokes, 2018; Glidden et al., 2016), the pronouns have been changed to 'they/them/theirs'. In application to working with adolescents, the term 'child' has been replaced with 'young person'. An additional guideline has been added (Guideline Nine) to reflect the findings in all Phases that therapy should be tailored to the individual client.

It is hoped this guidance could be used as a framework or 'blueprint' (Grant and Osanloo, 2014) for future research studies into the efficacy of this approach and potentially implemented into training programmes for therapists. The researcher hopes these re-developed guidelines and the collective findings of this research can be used as a starting point for neurodiversity-affirming therapeutic practices which are desperately required to support autistic adolescents' mental health, especially post-pandemic.

18.4 Strengths and Limitations of the Research

The individual strengths and limitations can be viewed in the corresponding chapters. The main strength of the research is the methodology, philosophical and conceptual framework that guided each Phase. Collectively the findings have influenced further studies and phases in a sequential manner; ensuring validity and reliability in the results and justifying the research as meeting identified gaps in knowledge. Using the philosophical framework to inform methodology and methods chosen, a guidance for future research and clinical practice has been created which has the potential to benefit a large population.

The ’design and refine’ process utilising stakeholder involvement (O'Cathain et al., 2019) is another strength of this research. The inclusion of service-user voice in the pilot studies strengthened the reliability of the research and ensured the research was accessible to the population it hoped to reach. Conducting this research in a sequential manner allowed refinements between Phases and Studies to be made, which is evidenced by the ethics amendments. This ensured that each Phase influenced the next Phase and was informed by the findings; increasing validity in the results gained.

Time and resource limitations did constrain what the intervention could achieve and whilst there are significant strengths of the research, the findings would be stronger had there been larger sample-sizes and co-production of research with stakeholders. In addition, this research struggled with the recruitment of autistic adolescents and further investigation as to how to best incorporate these young people into research is essential. The sample in Phase One is reflective of similar types of research within the UK, but a larger sample would have enabled different analysis to be run which may have found stronger results. A larger sample in both Phases Two and Three could have allowed a deeper understanding from the qualitative research to be gained.

Based on the time limitations and the research being part of a doctoral thesis, the researcher was unable to co-produce the research with therapists, trainees or autistic adolescents. The co-creation of research with service-users can ‘facilitate the feasibility, acceptability and engagement with the intervention’ (O’Cathain et al., 2019, p.5) as well as define ‘research agendas to meet their needs’ (Boaz et al., 2018, p.2). Future research should prioritise co-production with individuals at all stages of research design, implementation, write-up and dissemination. This ensures the development of the most accessible intervention that produces the most meaningful outcomes (Boaz et al., 2018).

18.5 Recommendations for Future Research

Whilst each of the study objectives and aims were successfully achieved, the limitations of the research and clinical implications identify areas for future investigation. The findings from this each Phase of the research highlighted the importance of co-production in research with autistic populations. Therefore, all future research should be co-produced with autistic individuals. Recommendations by Donetto et al. (2015) may be beneficial in shaping future interventions using the Experience-based Co-design approach. This provides a framework for how to involve stakeholders in the design and delivery of research and healthcare interventions.

18.5.1 Research into the Efficacy of the Proposed Guidelines

A future study that implements the guidelines proposed from this research is essential to better understand how accessible and beneficial this approach to therapeutic working could be for supporting autistic adolescents' mental health. This research should focus on better understanding the need for time whilst using these guidelines and considering a way to evaluate therapeutic outcomes that are autism affirming and appropriate to this population.

A potential option for how this may be done is to use the phenomenological approach suggested by (Pantazakos and Vanaken, 2023). This approach highlights the importance of distinguishing 'between personality traits, behaviors, mental formations et cetera that should be ascribed to the autistic core self, and those that may be legitimately negotiated within therapy (Pantazakos and Vanaken, 2023, p.7). Using a phenomenological approach encourages 'clinicians [to] immerse themselves into autistic phenomenology and pay due credit to autistic first-person experiences, especially regarding the meaningfulness of procured results. In turn, phenomenology…is also the primary tool for articulating the effect of, methodologically informing, evaluating, and choosing between, autism clinical therapies' (Pantazakos and Vanaken, 2023, p.8). At a broader level phenomenology invites collaboration with the client on their therapy process and outcomes that allows the therapist to strike 'a delicate balance must be found between respecting self-determination and challenging a client enough to overcome cognitive, emotional, and behavioral automations which may all but serve their mental wellbeing' (Pantazakos and Vanaken, 2023, p.7). Future research could look at whether a phenomenological approach to evaluating the proposed guidelines with clients is applicable, in order to ensure every aspect of the therapeutic process (including gathering outcome data) is affirmative and client-led.

Another potential (and more in fitting with the current gold-standard of research) way to conduct this future research is through a comparison study with other therapy offers for autistic adolescents. This is likely to be more challenging as the literature outlined in Chapters One and Two highlighted that the majority of research focused on outcomes and interventions that address autistic behaviours instead of co-occurring mental health conditions. Therefore, a true comparison would be hard to establish, but if possible, it would be worthwhile to assess benefits of this approach for mental wellbeing over a longer follow-up period. This research would enable cost and time-effectiveness to be considered which may influence future policies and therapeutic offers of support.

18.5.2 Research into the Training Offer for Therapists

The current research identified several important and useful suggestions for improving therapeutic training offers, which may result in increased confidence for therapists working with autistic individuals. In turn this may improve access to therapy for these clients; holding benefit for mental health and wellbeing. Future studies should build upon the findings outlined in this thesis and consider how best to implement these into training practices in a neurodiversity affirming way. It would be of benefit for autistic individuals/therapists to co-produce learning materials and be involved in the teaching process. In order to effectively evaluate these changes, an appropriate and validated measure of competency and confidence would need to be created as the current measures are varied in constructs; reflecting the literature (see Chapter Eight). The researcher hopes to co-create these materials with students and other lecturers within their role at the University of Leeds.

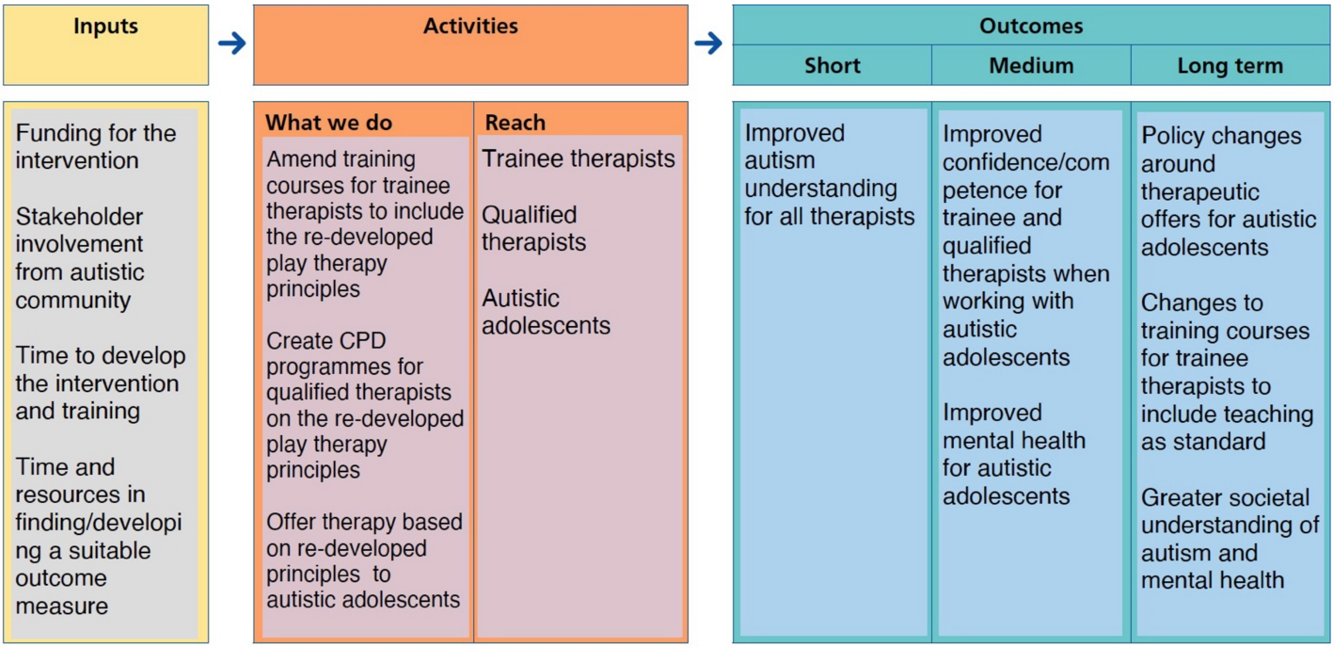
An additional study should also look at replicating Study Five with a wider range of trainee therapists from different training establishments. This would enable a greater pool of data to be created, from which conclusions about the practicality of working in this way could be drawn. The findings of this research may support the development of the therapeutic approach and better understand how to support trainee therapists when working in this way.

18.5.3 Research into the Mental Health Concerns of Autistic Individuals

The findings from the current research supported previous early research that suggests autistic adolescents have been disproportionately affected by COVID-19 and are facing a mental health crisis. The research suggested potential reasons for this including stigma, lack of therapeutic support and experiencing COVID-19 as a loss or ACE. A future study aiming to understand these components on a larger scale is likely to influence an overall understanding of autism and help create improved therapeutic interventions that could support current needs. Special consideration should be given as to how best to gain this data based on the methodological difficulties experienced in Phase Two. It is likely that co-production of this research with autistic communities could better inform the most appropriate way to include this client group.

18.6 Theoretical Contribution

Whilst the aim of this research was not to develop a theory due to its exploratory nature, a tentative suggestion of a logic model (ESS, 2020) can be made from the collective findings. The proposed logic model (see Figure 16) aims to outline how the current research could provide the foundation for a future complex intervention and considers the possible outcomes of this. The logic model builds upon the foundational theories of Play Therapy (Axline, 1969) and Person-Centred Theory (C. Rogers, 1957) that underpinned this thesis and dependent on the outcomes of the proposed complex intervention, has the potential to underlie a future Theory of Change.



Inputs	Activities		Outcomes		
	What we do	Reach	Short	Medium	Long term
Funding for the intervention Stakeholder involvement from autistic community Time to develop the intervention and training Time and resources in finding/developing a suitable outcome measure	Amend training courses for trainee therapists to include the re-developed play therapy principles Create CPD programmes for qualified therapists on the re-developed play therapy principles Offer therapy based on re-developed principles to autistic adolescents	Trainee therapists Qualified therapists Autistic adolescents	Improved autism understanding for all therapists	Improved confidence/competence for trainee and qualified therapists when working with autistic adolescents Improved mental health for autistic adolescents	Policy changes around therapeutic offers for autistic adolescents Changes to training courses for trainee therapists to include teaching as standard Greater societal understanding of autism and mental health

Figure 16: A Logic Model of the Proposed Complex Intervention

18.7 Future Aims & Dissemination Plan

The researcher intends to submit Phase One of the research to the Journal of Counselling and Psychotherapy Research as two partner-papers. The research from Phase Two will be submitted to the Journal of Health Psychology as two separate but partnered papers also. The results from Phase Three will be submitted to the Journal of Counselling and Psychotherapy Research as a logical follow-up from the systematic review and Phase One findings. The researcher hopes to build upon the findings from all phases of this research through application to the Marie Curie (MCSA) Postdoctoral Research Fellowship.

18.8 Reflexivity in Research

The researcher wishes to acknowledge the benefit and importance of reflexivity throughout this research. Throughout the process of conducting the studies, there were challenges and results that acted as reminders that research is often unpredictable. Through reflection on the researchers' initial response to these instances, the researcher was able to ensure the validity and reliability of the research by acknowledging their own biases and hopes for the findings and being aware of the role these played in the formation of the research and conclusions drawn from it.

18.9 Conclusion

This research has highlighted that nondirective therapy guided by play therapy principles has the potential to be beneficial for autistic adolescents' mental health. Based on the findings, there is a critical need for a range of therapeutic services to be offered to autistic adolescents in line with the spectrum nature of their diagnosis and a need for affirming mental health care. The amended guidelines developed from this thesis hold potential in meeting some of this need. Future research must build upon the current findings to develop training programmes and adapt therapeutic offers. This has far-reaching implications for autism awareness and mental health at both an individual and societal level. The researcher hopes this work can provide a starting point, upon which a fairer, affirming and more inclusive society can be created that values each individual and prioritises mental health provision for all.

Appendix A – Study One Survey Questions

Provide information sheet and gain informed consent before continuing

Demographic Questions	Possible Answers
Gender:	Male Female Non-binary Transgender Other
Age:	18-24 25-34 35-44 44 – 54 55+
Ethnicity:	White-British White-Other Mixed Indian Chinese Pakistani Bangladeshi Black-British Black-Other African Caribbean Gypsy Traveller Arab Other
Professional Body:	UKCP BACP CPCAB COSCA
Years since qualified:	3 – 5 5-8 8-10 10+
Working as a psychotherapist/counsellor currently:	Yes No

Please note the terms 'autistic adolescent' and 'adolescent with autism' are used interchangeably in the following survey, to reflect the terminology identified by the autism community (Kenny et al., 2016)

For the following questions please consider these definitions when answering:

Non-directive therapy: 'approach to psychotherapy and counseling in which the therapist or counselor establishes an encouraging atmosphere and clarifies the client's ideas rather than directing the process. The client leads the way by expressing his or her own feelings, defining his or her own problems, and interpreting his or her own behaviour' (VandenBos, 2007) e.g., person-centred therapy

Directive therapy: 'an approach to counseling and psychotherapy in which the therapeutic process is directed along lines considered relevant by the counselor or therapist. Directive counseling is based on the assumption that the professional training and experience of the counselor or therapist equip him or her to manage the therapeutic process and to guide the client's behavior' (VandenBos, 2007) e.g., CBT, skills training, behavioural

Questions	**Possible Answers**
Do you have experience of working with autistic adolescents?	Yes No *(end participation)*
How many autistic adolescents have you worked with?	1-5 5-10 10+
What orientation/theoretical background have you used? Tick as many as required:	Person-centred Directive: CBT/Behavioural/Skills Training EMDR Non-directive Play Therapy Directive Play Therapy Other non-directive therapy (please state): Other directive therapy (please state):
Were you given training during your professional qualification (PG Dip) to prepare you for working with autism?	Yes No
Do you feel confident about working with autistic adolescents?	Yes No
Do you feel competent to work with adolescents with ASD?	Yes No
Do you think it is important for the therapist to have some knowledge of autism?	Yes No

Do you think non-directive therapy has potential to be beneficial for adolescents with ASD?	Yes No
(conditional on previous answer) If no: What are your reasons? (tick as many as required)	Not enough research Research shows directive is effective Autistic adolescents cannot engage in non-directive therapy Other (please state)
Do you think there is benefit to parents/carers being involved in the therapy? *E.g., information sharing that protects confidentiality but assists in their understanding of the child and support required*	Yes No
Are you happy to be contacted for a short (30 min max) telephone/online interview to answer more questions about your opinions?	Yes No
Please enter your email address if you wish to be contacted. The researcher will use this email to arrange a further interview.	
Any other comments you wish to share?	

Thank you for participating. Please make a note of your submission ID, you will need this should you wish to withdraw your participation in the next 2 weeks. (*contact details of researcher provided again)*

Appendix B – Study One Semi-Structured Interview Questions

Provide information sheet and gain informed consent before continuing

Please note the terms 'autistic adolescent' and 'adolescent with autism' are used interchangeably in the following survey, to reflect the terminology identified by the autism community (Kenny et al., 2016)

For the following questions please consider these definitions when answering:

Non-directive therapy: 'approach to psychotherapy and counseling in which the therapist or counselor establishes an encouraging atmosphere and clarifies the client's ideas rather than directing the process. The client leads the way by expressing his or her own feelings, defining his or her own problems, and interpreting his or her own behaviour' (VandenBos, 2007) e.g., person-centred therapy

Directive therapy: 'an approach to counseling and psychotherapy in which the therapeutic process is directed along lines considered relevant by the counselor or therapist. Directive counseling is based on the assumption that the professional training and experience of the counselor or therapist equip him or her to manage the therapeutic process and to guide the client's behavior' (VandenBos, 2007) e.g., CBT, skills training, behavioural

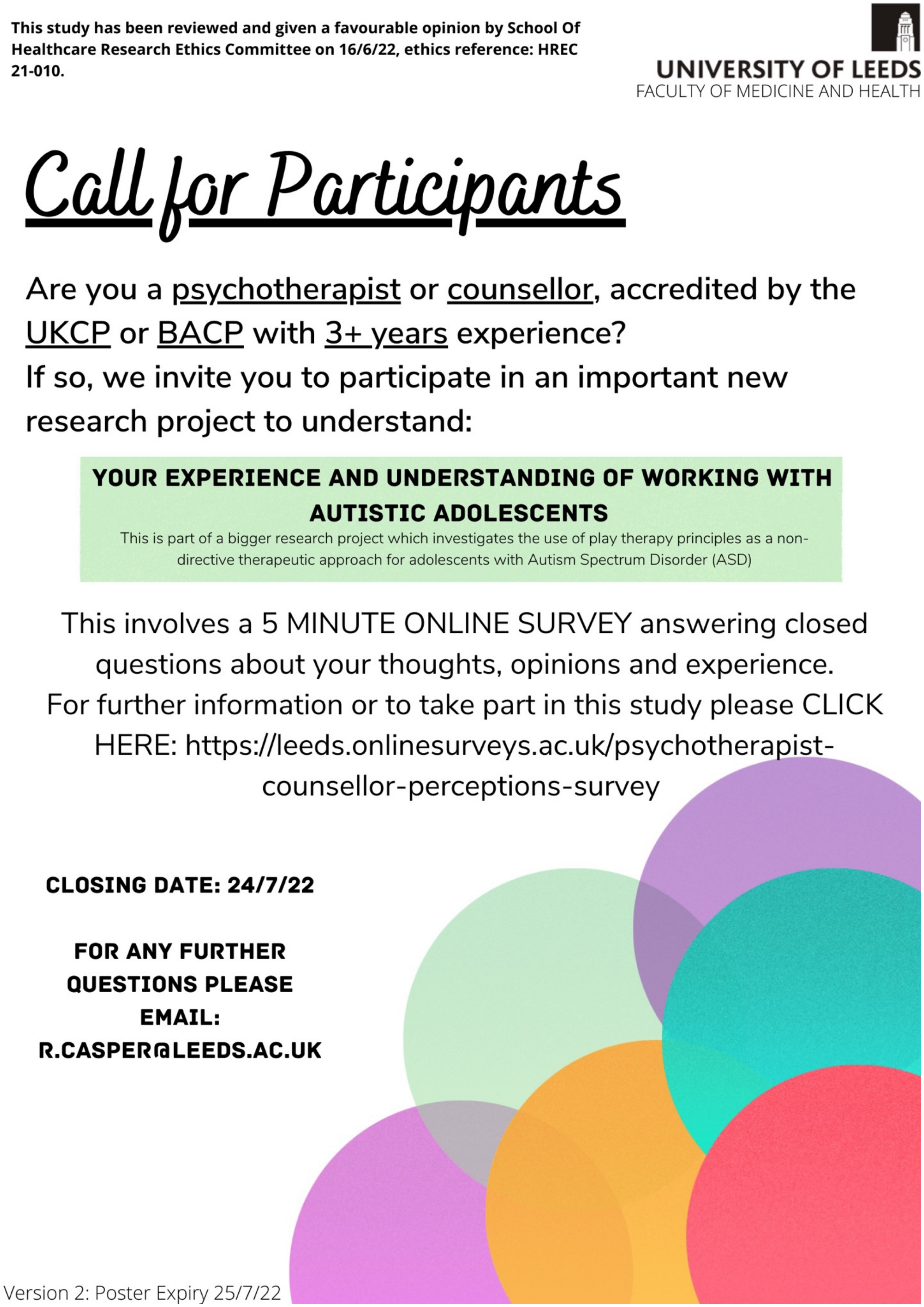
<u>Questions:</u>

1. What do you think the challenges to counselling autistic adolescents are?
2. What is your experience of counselling adolescents with autism?
3. How would you feel about offering non-directive therapy to autistic adolescents?
4. Are you seeing an increase in referrals for adolescents with ASD?
    a. If so, why do you think that is?
5. How could your training have better prepared you for working with autism?
    a. If it prepared you fully, what did they do that was helpful?

6. What is your opinion on directive therapies being offered more than non-directive therapies to autistic adolescents?
7. Do you think therapists could do more to support autistic adolescents in therapy?
    a. If so, what could they do?
8. What is your experience of involving parents in the therapeutic process?
    a. If you have involved them, what was helpful and what was difficult?
    b. If not, why?

Thank you for participating (*contact details of researcher provided again)*

Appendix C – Recruitment Poster Study One



This study has been reviewed and given a favourable opinion by School Of Healthcare Research Ethics Committee on 16/6/22, ethics reference: HREC 21-010.

UNIVERSITY OF LEEDS
FACULTY OF MEDICINE AND HEALTH

Call for Participants

Are you a psychotherapist or counsellor, accredited by the UKCP or BACP with 3+ years experience?
If so, we invite you to participate in an important new research project to understand:

YOUR EXPERIENCE AND UNDERSTANDING OF WORKING WITH AUTISTIC ADOLESCENTS

This is part of a bigger research project which investigates the use of play therapy principles as a non-directive therapeutic approach for adolescents with Autism Spectrum Disorder (ASD)

This involves a 5 MINUTE ONLINE SURVEY answering closed questions about your thoughts, opinions and experience.
For further information or to take part in this study please CLICK HERE: https://leeds.onlinesurveys.ac.uk/psychotherapist-counsellor-perceptions-survey

CLOSING DATE: 24/7/22

FOR ANY FURTHER QUESTIONS PLEASE EMAIL: R.CASPER@LEEDS.AC.UK

Version 2: Poster Expiry 25/7/22

Appendix D – Recruitment Text for All Phases

PHASE ONE:

CALL FOR PARTICIPATION:

Are you a psychotherapist/counsellor who is a member of the UKCP/BACP and has been qualified for 3+ years? If so, you are invited to participate in our research project, which aims to survey counsellors/psychotherapists and gain insight into their experience and understanding of working with autistic adolescents. If you fit this criteria, please click on the link to view information, consent form and participate:

https://leeds.onlinesurveys.ac.uk/psychotherapist-counsellor-perceptions-survey

Please email the lead researcher Rachel if you have any questions:

r.casper@leeds.ac.uk

This study has been reviewed and given a favourable opinion by School of Healthcare Research Ethics Committee on 13/6/22, ethics reference: HREC 21-010.

POSTER INSERTED

PHASE TWO:

“CALL FOR PARTICIPATION:

Are you between 13-18 years old and have an autism diagnosis? If so, then we want to hear from YOU! This research aims to understand the impact of COVID19 on mental health of autistic teenagers and hopefully improve mental health services and therapy. If you fit this criteria and want to share your experience and ideas, please click on the link to view information, consent form and participate: LINK INSERTED

Please email the lead researcher Rachel if you have any questions:

r.casper@leeds.ac.uk

This study has been reviewed and given a favourable opinion by _______________ Research Ethics Committee on [date], ethics reference [ref]”

POSTER INSERTED

PHASE THREE: Email to students

Hi all,

I am just emailing you to share with you some research I am currently undertaking for my PhD. and invite you to participate. I am interested in your opinions on what training you would need to work in a non-directive way with autistic adolescents. I have attached the information sheet for you to look over as well as a link to the consent form. The research will involve an online focus group via Microsoft Teams at a mutually convenient time/date for us all. The group will last no longer than 1 hour and will provide an opportunity to discuss the proposed guidelines for this non-directive working and consider the training you would need to work in this way.

If you would like to participate please read the information sheet and complete the consent form by DATE. I will then be in touch to arrange a date/time. If you have any questions please email me.

Thank you for your time!

Appendix E – Study One Information Sheet

Participant Information Sheet

An investigation into the use of play therapy principles as a non-directive therapeutic approach for adolescents with Autism Spectrum Disorder (ASD)

PHASE ONE: ONLINE QUESTIONNAIRE

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the researcher if you have any questions or would like more information. Take time to decide whether or not you wish to take part.

This study has been reviewed and given a favourable opinion by School of Healthcare Research Ethics Committee on [date], ethics reference [ref].

The purpose of the project

This project aims to survey counsellors/psychotherapists and gain insight into their experience and understanding of working with autistic adolescents. This is phase one of a complex intervention which intends to evaluate the potential of non-directive therapy for adolescents with ASD.

Why have I been chosen?

You are viewing this information sheet because you have accessed the link sent out via social media/email. As such you have identified yourself as a counsellor/psychotherapist, registered with either the BACP or UKCP and have been qualified for a minimum of 3 years.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet and be directed to complete the informed consent on the next page. You can withdraw your participation up to 2 weeks after completing this survey, after this data analysis will have begun. You do not have to give a reason for withdrawal.

What do I have to do?/ What will happen to me if I take part?

After completing the informed consent form you will be directed to the survey. This will ask some demographic information followed by closed questions about your thoughts and perceptions of working with autistic adolescents as well as any experience you have. This survey will take approximately 5 minutes and should be completed in one attempt.

Upon completion of the survey you will be asked if you consent to a follow-up 30 minute telephone/online interview of open questions about your thoughts, opinions and experience working therapeutically with autistic adolescents. This is also voluntary and a new information sheet and informed consent form will be provided, with follow-up contact from the researcher to organise a time suitable for you.

You will be asked to provide your email address for a copy of the information sheet to be sent to you. Data collected will be anonymised and analysed for statistical patterns.

What are the possible disadvantages and risks of taking part?

There is a minimal risk of discomfort to participation in recalling some therapeutic encounters. It is not anticipated this poses a significant risk to wellbeing.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those participating in the project, it is hoped that this work will be used to inform and shape future training programmes of counsellors/psychotherapists. As well as provide insight into potential barriers for accessing non-directive therapy that autistic adolescents may face.

Use, dissemination and storage of research data

Data will be stored securely as per the University of Leeds Data Protection Policy for 5 years. The findings of these results are intended to be published in a peer-reviewed journal and shared with other professionals.

What will happen to my personal information?

All data collected from the surveys will be anonymous. Participants will not be identifiable from the results collected. Informed consent forms and email addresses will be stored securely, separately to the results.

What will happen to the results of the research project?

All the contact information that we collect about you during the course of the research will be kept strictly confidential and will be stored separately from the research data. We will take steps wherever possible to anonymise the research data so that you will not be identified in any reports or publications.

It is hoped the results of this research will be published within 12 months of data collection, in a peer-reviewed journal. Details of this publication will be sent to you via the email address provided. You will not be identified in any report or publication if findings.

The data collected during the course of this project might be used for additional or subsequent research.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

This research will seek to understand your opinions, thoughts and feelings as well as potential experience of therapeutic working with autistic adolescents. These findings will contribute to the overall investigation into the potential benefit of using play therapy principles as non-directive therapy for autistic adolescents.

Who is organising/ funding the research?

The research is being conducted at the University of Leeds, Faculty of Medicine and Health.

Contact for further information

Lead researcher: Rachel Casper
Email: r.casper@leeds.ac.uk

Supervisor: Dr Netalie Shloim
Email: n.shloim@leeds.ac.uk

Finally …

Thank you for taking time to read through this information sheet and considering participation in this project. Copies of informed consent and information sheets will be sent to the email address you provide.

Appendix F – Study One Informed Consent Form Online

STUDY ONE: SURVEY
OPENING STATEMENT AND INFORMED CONSENT VIA ONLINE SURVEY

You are being invited to participate in a research study titled: An investigation into the use of play therapy principles as a non-directive therapeutic approach for adolescents with Autism Spectrum Disorder (ASD). This study is being done by Rachel Casper from the University of Leeds. If you wish to contact the researcher with any questions or concerns please do so via email: r.casper@leeds.ac.uk

The purpose of this research study is to survey counsellors/psychotherapists and gain insight into their experience and understanding of working with autistic adolescents. This is phase one of a complex intervention which intends to evaluate the potential of non-directive therapy for adolescents with ASD.

This survey will take you approximately 5 minutes to complete. Your participation in this study is entirely voluntary and you can withdraw up to 2 weeks after completing this survey without giving a reason. You do not have to answer any questions you do not want to.

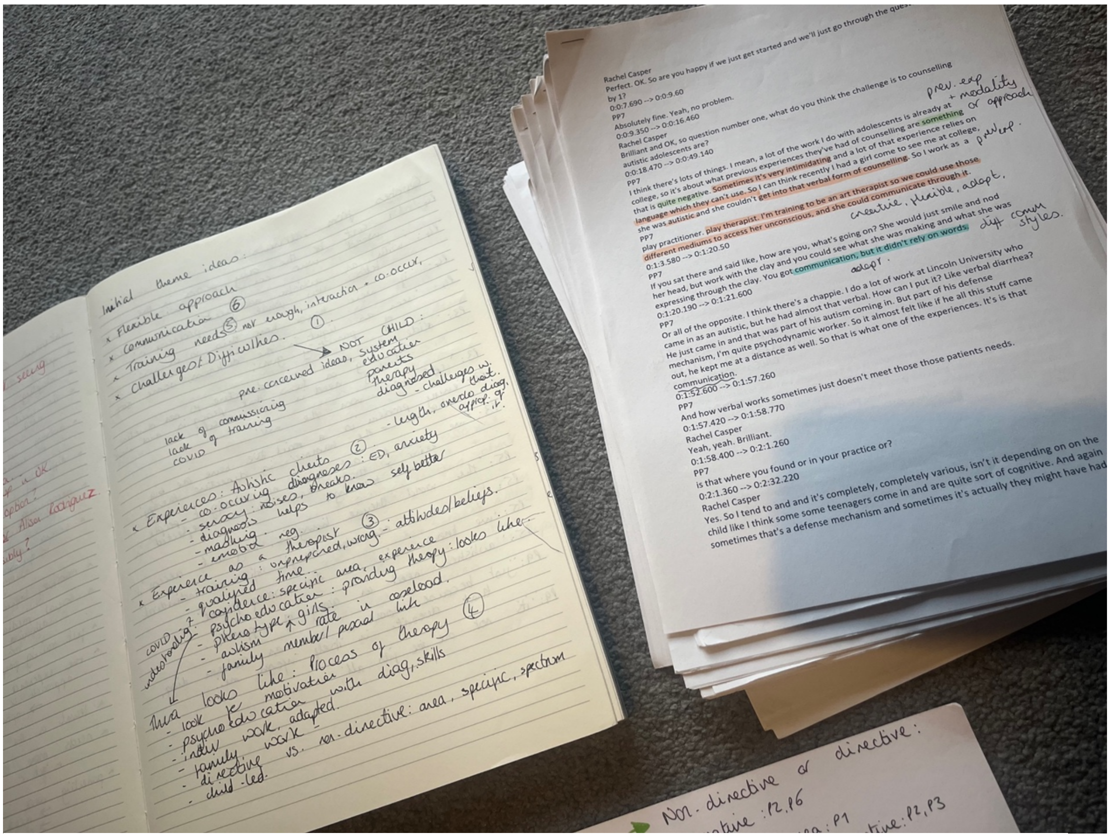
We believe there are no known risks associated with this research study; however, as with any online related activity the risk of a breach is always possible. To the best of our ability your participation in this study will remain confidential, and only anonymised data will be published. We will minimise any risks by storing identifiable information separately to the data. All data is stored managed in line with the University of Leeds Data Policy. Data will be destroyed 5 years after the study has completed. Further information is available via the University of Leeds Privacy Notice.

PLEASE TICK THE BOX TO CONFIRM YOU HAVE READ THE INFORMATION SHEET AND ARE PROVIDING INFORMED CONSENT:

Appendix G – Privacy Notice for All Phases

Please see link: https://ris.leeds.ac.uk/privacy-notice/

Appendix H – Coding Process for Study Two


Initial theme ideas:
- x Flexible approach
- x Communication ⑥
- x Training needs ⑤ not enough, interaction + co-occur,
- x Challenges/Difficulties ①

pre-conceived ideas, → NOT CHILD: system, education, parents, therapy, diagnosed - challenges w. that.

lack of commissioning
lack of training
COVID

- length, once diag. approp. of it.

- x Experiences: Autistic clients ②
  - co-occuring diagnoses: ED, anxiety
  - sensory: noises, breaks.
  - diagnosis helps to know self better
  - masking
  - emotional reg.
- x Experience as a therapist ③ - attitudes/beliefs.
  - training: unprepared, wrong.
  - qualified time
  - confidence: specific area, experience
  - psycho education: providing therapy: looks like
  - stereotype ↑ girls
  - autism rate in caseload.
  - family member/ personal link

COVID ? understanding

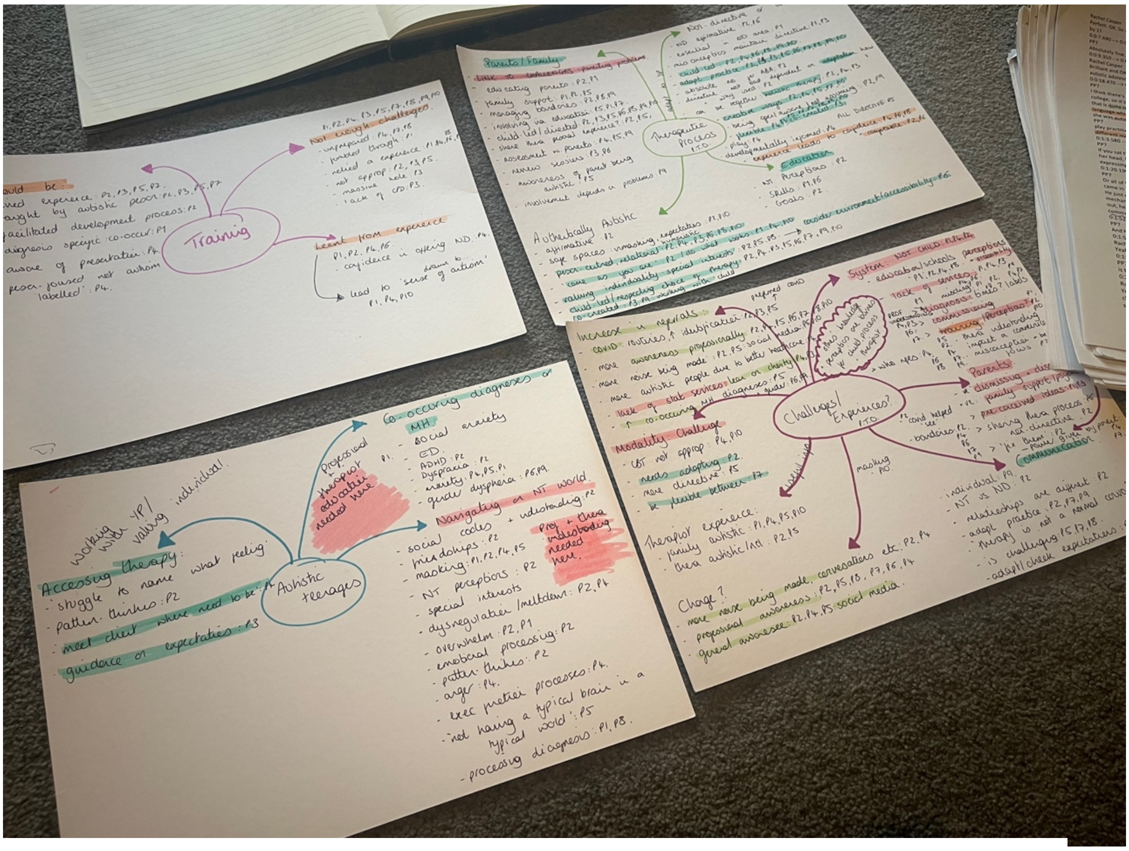
Thera looks like: Process of therapy ④
- look je motivation
- psycho education with diag, skills
- indiv work, adapted.
- family work
- directive vs. non-directive: area, specific, spectrum
- child-led.

Rachel Casper
Perfect. OK. So are you happy if we just get started and we'll just go through the ques
by 1?
0:0:7.690 --> 0:0:9.60
PP7
Absolutely fine. Yeah, no problem.
0:0:9.350 --> 0:0:16.460
Rachel Casper
Brilliant and OK, so question number one, what do you think the challenge is to counselling autistic adolescents are?
0:0:18.470 --> 0:0:49.140
PP7
I think there's lots of things. I mean, a lot of the work I do with adolescents is already at college, so it's about what previous experiences they've had of counselling are something that is quite negative. Sometimes it's very intimidating and a lot of that experience relies on language which they can't use. So I can think recently I had a girl come to see me at college, she was autistic and she couldn't get into that verbal form of counselling. So I work as a play practitioner. play therapist. I'm training to be an art therapist so we could use those different mediums to access her unconscious, and she could communicate through it.
PP7
0:1:3.580 --> 0:1:20.50
PP7
If you sat there and said like, how are you, what's going on? She would just smile and nod her head, but work with the clay and you could see what she was making and what she was expressing through the clay. You got communication, but it didn't rely on words.
0:1:20.190 --> 0:1:21.600
PP7
Or all of the opposite. I think there's a chappie. I do a lot of work at Lincoln University who came in as an autistic, but he had almost that verbal. How can I put it? Like verbal diarrhea? He just came in and that was part of his autism coming in. But part of his defense mechanism, I'm quite psychodynamic worker. So it almost felt like if he all this stuff came out, he kept me at a distance as well. So that is what one of the experiences. It's is that communication.
0:1:52.600 --> 0:1:57.260
PP7
And how verbal works sometimes just doesn't meet those those patients needs.
0:1:57.420 --> 0:1:58.770
Rachel Casper
Yeah, yeah. Brilliant.
0:1:58.400 --> 0:2:1.260
PP7
is that where you found or in your practice or?
0:2:1.360 --> 0:2:32.220
Rachel Casper
Yes. So I tend to and and it's completely, completely various, isn't it depending on on the child like I think some some teenagers come in and are quite sort of cognitive. And again sometimes that's a defense mechanism and sometimes it's actually they might have had

prev. exp
+ modality or approach
prev exp.
creative, flexible, adapt.
diff comm styles.
adapt.

Non-directive or directive:

Initial highlighting of transcripts and possible codes



Initial brainstorm of themes and codes

Appendix I – Coding Outline Process

Code	Subtheme	Theme	Quotes
co-creation adapting therapy flexible approach education child led relational	Working with the child	**Theme 2:** Collaborative working - captures the need for co-creation and child-led therapy as well as importance of working with the family	slide the scale from directive to non-directive is depending on how the person is and what they need in that moment they have to find their own unique way forward an environment that works for them you must remember they're still an individual
involving in admin involvement led by child support for parents education managing boundaries/confidentiality	Working with the family		autistics need an army of support get knowing your child better
choice of therapy/flexibility in approach adapting dynamics of therapy considering accessibility therapist understanding of autism	Valuing the individual	Theme 1: Captures something about needing enough knowledge, awareness and understanding to increase access to therapy, be flexible and adapt but not allowing this to determine the therapeutic process from rigid perceptions	you must remember they're still an individual just because someone has an autism diagnosis that doesn't in itself inform me therapy is not a nromal conversation, it is intimidating autism isn't the focus of the work
Knowing child/individuality Adaptive/flexible in approach Creative Not asssuming/expecting Communication as a challenge	Communication		the world thy're living in, they can't access it as a NT therapist [communication] is not something you have given thought to, ever.
need for boundaries power given by parent pre-conceived ideas/lack of understanding who refers/who's choice is therapy	Parents knowledge, perceptions and understanding	**Theme 2: Barriers/Challenges** (all the things that make working with this population difficult)	parents are dismissing or disabling seen as light in the darkness, some sort of parenting guru/they want me to fix them she had one very disabled version of autism in her head with an autistic adolescent, someone else tells you what the problem is
lack of training frame of reference/autistic lens hold understanding/knowledge flexbility in approach/communication modality as a barrier	Therapist knowledge, perceptions & understanding		every problem is a nail, we have one big hammer and the hammer is directive therapy I can't be the only person in the world that can work with this YP if you do not understand the lens of autism, all you're doing is shoving your crap down autistics throat therapy is neuro-normative there's not enough open-mindedness that we could achieve the same outcomes in a less directive way that diesn't make the young person feel like they're the one in the wrong.
accessibility in education educators understanding of autism diagnosis general assumptions of autism lack of services/commissioning	Professional knowledge, perceptions & understanding		is it the child or the school I need to be supporting they do this ridiculous screening designed for boys' people will bring clients to me and say this young person is autistic as if that is some sort of barrier it is never the child, it is the system CBT has won the war
lack of appropriate training learn from experience experience leads to confidence suggested improvements	Training	**Theme 3:** (training was a question that was asked about because of the survey results). Something about 'fumbling way through' and there being 'other ways to learn' and then ideas for what would have helped them 'lived-experience'.	fumbling way through, get it wrong and learning from that, when I look back now I think oh my god what were you doing there are other ways to learn' we need to act like neruodivergent people exist and that needs to be relfected in the training no-one at any point has spoken to somebody who is autitic, it is a big problem in our profession
Impact of COVID Increased awareness of mental health co-occuring with autism better professional awareness more diagnosis Impact of social media: general awareness	More referrals	**Theme 4:** all notice increase in referrals for varying reasons generally about better awareness and understanding ALTHOUGH lots querying if now an over-reliance on diagnosis	it is more on the agenda there is something going wrong somewhere the kids are flagging it up

Appendix J – Study Two Information Sheet

Participant Information Sheet

An investigation into the use of play therapy principles as a non-directive therapeutic approach for adolescents with Autism Spectrum Disorder (ASD)

PHASE ONE: ONLINE/PHONE INTERVIEW

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the researcher if you have any questions or would like more information. Take time to decide whether or not you wish to take part.

This study has been reviewed and given a favourable opinion by School of Healthcare Research Ethics Committee on [date], ethics reference [ref].

The purpose of the project

This project aims to interview counsellors/psychotherapists and gain insight into their experience and understanding of working with autistic adolescents. This is phase one of a complex intervention which intends to evaluate the potential of non-directive therapy for adolescents with ASD.

Why have I been chosen?

You are viewing this information sheet because you consented to be contacted about a follow-up interview after completing the prior survey. As such you have identified yourself as a counsellor/psychotherapist, registered with either the BACP, UKCP or other professional body, been qualified for a minimum of 3 years and have already taken part in the first part of this research.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet and sent an informed consent form to return. You can withdraw your participation up to 2 weeks after completing the interview, after this data analysis will have begun. You do not have to give a reason for withdrawal.

What do I have to do?/ What will happen to me if I take part?

You will complete a 30 minute telephone/online semi-structured interview answering open questions about your experience, thoughts, feelings and opinions of non-directive therapeutic working with autistic adolescents. This interview will be recorded, then transcribed for data analysis purposes.

The audio recordings of your interview will be used only for analysis. The recording will be uploaded to a secure server within 24 hours and anonymised. The recording will be transcribed and only the transcription will be included in the research. No one outside the project will be allowed access to the original recordings.

What are the possible disadvantages and risks of taking part?

There is a minimal risk of discomfort to participation in recalling some therapeutic encounters. It is not anticipated this poses a significant risk to wellbeing.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be used to inform and shape future training programmes of counsellors/psychotherapists. As well as provide insight into potential barriers for accessing non-directive therapy that autistic adolescents may face.

Use, dissemination and storage of research data

Data will be stored securely as per the University of Leeds Data Protection Policy for 5 years. The findings of these results are intended to be published in a peer-reviewed journal and shared with other professionals.

What will happen to my personal information?

All data collected from the interviews will be anonymous. Participants will not be identifiable from the results collected. Informed consent forms, email addresses and audio recordings will be stored securely, separately to the results.

What will happen to the results of the research project?

All the contact information that we collect about you during the course of the research will be kept strictly confidential and will be stored separately from the research data. We will take steps wherever possible to anonymise the research data so that you will not be identified in any reports or publications.

It is hoped the results of this research will be published within 12 months of data collection, in a peer-reviewed journal. Details of this publication will be sent to you via the email address provided. You will not be identified in any report or publication if findings.

The data collected during the course of this project might be used for additional or subsequent research.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

This research will seek to understand your opinions, thoughts and feelings as well as potential experience of therapeutic working with autistic adolescents. These findings will contribute to the overall investigation into the potential benefit of using play therapy principles as non-directive therapy for autistic adolescents.

Who is organising/ funding the research?

The research is being conducted at the University of Leeds, Faculty of Medicine and Health.

Contact for further information

Lead researcher: Rachel Casper
Email: r.casper@leeds.ac.uk

Supervisor: Dr Netalie Shloim
Email: n.shloim@leeds.ac.uk

Finally …

Thank you for taking time to read through this information sheet and considering participation in this project. Copies of informed consent and information sheets will be sent to the email address you provide.

Appendix K – Study Two Consent Form

Consent to take part in: An investigation into the use of play therapy principles as a non-directive therapeutic approach for adolescents with Autism Spectrum Disorder (ASD)	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated 20/4/22 explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw without giving any reason/ until 2 weeks after my involvement has ended and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. I have been made aware that I can contact the lead researcher Rachel Casper via email on r.casper@leeds.ac.uk and ask any questions or withdraw my data until the date specified. I understand that if I withdraw my data, it will be removed from the analysis and destroyed with immediate effect.	
I understand that members of the research team may have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential	
I understand that the data collected from me may be stored and used in relevant future research in an anonymised form	
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	RACHEL CASPER
Signature	R.Casper
Date	

Appendix L – Study Three Survey Questions

Provided information sheet (parent and child) and gain informed consent before continuing. Encouraged asking trusted adult for help in reading information sheet or understanding questions. If this option is ticked: asks for parental consent and parental email.

Demographic Questions	**Possible Answers**
Is someone helping you answer these questions?	Yes (please state how) No
Do you have an official autism diagnosis?	Yes No (ends participation)
Gender:	Male Female Non-binary Transgender Other
Age:	13 14 15 16 17
Ethnicity:	White-British White-Other Mixed Indian Chinese Pakistani Bangladeshi Black-British Black-Other African Caribbean Gypsy Traveller Arab Other
Do you have a mental health condition diagnosed by a doctor?	Yes No
If yes, what is your condition? (tick all appropriate)	Anxiety Depression OCD Psychosis Other (please state)

	Prefer not to say

Questions	**Possible Answers**
Before COVID19 how was your mental health?	Likert Scale (with emoji/faces) 1 (really bad) - 5 (really good)
How is your mental health now?	Likert Scale (with emoji/faces) 1 (really bad) - 5 (really good)
If it has got worse, do you think COVID19 had an impact?	Yes No Not Sure It has not got worse
If yes, what caused this? (tick as many as required)	Not going to school Not seeing friends Not seeing family Not being able to go to places where I was getting support e.g., counselling, groups, doctors Being unwell Caring for someone who was unwell Other (please state)
Are you getting support for your mental health?	Yes No
If yes, who from? (tick as required)	School CAMHS Doctors Counsellor/Therapist Other (please state)
If no, why not? (tick as required)	On a waiting list I have not told anyone yet My support has ended Other (please state)
Do you think there is enough understanding about autism from others?	Yes No
Do you think there is enough understanding about mental health from others?	Yes No
Have you ever felt that your mental health was ignored because you have autism?	Yes No

If you have had counselling or therapy before was it helpful?	Yes No I have not had counselling or therapy before
If yes, what kind of counselling or therapy did you have?	CBT Skills Training Art Therapy Play therapy Talking therapy (where you talk about yourself and your feelings to a counsellor/therapist NOT Speech and Language) Other (please state)
If no, why not?	I did not like my counsellor My counsellor did not understand me My counsellor told me what to do/gave too much advice My counsellor thought autism was a problem Other (please state)
Are you happy to be contacted for a short online focus group to answer more questions about your opinions? Your parents will also be contacted to ask their permission	Yes No
Would you like to be contacted about therapy sessions with a psychotherapist? Your parents will be contacted also to ask their permission	Yes No
Please enter your parents email address to receive the information sheet	

Thank you for participating (*contact details of researcher provided again), if any of these questions have made you feel upset or distressed, please contact the researcher.*

Appendix M – Study Four Focus Group Questions

Provide information sheet and gain informed consent before continuing

For the following questions please consider these definitions when answering:

Nondirective therapy: The therapist or counsellor is encouraging and does not direct the session or tells you what to do. You lead the session by sharing your feelings, problems and understanding your behaviour supported by the therapist.

Directive therapy: The therapist or counsellor leads the session based on what they think is important to you. The counsellor/therapist has training and experience which helps them tell you how to change your behaviour.

<u>Questions:</u>

1. What do you think could be done to improve mental health support for autistic adolescents?
2. Listening to the two definitions of types of therapy, which one would you find most useful and why?
3. Looking at these guidelines for therapy, what are your thoughts on this? (show them the eight guidelines/share screen) and talk through each in turn:

Develop a warm and friendly relationship with you.
Accepts the you as you are
Encourages you to express all your feelings
Listens to your feelings and helps you understand yourself and your behaviour
Believes in you to make your own choices, make changes and solve your problems.
Does not lead the session or tell you what to do but follows what you want to do
Does not hurry the therapy or tell you when to end your sessions
Explains what their job is and what you can expect from them and what they expect from you

4. What could counsellors or therapists do to better support you and your mental health?
5. What has been the hardest part of COVID19?
6. Would it be helpful if there was some support given to your parents to help them better support you at home?
7. If yes, what would be helpful for parents to know or learn?

Thank you for participating (*contact details of researcher provided again)*

Appendix N – Phase Two Adolescent Information Sheet

Information Sheet

What is the research?

We are doing some **research** 
It is about **autism, mental health and COVID19.**   
Research can help us make **support better** 

Why me?

	You **are between 11-18 years old**
	You are **autistic** or **have autism**

Who is doing the research?

 	The **supervisors** of this research are: **Dr Netalie Shloim** (top picture) & **Dr Judith Hebron** (bottom picture).
	The main researcher is **Rachel Casper,** she is a **psychotherapist** and **counsellor**
	This research is being completed at the **University of Leeds.**

Why are we doing the research?

 	Some young people have **mental health problems** such as anxiety or depression This can make **life hard** to cope with They may feel **sad, angry or worried** They may feel lots of **different emotions** and have **pains in their bodies** too
 	**Young people** with **autism** might be **more likely** to have **mental health problems**
	**COVID19** might have made young peoples' **mental health problems worse**
	There are **different ways** to help them **feel better** **Therapy or counselling** is something that **might help**
	**One type** of therapy is called **non-directive therapy** **Non-directive therapy allows you to talk, play or be creative** This might help you feel **better**
	Research can **help us learn more about the impact of COVID19**

What happens in the research?

	Between **50-100** young people will take part
	You will complete an **online questionnaire** on your own
	This will take about **5 minutes**
	Someone at home or school can **help you read** or **understand the questions** if you are stuck

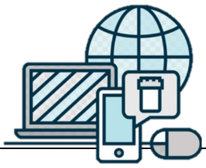
What next?

	After the questionnaire, between **5-10 young people** will be asked to join an **online group**
	The group will be asked **questions** to share their **thoughts and opinions** about **mental health, COVID19** and the **support** you would like
	This will take between 30 minutes and will be run by Rachel Casper

What will I have to do?

	You will **agree** to take part in the research by **writing your name on a consent form.** **Rachel Casper** and **your parents** can **help you** with this.
	You will **answer some questions** about **you, your feelings** and **how COVID19 impacted you.** This will be on the **computer.**
	**Some** of you will **take part in the online group** to answer **more questions** and **share your opinions and thoughts.**
	You **don't** have to **put your cameras or name on** the screen. You can be **anonymous.** We will just **hear your voice.**
	Rachel Casper will take **sound recordings** of the online group. This helps us to **remember** what you said **Only the researchers** will **hear the recordings** They will be kept **safe**

Where will the research happen?

	The research will happen **online**

Will I get paid?

	You will **not get paid** for taking part in the research

Do I have to take part?

	**You can decide** You **don't have to** take part
	If you change your mind, **you can stop** at any time You **don't** have to **give a reason**
 	You don't have to decide now, you can **think about it** and **take your time** You can **read** the **information again** You can **talk to your family** to **help you decide**

What might be good about taking part?

	You might **enjoy** taking part
	You will **help other young people** in the **future to get better help** by **sharing your ideas and opinions**

What might be **difficult** about taking part?

  	You might **feel tired** after the research You might **not want to talk** about or **remember** how you feel or things that have happened in the past You might not want to **share your feelings and opinions with others** in the **online group. If you feel upset at any time, you can turn your microphone off and take a minute to calm down before re-joining the group. You can email Rachel afterwards or contact the support services listed below.** It will **take** up **your time**

Is the research safe?

	An **ethics committee** has decided the research is **safe to go ahead**

What will happen after the research?

	The **researchers** will **look at the results**

	They will **learn more** about **how COVID19** affected **mental health problems**
 	The results will be **shared with other researchers, therapists and families.** Your information will **not** be shared All information will be **anonymous;** so **nobody would know you had taken part** The results will be **published in a journal** and **talked about at a conference**
	**If you decide you do not want to take part after you have finished the questionnaire or focus group, you can withdraw your answers up to 4 weeks from participating by emailing Rachel**
	If what you have shared in the focus group makes you feel upset or worried you should do one of these: **Tell a trusted adult** **Contact Rachel via email for support or** **Contact one of the below support services:** **Kooth:** https://www.kooth.com/ **Live chats, online journal and discussions** **Childline:** 0800 1111 **Counsellors available until 10pm online** **Samaritans:** 116 123 **24 hour helpline**

What next?

	You can tick to confirm you understand at the bottom of this page and continue to complete the consent form and research.

	You can **ask more questions** if you are undecided by emailing Rachel: r.casper@leeds.ac.uk
	If you decide to take part but find it easier to write or read the forms on paper instead of online, you can email Rachel and ask for a copy to be posted to you
	If you decide to take part in the **online group** you will be given a **time and date.** And your parents will be asked to agree to you taking part.

Glossary

Psychotherapist – Someone who supports people with their mental health

Anonymous – Not sharing your name

Journal – A magazine that talks about mental health research

Conference – A meeting of people who work in mental health to share research

Appendix O – Study Three Parent Information Sheet

Participant and Parent/Carer Information Sheet

An investigation into the use of play therapy principles as a non-directive therapeutic approach for autistic adolescents.

PHASE TWO: ONLINE QUESTIONNAIRE

You/your child are being invited to take part in a research project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the researcher if you have any questions or would like more information. Take time to decide whether or not you wish to take part.

This study has been reviewed and given a favourable opinion by School of Healthcare Research Ethics Committee on 16th June 2022, HREC 21-010.

The purpose of the project

This project aims to survey adolescents (13-18 years) who are autistic and understand the impact of COVID19 on their mental health. This is phase two of a complex intervention which hopes to assess the potential of non-directive therapy (not CBT, skills training, behavioural interventions) for autistic adolescents.

Why have I been chosen?

You are viewing this information sheet because you/your child has accessed the link sent out via social media/email. As such you have identified yourself/your child as someone between the ages of 13-18 years who has an official autism diagnosis given by a Psychiatrist.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet and be directed to complete the informed consent on the next page. You can withdraw your participation up to 4 weeks after completing this survey, after this data analysis will have begun. You do not have to give a reason for withdrawal.

What do I have to do?/ What will happen to me if I take part?

After completing the informed consent form, you and your child will be directed to the survey. This will ask some information about you/your child followed by closed questions about your experience of COVID19 and the impact it had on your child’s mental health. This survey will take approximately 5 minutes and should be completed in one attempt. If you are helping your child complete the survey, please tick the box stating you have supported them at the start of the survey. We are really interested in the views of adolescents, so try as much as possible to be honest or capture their experience as they share it.

Upon completion of the survey you will be asked if you/your child consent to a follow-up online focus group to discuss mental health and COVID19 in more detail. This is also voluntary and a new information sheet and informed consent will be provided, with follow-up contact from the researcher to organise at a time suitable for you.

Upon completion of the survey you will also be asked if you consent be contacted and receive information about the next phase of this research, which is an offer of non-directive therapy for autistic adolescents with a qualified psychotherapist specialising in autism.

You will be asked to provide your email address for a copy of the information sheet and consent form to be sent to you. Data collected will be anonymised and analysed for statistical patterns.

What are the possible disadvantages and risks of taking part?

There is a risk of discomfort to participation in recalling some mental health concerns. It is not anticipated this poses a significant risk to wellbeing, but the researcher can be contacted if the participant experiences distress and support and signposting will be provided.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be used to inform and shape the therapy offered to adolescents with autism who may be experiencing mental health difficulties. Participants who consent to be contacted about the next phase may benefit from receiving therapy to support their mental health.

Use, dissemination and storage of research data

Data will be stored securely as per the University of Leeds Data Protection Policy for 5 years. The findings of these results are intended to be published in a peer-reviewed journal and shared with other professionals.

What will happen to my personal information?

All data collected from the surveys will be anonymous. Participants will not be identifiable from the results collected. Informed consent forms and email addresses will be sorted securely, separately to the results.

What will happen to the results of the research project?

All the contact information that we collect about you during the course of the research will be kept strictly confidential and will be stored separately from the research data. We will take steps wherever possible to anonymise the research data so that you will not be identified in any reports or publications.

It is hoped the results of this research will be published within 12 months of data collection, in a peer-reviewed journal. Details of this publication will be sent to you via the email address provided. You will not be identified in any report or publication if findings.

The data collected during the course of this project might be used for additional or subsequent research.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

This research will seek to understand your child's experience of COVID19 and the impact it had on their mental health. These findings will contribute to the overall investigation into the potential benefit of using play therapy principles as non-directive therapy for autistic adolescents.

Who is organising/ funding the research?

The research is being conducted at the University of Leeds, Faculty of Medicine and Health.

Contact for further information

Lead researcher: Rachel Casper

Email: r.casper@leeds.ac.uk

Supervisor: Dr Netalie Shloim
Email: n.shloim@leeds.ac.uk

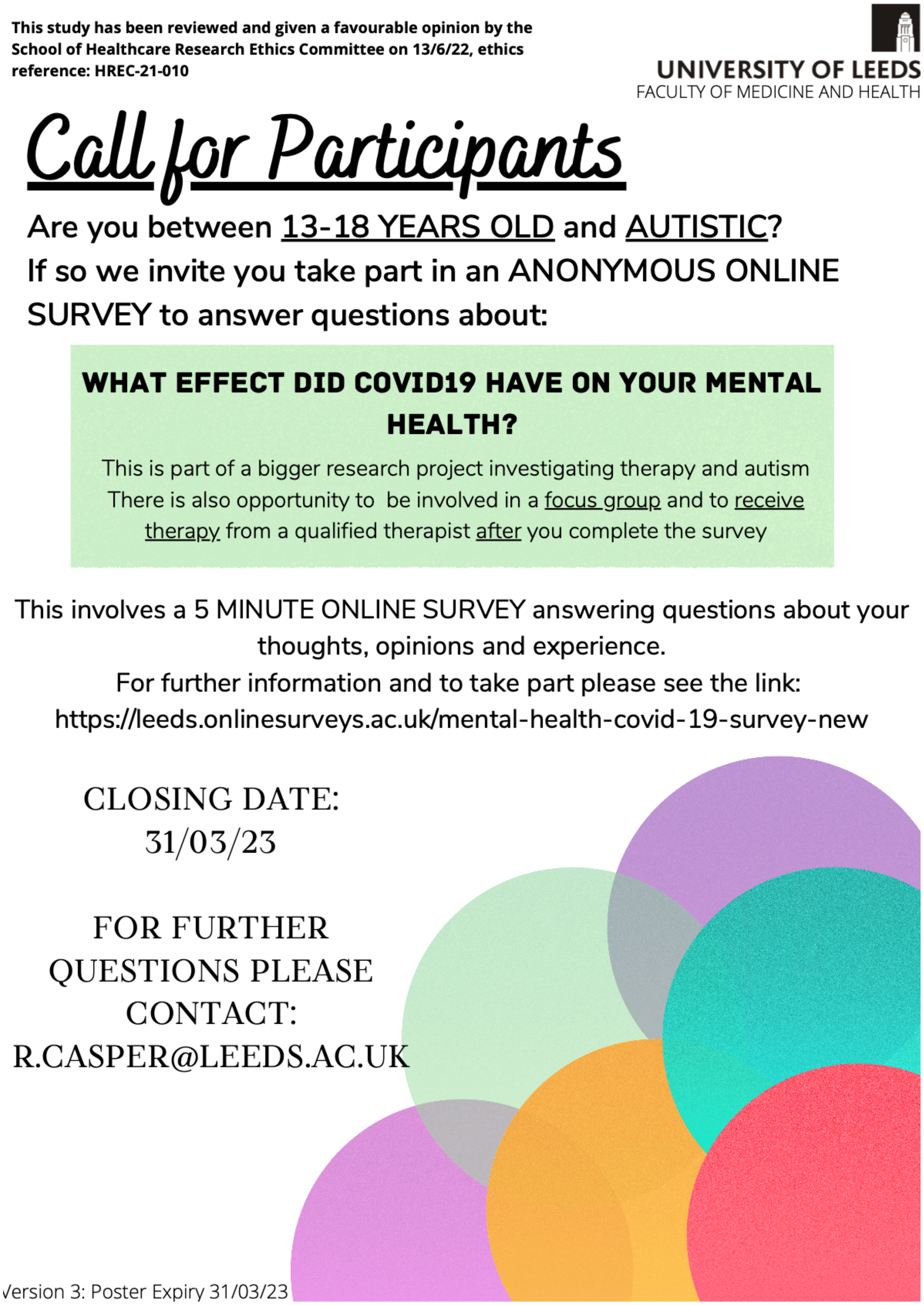
Finally …

Thank you for taking time to read through this information sheet and considering participation in this project. Copies of informed consent and information sheets will be sent to the email address you provide.

Appendix P – Study Three Video Information

Please use this link to view the video information: Appendix P.mov

Appendix Q – Study Three Recruitment Poster



This study has been reviewed and given a favourable opinion by the School of Healthcare Research Ethics Committee on 13/6/22, ethics reference: HREC-21-010

UNIVERSITY OF LEEDS
FACULTY OF MEDICINE AND HEALTH

Call for Participants

Are you between 13-18 YEARS OLD and AUTISTIC?
If so we invite you take part in an ANONYMOUS ONLINE SURVEY to answer questions about:

WHAT EFFECT DID COVID19 HAVE ON YOUR MENTAL HEALTH?

This is part of a bigger research project investigating therapy and autism
There is also opportunity to be involved in a focus group and to receive therapy from a qualified therapist after you complete the survey

This involves a 5 MINUTE ONLINE SURVEY answering questions about your thoughts, opinions and experience.
For further information and to take part please see the link:
https://leeds.onlinesurveys.ac.uk/mental-health-covid-19-survey-new

CLOSING DATE:
31/03/23

FOR FURTHER QUESTIONS PLEASE CONTACT:
R.CASPER@LEEDS.AC.UK

Version 3: Poster Expiry 31/03/23

Appendix R – Study Three Adolescent Informed Consent Form

Please tick the box to answer these questions about taking part. ☑
If you don't understand something, please ask me or someone close to you to explain.

	YES ☺	**NO** ☹
Do you understand what this project is about/have you understood the information sheet?		
Have you been able to ask questions about it?		
Do you understand that you can stop taking part if you change your mind?		
Do you understand you can withdraw your data up to 4 weeks after completing the questionnaire?		
Do you understand that you don't have to answer any questions you don't want to?		
Do you want to take part?		
Would you like to take part in the focus group to further share your thoughts?		

PLEASE TURN OVER OR CLICK NEXT
Please write your name: ______________________________
Please write today's date: ______________________________
Please sign: ______________________________________

Parents (if stated adolescent needs support):
Upon signing you agree for your child to take part and that you have read and understood the current research
Please write your name: ______________________________
Please write today's date: ______________________________
Please sign: ______________________________________

Researcher's name: RACHEL CASPER-WHITE
Today's date: ______________________________
Researcher's signature: ________________________

Appendix S – Study Three Parent Informed Consent Form

Participant and Parent/Carer Information Sheet

An investigation into the use of play therapy principles as a non-directive therapeutic approach for autistic adolescents.

PHASE TWO: ONLINE QUESTIONNAIRE

You/your child are being invited to take part in a research project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the researcher if you have any questions or would like more information. Take time to decide whether or not you wish to take part.

This study has been reviewed and given a favourable opinion by School of Healthcare Research Ethics Committee on 16th June 2022, HREC 21-010.

The purpose of the project

This project aims to survey adolescents (13-18 years) who are autistic and understand the impact of COVID19 on their mental health. This is phase two of a complex intervention which hopes to assess the potential of non-directive therapy (not CBT, skills training, behavioural interventions) for autistic adolescents.

Why have I been chosen?

You are viewing this information sheet because you/your child has accessed the link sent out via social media/email. As such you have identified yourself/your child as someone between the ages of 13-18 years who has an official autism diagnosis given by a Psychiatrist.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet and be directed to complete the informed consent on the next page. You can withdraw your participation up to 4 weeks after completing this survey, after this data analysis will have begun. You do not have to give a reason for withdrawal.

What do I have to do?/ What will happen to me if I take part?

After completing the informed consent form, you and your child will be directed to the survey. This will ask some information about you/your child followed by closed questions about your experience of COVID19 and the impact it had on your child’s mental health. This survey will take approximately 5 minutes and should be completed in one attempt. If you are helping your child complete the survey, please tick the box stating you have supported them at the start of the survey. We are really interested in the views of adolescents, so try as much as possible to be honest or capture their experience as they share it.

Upon completion of the survey you will be asked if you/your child consent to a follow-up online focus group to discuss mental health and COVID19 in more detail. This is also voluntary and a new information sheet and informed consent will be provided, with follow-up contact from the researcher to organise at a time suitable for you.

Upon completion of the survey you will also be asked if you consent be contacted and receive information about the next phase of this research, which is an offer of non-directive therapy for autistic adolescents with a qualified psychotherapist specialising in autism.

You will be asked to provide your email address for a copy of the information sheet and consent form to be sent to you. Data collected will be anonymised and analysed for statistical patterns.

What are the possible disadvantages and risks of taking part?

There is a risk of discomfort to participation in recalling some mental health concerns. It is not anticipated this poses a significant risk to wellbeing, but the researcher can be contacted if the participant experiences distress and support and signposting will be provided.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be used to inform and shape the therapy offered to adolescents with autism who may be experiencing mental health difficulties. Participants who consent to be contacted about the next phase may benefit from receiving therapy to support their mental health.

Use, dissemination and storage of research data

Data will be stored securely as per the University of Leeds Data Protection Policy for 5 years. The findings of these results are intended to be published in a peer-reviewed journal and shared with other professionals.

What will happen to my personal information?

All data collected from the surveys will be anonymous. Participants will not be identifiable from the results collected. Informed consent forms and email addresses will be sorted securely, separately to the results.

What will happen to the results of the research project?

All the contact information that we collect about you during the course of the research will be kept strictly confidential and will be stored separately from the research data. We will take steps wherever possible to anonymise the research data so that you will not be identified in any reports or publications.

It is hoped the results of this research will be published within 12 months of data collection, in a peer-reviewed journal. Details of this publication will be sent to you via the email address provided. You will not be identified in any report or publication if findings.

The data collected during the course of this project might be used for additional or subsequent research.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

This research will seek to understand your child's experience of COVID19 and the impact it had on their mental health. These findings will contribute to the overall investigation into the potential benefit of using play therapy principles as non-directive therapy for autistic adolescents.

Who is organising/ funding the research?

The research is being conducted at the University of Leeds, Faculty of Medicine and Health.

Contact for further information
Lead researcher: Rachel Casper
Email: r.casper@leeds.ac.uk

Supervisor: Dr Netalie Shloim
Email: n.shloim@leeds.ac.uk

Finally …

Thank you for taking time to read through this information sheet and considering participation in this project. Copies of informed consent and information sheets will be sent to the email address you provide.

Appendix T – Study Four Adolescent Consent Form

Please tick the box to answer these questions about taking part. ☑
If you don't understand something, please ask me or someone close to you to explain.

	YES ☺	**NO** ☹
Do you understand what this project is about/have you understood the information sheet?		
Have you been able to ask questions about it?		
Do you understand that you can stop taking part if you change your mind?		
Do you understand that you don't have to answer any questions you don't want to?		
Do you understand that everyone in the group will hear what everyone else shares? This means everyone will need to agree to keep the discussion private.		
Do you agree to have your answers recorded?		
Do you want to take part and give consent to show you have read the information sheet?		
Do you understand you can withdraw your data up to 4 weeks after taking part?		

PLEASE TURN OVER OR CLICK NEXT
Please write your name: ______________________________
Please write today's date: _____________________________
Please sign: _____________________________________

Researcher's name: RACHEL CASPER-WHITE
Today's date: _______________________________
Researcher's signature: ________________________

Appendix U – Study Four Parent Information Sheet

Participant and Parent/Carer Information Sheet

An investigation into the use of play therapy principles as a non-directive therapeutic approach for adolescents with Autistic Adolescents

PHASE TWO: ONLINE FOCUS GROUP

You/your child are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the researcher if you have any questions or would like more information. Take time to decide whether or not you wish to take part.

This study has been reviewed and given a favourable opinion by School of Healthcare Research Ethics Committee on 13th June 2022, ethics reference: HREC 21-010

The purpose of the project

This project aims to interview adolescents (aged 11-18 years) who have an autism diagnosis. This will take place in an online focus group. This is phase two of a complex intervention which intends to evaluate the potential of non-directive therapy for autistic adolescents.

Why have I been chosen?

You are viewing this information sheet because you/your child consented to be contacted about a follow-up focus-group after completing the prior survey. As such you/your child has identified yourself as an adolescent, aged between 11-18 years, who has an autism diagnosis and have already taken part in the first part of this research.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet and sent an informed consent form to return. You can withdraw your participation up to 4 weeks after completing the focus group, after this data analysis will have begun. You do not have to give a reason for withdrawal.

What do I have to do?/ What will happen to me if I take part?

You/your child will be involved in a 30 minute focus group that will take place online via Teams and be recorded. The group will be asked questions their experience of COVID19 and the impact on their mental health. This focus group will be recorded, then transcribed for data analysis purposes. The recording will not include video recording, there is no requirement to put your camera on and you will be given a participant number to replace your name. This will ensure you remain anonymous to others in the group and your involvement is confidential.

The audio recordings of the focus group will be used only for analysis. The recording will be uploaded to a secure server within 24 hours and anonymised. The recording will be transcribed and only the transcription will be included in the research. No one outside the project will be allowed access to the original recordings.

What are the possible disadvantages and risks of taking part?

There is a risk of distress to participation in remembering difficult events that may have happened. It is not anticipated this poses a significant risk to wellbeing. The researcher running the focus-group is a qualified psychotherapist and can be contacted if the participant experiences distress and support and signposting will be provided.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be used to inform and shape the therapy offered to adolescents with autism who may be experiencing mental health difficulties. Participants who consent to be contacted about the next phase may benefit from receiving therapy to support their mental health.

Use, dissemination and storage of research data

Data will be stored securely as per the University of Leeds Data Protection Policy for 5 years. The findings of these results are intended to be published in a peer-reviewed journal and shared with other professionals.

What will happen to my personal information?

All data collected from the focus group will be anonymous. Participants will not be identifiable from the results collected. Informed consent forms, email addresses and audio recordings will be stored securely, separately to the results.

What will happen to the results of the research project?

All the contact information that we collect about you/your child during the course of the research will be kept strictly confidential and will be stored separately from the research data. We will take steps wherever possible to anonymise the research data so that you will not be identified in any reports or publications.

It is hoped the results of this research will be published within 12 months of data collection, in a peer-reviewed journal. Details of this publication will be sent to you via the email address provided. You will not be identified in any report or publication if findings.

The data collected during the course of this project might be used for additional or subsequent research.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

This research will seek to understand your experience of mental health and the impact COVID19 had on you/your child. These findings will contribute to the overall investigation into the potential benefit of using play therapy principles as non-directive therapy for autistic adolescents.

Who is organising/ funding the research?

The research is being conducted at the University of Leeds, Faculty of Medicine and Health.

Contact for further information

Lead researcher: Rachel Casper-White
Email: r.casper@leeds.ac.uk

Supervisor: Dr Netalie Shloim

Email: n.shloim@leeds.ac.uk

Finally …

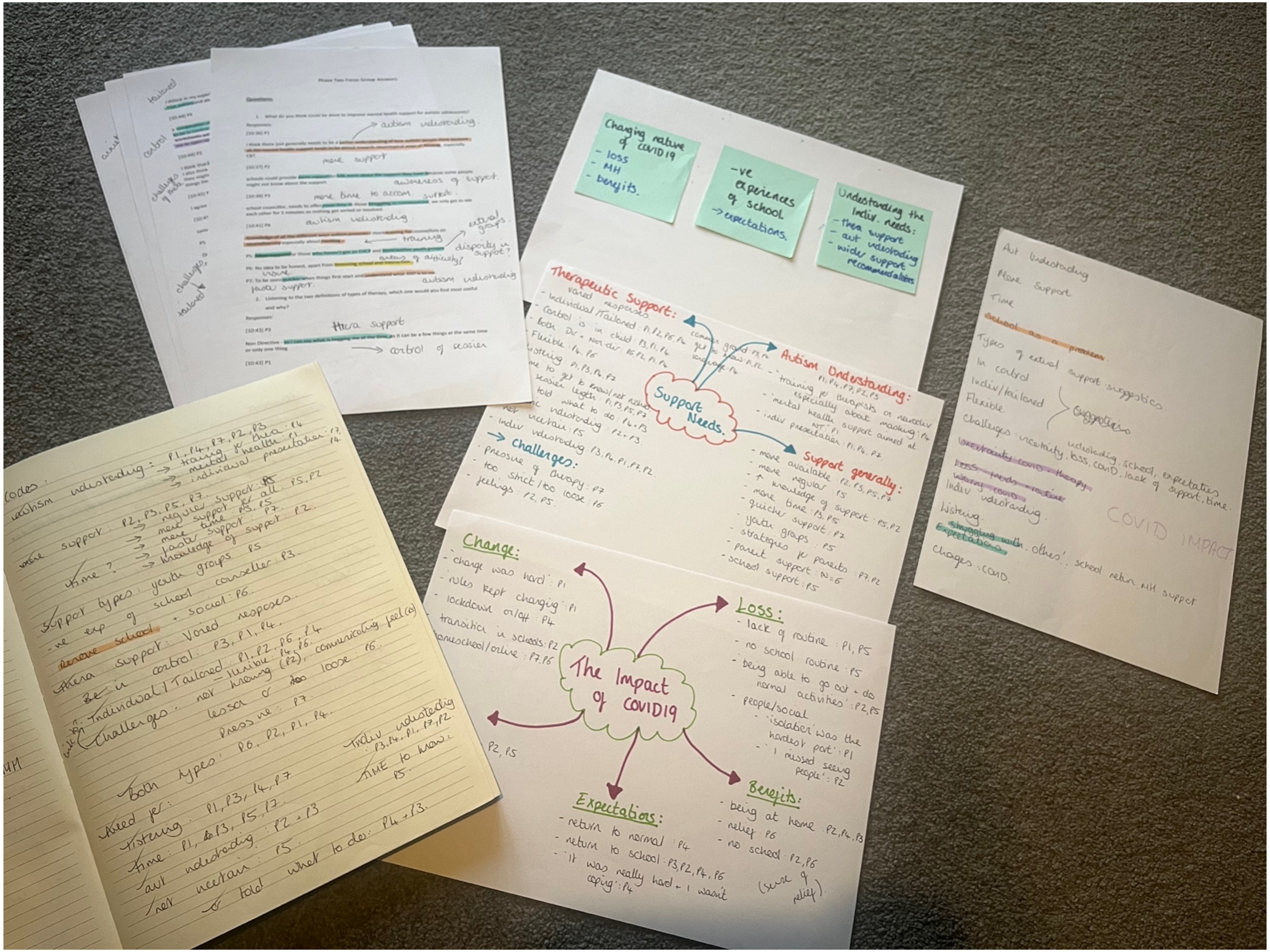
Thank you for taking time to read through this information sheet and considering participation in this project. Copies of informed consent and information sheets will be sent to the email address you provide.

Appendix V – Study Four Parent Consent Form

Consent to take part in: An investigation into the use of play therapy principles as a non-directive therapeutic approach for autistic adolescents **PHASE TWO: The impact of COVID19 on Mental Health in Autistic Adolescents**	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated [insert date] explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my child's participation is voluntary and that they are free to withdraw without giving any reason/ until 4 weeks after the involvement has ended and without there being any negative consequences. In addition, should they not wish to answer any particular question or questions, they are free to decline. I have been made aware that I can contact the lead researcher Rachel Casper via email on r.casper@leeds.ac.uk and ask any questions or withdraw their data until the date specified. I understand that if I withdraw their data, it will be removed from the analysis and destroyed with immediate effect.	
I understand that members of the research team may have access to my child's anonymised responses. I understand that their name will not be linked with the research materials, and they will not be identified or identifiable in the report or reports that result from the research. I understand that their responses will be kept strictly confidential	
I understand that the data collected from my child may be stored and used in relevant future research in an anonymised form	
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my child taking part in this research.	
I agree for my child to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of parent	
Name of child participant	
Parents signature	
Date	
Name of lead researcher	RACHEL CASPER
Signature & Date	

Appendix W – Study Four Coding Process



Appendix X – Study Five Focus Group Questions

Provide information sheet and gain informed consent before continuing. Then share screen and share below:

These eight guidelines outline play therapy principles, that are being proposed as a guide to non-directive working with autistic adolescents.

(1) Develop a warm and friendly relationship with the child.

(2) Accepts the child as she or he is.

(3) Establishes a feeling of permission in the relationship so that the child feels free to express his or her feelings completely.

(4) Is alert to recognise the feelings the child is expressing and reflects these feelings back in such a manner that the child gains insight into his/her behaviour.

(5) Maintains a deep respect for the child's ability to solve his/her problems and gives the child the opportunity to do so. The responsibility to make choices and to institute change is the child's.

(6) Does not attempt to direct the child's actions or conversations in any manner. The child leads the way, the therapist follows.

(7) Does not hurry the therapy along. It is a gradual process and must be recognised as such by the therapist.

(8) Only establishes those limitations necessary to anchor the therapy to the world of reality and to make the child aware of his/her responsibility in the relationship.

Questions:

1. Looking at each guideline in turn, what training would you need to work in this way? (go through individually)
2. Looking at each guideline in turn, how would this look for you in practice? (go through individually)
3. What might the barriers be to you working in this way?
4. Does this look like a feasible way of working with autistic adolescents?
5. Is there anything else you would add to these guidelines?

Appendix Y – Study Five Information Sheet

An investigation into the use of play therapy principles as a non-directive therapeutic approach for autistic adolescents.

PHASE THREE: TRAINING

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the researcher if you have any questions or would like more information. Take time to decide whether or not you wish to take part. Please note that your participation is entirely voluntary and not participating will have no adverse impact on your studies.

This study has been reviewed and given a favourable opinion by School of Healthcare Research Ethics Committee on 13/6/22, ethics reference HREC-21-010.

The purpose of the project

This project has an overall aim to assess the potential benefit of offering non-directive therapy (therapy led by the client) guided by play therapy principles to autistic adolescents (aged 11-18 years) for mental health and wellbeing. This is phase three of a complex intervention. The current phase invites trainee therapists to discuss and suggest the core components of training they would require to work therapeutically with autistic adolescents in a non-directive way that is guided by the following principles (Axline, 1969):

(1) Develop a warm and friendly relationship with the child.

(2) Accepts the child as she or he is.

(3) Establishes a feeling of permission in the relationship so that the child feels free to express his or her feelings completely.

(4) Is alert to recognise the feelings the child is expressing and reflects these feelings back in such a manner that the child gains insight into his/her behaviour.

(5) Maintains a deep respect for the child's ability to solve his/her problems and gives the child the opportunity to do so. The responsibility to make choices and to institute change is the child's.

(6) Does not attempt to direct the child's actions or conversations in any manner. The child leads the way, the therapist follows.

(7) Does not hurry the therapy along. It is a gradual process and must be recognised as such by the therapist.

(8) Only establishes those limitations necessary to anchor the therapy to the world of reality and to make the child aware of his/her responsibility in the relationship.

Why have I been chosen?

You are viewing this information sheet because you have been contacted by the lead researcher, Rachel Casper-White and expressed interest in participating. As such you have identified yourself as a trainee therapist.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet and sent an informed consent form to return. If you decide not to take part there will be no impact on your studies at the University of Leeds. Your participation is entirely voluntary. You can withdraw your participation up to 2 weeks after completing the focus group, after this data analysis will have begun. You do not have to give a reason for withdrawal.

What do I have to do?/ What will happen to me if I take part?

If you agree to participate you will provide informed consent. You will then be invited to attend a focus group with 10-12 participants that will take place online via Microsoft Teams at a mutually agreed date/time in the next 3-4 weeks. The focus group will be audio recorded and then written-up for data analysis purposes. The recording will be uploaded to a secure server within 24 hours and anonymised. The recording will be transcribed and only the transcription will be included in the research. No one outside the project will be allowed access to the original recording.

What are the possible disadvantages and risks of taking part?

There are no known risks associated with this research project. Should there be a disclosure of poor practice, criminal activity, potential harm, or anything additional that requires reporting, this will be stated immediately, reported to the lead researcher's supervisor and any relevant authority. This research project is entirely separate to your training programme and as such all data collected will have no bearing on your training. Should you share anything that is distressing you will have the opportunity to discuss this with the lead researcher privately after the focus group if you wish to.

What are the possible benefits of taking part?

You will contribute to important research that may help shape future training courses and the development of a non-directive therapeutic intervention for autistic adolescents.

Use, dissemination and storage of research data

Data will be stored securely as per the University of Leeds Data Protection Policy for 5 years. The findings of these results are intended to be published in a peer-reviewed journal and shared with other professionals.

What will happen to my personal information?

All data collected from participants will be anonymous. Participants will not be identifiable from the results collected. Informed consent forms, email addresses and audio recordings will be stored securely, separately to the results.

What will happen to the results of the research project?

All the contact information that we collect about you during the course of the research will be kept strictly confidential and will be stored separately from the research data. We will take steps wherever possible to anonymise the research data so that you will not be identified in any reports or publications.

It is hoped the results of this research will be published within 12 months of data collection, in a peer-reviewed journal. Details of this publication will be sent to you via the email address provided. You will not be identified in any report or publication if findings.

The data collected during the course of this project might be used for additional or subsequent research.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

The research will seek to understand your opinion and training needs for working non-directively with autistic adolescents based on play therapy principles. This research has been developed based on the findings of a prior systematic review and Phases One and Two of this research. The results from this study may be used to inform future training provision for counsellors/psychotherapists and the creation of a non-directive intervention study.

Who is organising/ funding the research?

The research is being conducted at the University of Leeds, Faculty of Medicine and Health.

Contact for further information

Lead researcher: Rachel Casper-White

Email: r.casper@leeds.ac.uk

Supervisor: Dr Netalie Shloim

Email: n.shloim@leeds.ac.uk

Finally …

Thank you for taking time to read through this information sheet and considering participation in this project. Copies of informed consent and information sheets will be sent to the email address you provide.

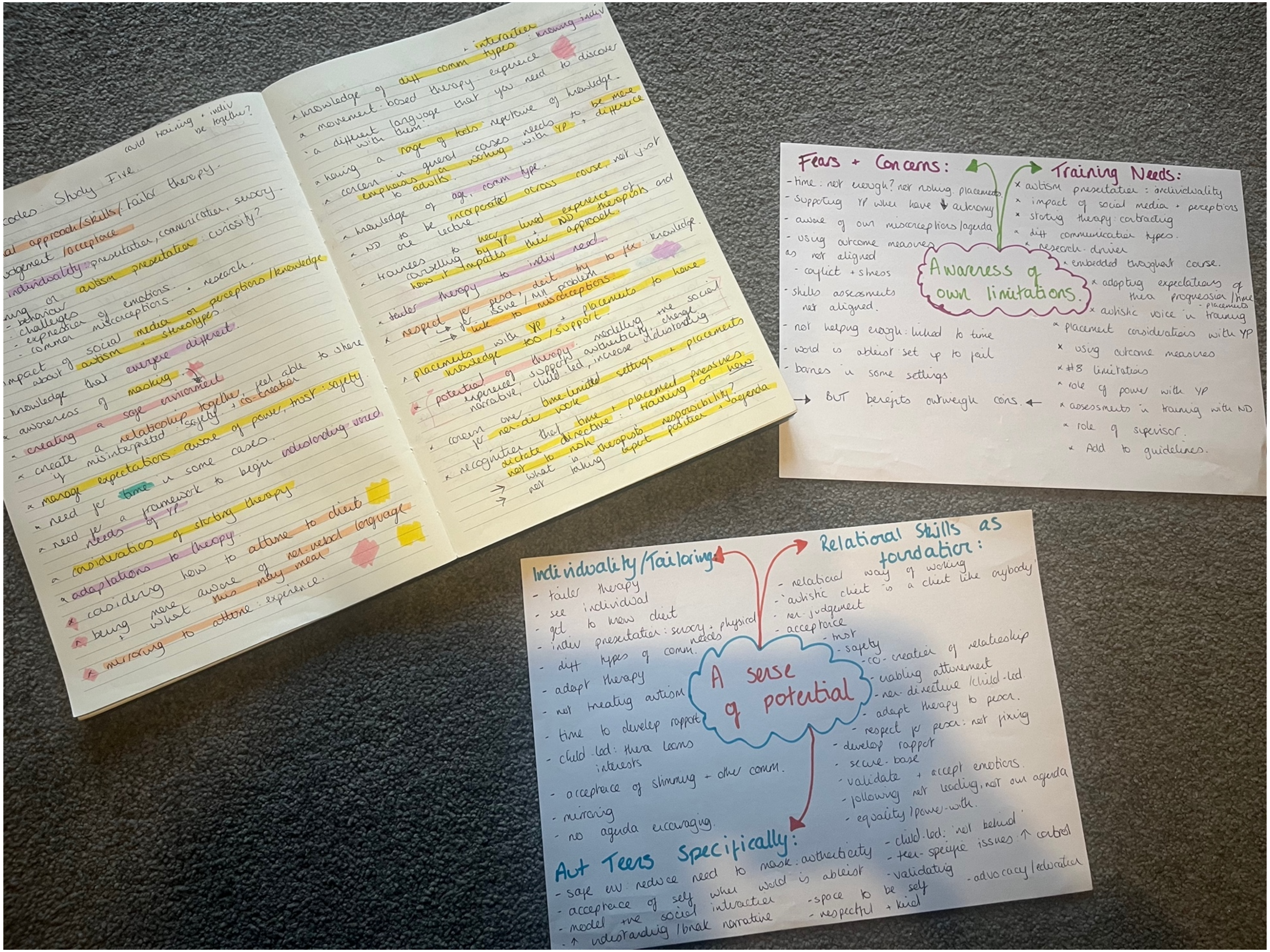
Appendix Z – Study Five Consent Form

Consent to take part in: PHASE THREE: Exploring the training needs of trainee therapists when working non-directively with autistic adolescents	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated [insert date] explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and I am free to withdraw without giving any reason/ until 2 weeks after the involvement has ended and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. I have been made aware that I can contact the lead researcher Rachel Casper-White via email on r.casper@leeds.ac.uk and ask any questions or withdraw my data until the date specified. I understand that if I withdraw my data, it will be removed from the analysis and destroyed with immediate effect.	
I understand that members of the research team may have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential	
I understand that the data collected may be stored and used in relevant future research in an anonymised form	
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of participant	
Signature	

Date	
Name of lead researcher	RACHEL CASPER-WHITE
Signature	R.Casper-White
Date	8/7/2023

Appendix Zi Coding Process



could training + indiv be together?

codes: Study Five.

al approach/skills/: tailor therapy.

judgement/acceptance

individuality: presentation, communication, sensory.

autism presentation: curiosity?

ing on
- behaviour
- challenges of emotions.
- expression misconceptions.
- common

+ research.

impact of social media or perceptions/knowledge about autism + stereotypes.

knowledge that everyone different.

awareness of masking.

creating a safe environment

create a relationship together, feel able to share if misinterpreted: safety + co-creation

manage expectations: aware of power, trust: safety.

need for time in some cases.

need for a framework to begin understanding voice needs of YP.

considerations of starting therapy

adaptations to therapy.

considering how to attune to client

being more aware of non-verbal language + what this may mean

mirroring to attune: experience.

knowledge of diff comm types + interaction: knowing indiv

movement-based therapy experience

a different language that you need to discover with them.

having a range of tools repertoire of knowledge.

concern in general cases needs to be more emphasis on working with YP + difference to adults.

knowledge of age, comm type.

ND to be incorporated across course, not just one lecture.

trainees to hear lived experience of counselling by YP + their ND therapists and how it impacts approach.

tailor therapy to indiv need.

respect for person, dont try to fix: knowledge
→ for issue / MH problem
→ link to misconceptions.

placements with YP + placements to have knowledge too / support.

potential of therapy: modelling the social experience, support authenticity, change narrative; child led, increase understanding.

concern over time-limited settings + placements for non-dir work

recognition that time + placement pressures dictate directive: training or new not to rush what is therapists responsibility? input position + agenda

→ what is taking

→ not

Fears + Concerns:

- time: not enough? not rolling placements.
- supporting YP when have ↓ autonomy
- aware of own misconceptions/agenda
- using outcome measures as not aligned
  - conflict + stress
- skills assessments not aligned.
- not helping enough: linked to time
- world is ableist: set up to fail
- barriers in some settings

→ BUT benefits outweigh cons. ←

Awareness of own limitations.

Training Needs:

× autism presentation: individuality
× impact of social media + perceptions
× starting therapy: contracting
× diff communication types.
× research-driven
× embedded throughout course.
× adapting expectations of thera progression/time - placements
× autistic voice in training
× placement considerations with YP
× using outcome measures
× #8 limitations
× role of power with YP
× assessments in training with ND
× role of supervisor.
× Add to guidelines.

Individuality/Tailoring:

- tailor therapy
- see individual
- get to know client
- indiv presentation: sensory + physical needs
- diff types of comm.
- adapt therapy
- not treating autism
- time to develop rapport
- child-led: thera learns interests
- acceptance of stimming + other comm.
- mirroring
- no agenda encouraging.

A sense of potential

Relational Skills as foundation:

- relational way of working
- autistic client is a client like anybody
- non-judgement
- acceptance
  - trust
  - safety
  - co-creation of relationship
- enabling attunement
- non-directive/child-led.
- adapt therapy to person.
  - respect for person: not fixing
- develop rapport
- secure base
- validate + accept emotions.
- following not leading, not own agenda
- equality/power-with.

Aut Teens Specifically:

- safe env: reduce need to mask: authenticity
- acceptance of self when world is ableist
- model the social interaction
- ↑ understanding/break narrative
- child-led: not behind
- teen-specific issues: ↑ control
- validating
- space to be self
- respectful + kind
- advocacy/education

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