A Thematic Analysis study of the challenges and potential of child and adolescent psychoanalytic psychotherapy with autistic young women.

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Abstract

This study explores the experiences of psychoanalytic psychotherapists working with autistic females in late adolescence, with particular attention to clinicians practising within NHS neurodevelopmental (ND) teams. Using a qualitative design, six child and adolescent psychotherapists were interviewed, with four interviews analysed using Thematic Analysis. The study aimed to identify key themes arising in psychoanalytic work with this patient group, focusing on both clinical challenges and therapeutic possibilities.

Five overarching themes were identified: 1. Autism can have different meanings; 2. Unstable relationships, identity and communication; 3. The importance of unconscious communication; 4. The need to offer flexibility and containment and 5. Endings and the complexity of letting go.

Therapists described difficulties in early engagement and identity formation, with autistic identity experienced as context-dependent, and both empowering and constraining. Clinical work often required adaptations in technique, including heightened attention to non-verbal communication, careful use of language and sensitivity to countertransference. Therapists also reported adopting facilitative roles within wider professional and family networks, which supported containment and collaborative understanding.

Despite the challenges, participants described significant therapeutic change, particularly in longer-term treatments of two years or more. The findings suggest that psychoanalytic psychotherapy, when sustained and adapted to the developmental and relational needs of autistic young women, may support meaningful psychological growth and transformation.

Introduction

This study explores the experiences of a small group of child and adolescent psychoanalytic psychotherapists offering psychoanalytic psychotherapy to autistic young women in late adolescence. The research focuses on clinicians working within specialist neurodevelopmental (ND) teams in NHS Child and Adolescent Mental Health Services (CAMHS), all based in London.

The project emerged from the researcher's experience as a trainee child and adolescent psychoanalytic psychotherapist working across both ND and generic CAMHS placements. During this time, autistic adolescent females appeared underrepresented in referrals.

The researcher observed that autistic females referred to CAMHS often presented with severe and debilitating difficulties, which intensified during adolescence. Presentations often involved significant anxieties during the transition to adulthood, complex peer relationships, concerns about body image and challenging life circumstances. Understanding these presentations appeared to require attention to internal emotional conflicts alongside external pressures, rather than a focus on diagnostic formulation alone. These observations prompted an interest in exploring such clinical work through a psychoanalytic lens.

The study aims to respond to a broader need within the psychoanalytic profession to engage more fully with neurodiversity and gendered experience in child and adolescent mental health. Both autistic females and the perspectives of psychoanalytic psychotherapists working with this group remain underrepresented in psychoanalytic literature. While psychoanalysis has historically had a complex and at times problematic relationship with autism and

disability, contemporary psychoanalytic psychotherapy has increasingly shifted away from deficit-based models towards attending to alternative forms of expression and symbolic meaning (Alvarez, 1992).

Although developmental and scientific research has substantially advanced understanding of autism within biological and medical frameworks, questions often remain regarding emotional and relational experience. Psychoanalytic psychotherapy may offer particular insight here, drawing upon knowledge from infant observation, early development and attachment theory, and in its sensitivity to non-verbal and unconscious communication. Such capacities may be especially relevant when working with autistic individuals whose emotional states may not always be easily verbalised or symbolised and whose presentations, particularly among females, may diverge from dominant diagnostic narratives (National Autistic Society, n.d.-a).

This study therefore seeks to explore psychoanalytic psychotherapists' experiences of working with autistic young women in late adolescence, with the aim of illuminating the clinical dilemmas, including emotional and relational challenges involved for both clinicians and patients. By emphasising therapists' perspectives, the research aims to contribute to a more nuanced and inclusive psychoanalytic understanding of autism, gender and adolescence. It does not seek to replace existing knowledge from other disciplines, but to add to the ongoing psychoanalytic dialogue and support a more integrated conceptualisation of this patient group.

Literature Review

Introduction

This chapter reviews the literature relevant to the research question, which explores themes in the contemporary practice of psychoanalytic psychotherapy with autistic adolescent females working within NHS neurodevelopmental teams. While there is a substantial and growing body of literature on autism more broadly, much of this work has historically focused on male presentations, with female autistic experience remaining comparatively under-researched and under-theorised. Only in recent years has increasing attention been paid to the ways in which autism may present differently in females, particularly during adolescence.

As a result, there is a limited body of literature that directly addresses psychoanalytic psychotherapy with autistic adolescent females. Much of the existing psychoanalytic writing on autism predates current understandings of autistic presentation, while contemporary mental health literature addressing autistic females has mostly tended to emerge from developmental rather than psychoanalytic frameworks. Consequently, this review draws on a range of related but not always directly overlapping bodies of work, with links to adolescent autistic females sometimes inferred rather than explicitly articulated.

More recently, a small number of clinically oriented texts have begun to address the specific needs of autistic young women within mental health services. These works, drawing on the accounts of autistic females who have accessed services, highlight factors that have shaped both positive and negative experiences of care and emphasise the importance of gender-sensitive and developmentally informed approaches (Bullivant, 2018; Cook & Garnett, 2018; Hendrickx, 2015). However, these contributions rarely engage in depth with psychoanalytic

theory or practice, leaving a gap in understanding how psychoanalytic psychotherapy may be experienced and utilised with this population within NHS settings.

In response, this literature review brings together several relevant strands of writing. It begins with a brief overview of autism, followed by a discussion of adolescence from a psychoanalytic perspective. The review then considers literature on adolescent females and mental health, before examining research and clinical writing on autistic females, including work on gendered presentations and the challenges of diagnosis. The final sections review psychoanalytic literature on autism, including its historical development, key theoretical contributions and the emerging evidence base for psychoanalytic work with autistic individuals. By synthesising these areas, the chapter aims to provide a conceptual framework for the current study and to situate the research question within the existing literature.

Outline of how the literature research was carried out

Inclusion and exclusion

As the bulk of empirical research in autism stems from disciplines other than psychotherapy, it was not possible to focus solely on psychoanalytic literature in this review. However, it was thought that the inclusion of research from other disciplines might also provide a more comprehensive account of the main areas of thinking and interest in this field. Additionally, research from other disciplines would highlight some of the differences in focus between biological and diagnostic-centred papers and those that emphasise more emotional and relational aspects, or with a focus on experience.

There was insufficient space in this review to do justice to the full scope of autism-centred literature, and therefore, some of the wider-researched areas less specific to the research question (e.g. papers on Theory of Mind), have been excluded from this review. Although Theory of Mind has been highly influential in cognitive accounts of autism and constitutes a substantial body of research, engaging with it in sufficient depth was beyond the scope of this small-scale qualitative study. The research question centres on psychoanalytic understandings of the therapeutic process and therefore prioritises the emotional and relational dimensions of clinical work. As these concerns are less directly aligned with cognitive frameworks, Theory of Mind was considered less directly relevant to this study.

The literature search involved five different methods:

- Online text searches in Google Scholar using terms and phrases relevant to the research question, such as 'Adolescent females in psychotherapy', 'Autism and females', 'Autism and psychotherapy' and 'Autism and psychoanalytic psychotherapy'.
- Online searches for empirical studies using the PEP Archive, which was accessed via the Tavistock and Portman library database.
- Citation searching - finding additional papers through scanning the reference lists or bibliographies of relevant articles.
- Recommendations from clinical professionals / author or article searches.
- Surveying my own personal library for psychoanalytic books and articles.

Additional information was gathered from online searches of autism-specific websites and books by autistic females.

The PEP archive was chosen on the advice that this database held the most current empirical research, single case studies, articles and journals relating to autism and any articles relating to autism and females. The search included:

- Studies about or including adolescent autistic females (aged 13-25).
- Studies focused on the mental health of autistic adolescents.
- Studies about psychoanalytic psychotherapy.
- Studies with links to full text articles.

The search focused on literature written in the English language, although not specifically stemming from the UK. This decision was made as a way to broaden the perspective within the study on autism in Western research. Choosing only English-language studies also related to the Western setting and clinical base of the researcher and research participants, who were all resident in the UK.

To conduct the search, the research question was broken down into key words (diagram A). Following this, the Boolean operator 'or' was used initially to diversify the search within the titles of each category and the operator 'and' was used to combine searches.

Diagram A

Category 1	**Category 2**	**Category 3**
Autis*	Female*	Psychothera*
ASD	"Young women"	"Psychoanalytic psychotherapy"
Asperger's	Girl*	Therap*

The search yielded only two results, and neither fell within the remit for inclusion in this study. Following searches combining categories 1 and 2 alone produced 39 results and similarly, a search of categories 1 and 3 alone produced 48 results. Filters were then used to locate articles written in English and with linked full text and according to date of publication (pre 1990 excluded, aside from classic psychoanalytic texts), age range and therapeutic modality (articles unrelated to psychotherapy, such as CBT-focused were excluded). Two duplicates were also excluded.

Altogether, 37 articles were left. Among these, none were specific to autistic females. Themes were limited to either psychoanalytic discussion of autistic experience or diagnostic ambiguity, historical and current perceptions of autism within psychoanalysis and a few single-case studies of autistic patients in psychotherapy.

Autism

Autism, also referred to as Autistic Spectrum Disorder (ASD), Autistic Spectrum Condition (ASC) and formerly also Asperger's Syndrome, is a lifelong neurodevelopmental condition. Current UK prevalence estimates from government surveys, suggest that approximately 1 in 100 people are autistic. This estimate includes individuals with and without a diagnosis. Other prevalence studies, however, have indicated that this figure is inaccurate, with the number of autistic individuals being much higher (*National Autistic Society*, n.d.).

As autism is a spectrum condition, presentations can vary for each individual, meaning there is no set definition of an autistic presentation. Current diagnostic criteria leading to a diagnosis of autism in the UK rely on assessments of an individual's capacities in aspects of social communication, social interaction and behaviour patterns, also known as the triad of

impairments. Although delays in developmental processes during infancy may lead to early diagnoses of autism, females are most commonly diagnosed in adolescence and adulthood, often after significant struggle or psychological breakdown. Although the triad of impairments captures important relational and communicative aspects of autism, it gives less explicit attention to emotional experience and sensory processing, all of which are important within psychoanalytic theory and practice.

Autism and mental health

Crane et al., (2019), conducted collaborative research with the participation of two autistic individuals who were involved in all aspects of research design, implementation and analysis of findings. The study involved 130 participants. It explored the mental health issues faced by autistic adolescents and young adults aged 16-25 years old and their experiences of accessing support. Participants described their experiences of ordinary situations in very different and more negative ways than those without a diagnosis. For example, they regularly reported feelings of worthlessness, reduced confidence, inability to face up to problems and consistently feeling under strain and the majority experienced mental health problems, which they believed exacerbated the above struggles.

One crucial outcome of these findings was that despite most participants having sought help from professionals, very few felt confident about approaching mental health services. This was despite outlining their confusion or lack of understanding about their mental health issues and how symptoms might differ from other more ordinary life experiences. Furthermore, very few considered the professional help they had received to be of value. Most participants felt uncomfortable discussing their mental health issues with the professionals they saw and had sought support from family and friends instead. This was also

felt to be the most beneficial for improvement of wellbeing. An additional number of participants had accessed help through charities and reported positively about the support they received.

As a way of expanding on these findings, the following section will focus on understanding adolescence in more general terms, from a psychoanalytic perspective. This felt particularly important given that adolescence is often a period during which autistic females experience increased difficulties, partly due to the growing social and environmental demands characteristic of this developmental stage.

Adolescence - a psychoanalytic perspective

Adolescence is known to be a time in which the child's physical and mental structure develop rapidly and need a lot of reorganisation. From a psychoanalytic perspective, it is a time understood to represent a second individuation process (Blos, 1967), during which the adolescent is faced with the return of earlier developmental conflicts as they renegotiate earlier object relations. It involves the reworking of paranoid-schizoid and depressive anxieties (Klein, 1935) in the hope of psychically separating from parental figures. This process presents the young person with new emotional and biological challenges and new experiences of guilt and reparation.

According to Freud (1905), the reactivation of the oedipal complex occurs during adolescence, as libidinal energy is redirected from infantile attachments to external objects. In more recent years, Margot Waddell (1998/2018), like Freud, emphasised how adolescence represents a second chance at development, where unresolved conflicts from earlier stages of life are revisited and the dual demands of separation and individuation are grappled with. The

individual must negotiate the tension between holding onto infantile attachments and strive towards autonomy, reworking unconscious conflicts related to dependency, rivalry, and the consolidation of sexual identity. The physical changes of puberty also bring the body into sharp focus, creating both excitement and anxiety as the individual attempts to understand themselves as an emerging sexual being.

The loss of childhood certainties and the emergence of a more defined ego ideal can cause adolescents to move between states of omnipotence and vulnerability. Whilst in these states, the seeking of refuge in peer groups or new ideologies can help to manage the anxieties provoked by the transition into adulthood. The capacity for mourning, whether of the lost childhood self or the security of earlier attachments, therefore, becomes central to the adolescent’s psychic development.

Socially, peer relationships can function as external representations of internal dynamics, where for example, idealisation or rivalry might play out in group situations. This is one example of how the adolescent can locate split-off parts of themselves into others as a way of managing internal anxiety. Investment in parental figures also begins to shift onto peers and romantic objects but can stir up further confusion and anxiety around the sense of loss that is generated.

Psychoanalytic perspectives also recognise the impact of societal and cultural factors on adolescent mental health. For example, Freud’s writings about melancholia (1917), can be seen to shed further light on the unconscious processes underpinning adolescent depression, showing how feelings of worthlessness, guilt and self-criticism could link to unresolved early losses, alongside internalised parental expectations and the challenges of

individuation. Attachment theory, first developed by John Bowlby (1969), provided a later framework for understanding how early relational patterns can influence adolescent mental health. For example, it was discovered that individuals with insecure or disrupted attachment histories struggled with issues of trust, self-esteem and emotional regulation. This left them more susceptible to difficulties such as anxiety and depression.

Additionally, Laufer (1997) highlighted the centrality of the 'adolescent breakdown' as a response to the demands of psychic integration. For Laufer, the adolescent faces the challenge of constructing a cohesive sense of self while confronting the often-ambivalent relationship to their body. The tension between the idealised phantasies of the self and the reality of the external world can lead to intense feelings of alienation, as well as rage and despair. Behaviours such as acting out, withdrawal or being self-destructive can be understood as expressions of the adolescent's struggle to manage this psychic struggle.

Adolescent females and mental health

For females, changes during adolescence are often accompanied by specific challenges related to identity and relationships, further complicated by the interplay of societal expectations and gender norms, as well as the emergence of sexuality. Adolescent females are disproportionately affected by mental health difficulties, and this is reflected in concerning statistics. In England, women aged 16 to 24 are almost three times as likely (26%) to experience a common mental health issue, such as depression, anxiety, eating disorders and self-harming behaviours, compared to their male counterparts (9%). Additionally, 25.7% of women and 9.7% of men in this age group report having self-harmed at some point in their lives. Body image concerns are particularly prevalent among adolescent girls. A survey revealed that 46% of girls reported that their body image causes them to worry 'often' or

'always', compared to 25% of boys. Furthermore, nearly half of 17-19-year-olds with a diagnosable mental health disorder have self-harmed or attempted suicide at some point, rising to 52.7% for young women (Mental Health Foundation, 2025). Adolescent females are also particularly vulnerable to the pressures of perfectionism and academic achievement. The increase in social media use is now also understood to be significantly amplifying many of these challenges (Nakazawa & Njoroge, 2023).

The mental health landscape for autistic females is even more complex and multifaceted. Research consistently indicates that this group is at a higher risk for a range of mental health difficulties, including anxiety disorders, depression and eating disorders. For example, Hollocks et al., (2019) reported that approximately 70% of autistic individuals experience co-occurring mental health conditions, with females showing particularly high rates of anxiety and mood disorders. Similarly, autistic females are disproportionately represented in clinical populations for eating disorders, such as anorexia nervosa, with one study suggesting that up to 20% of individuals diagnosed with anorexia may meet criteria for autism (Westwood & Tchanturia, 2017). One particularly alarming fact is the elevated risk of self-harm and suicidal behaviours in this group. Autistic females are up to three times more likely than their neurotypical peers to engage in self-injurious behaviours, with suicidal ideation rates reaching 50% in some studies (Cassidy et al., 2018).

A variety of interrelated factors contribute to the heightened mental health risks in autistic adolescent females. These include:

- **Camouflaging and Masking:** Presentation such as mimicking neurotypical social behaviours, (e.g. facial expressions or gestures); suppressing or disguising behaviours (e.g. stimming) or using scripted language (Dean et al., 2017; Hull et al., 2017).
- **Gender Bias and Diagnostic Delays**
- **Social Pressures and Bullying:** Autistic adolescent females often face intense social pressures to conform to gendered expectations of behaviour and appearance. Many report experiences of bullying, exclusion and social rejection, which further undermine self-esteem and contribute to mental health difficulties (Hebron & Humphrey, 2014).
- **Sensory Sensitivities and Overload:** Sensory processing differences, such as heightened sensitivity to light, sound, or touch, are common in autism and can be particularly distressing during adolescence. The cumulative impact of sensory overload can lead to chronic stress, anxiety and avoidance behaviours (Mazurek et al., 2013).
- **Intersectionality and Comorbidities:** Intersectional factors, such as socioeconomic status, ethnicity and sexual orientation, further shape the mental health experiences of autistic females. Additionally, autistic individuals often experience co-occurring conditions, such as ADHD or PTSD, which complicate their mental health profiles and treatment needs.

Autistic females, who may already struggle with somatic and sensory integration, may experience bodily changes as disorganising (Trevisan et al., 2021). Some clinical evidence has suggested that autistic females are more likely to present with heightened separation anxiety and dependency on maternal figures than autistic males (Capps et al., 1994). Sexual development poses a further set of challenges, particularly in the context of autistic females'

social vulnerabilities and tendency to rely on strategies to simulate social and emotional behaviours that are not organically felt (i.e. 'masking' or 'camouflaging'). While adolescent sexuality typically brings with it increased capacity for relatedness, autistic females may face more difficulties when it comes to negotiation of sexual interest or consent, due to challenges in understanding social cues and emotions (Lai et al., 2012). These difficulties can leave autistic females susceptible to exploitation, particularly when there is a strong drive to belong or to conform to societal expectations. Furthermore, research has shown how these issues are also known to provoke anxiety in parents of autistic females and influence a more 'hands-on' approach (Cridland et al., 2014).

The mental health challenges faced by autistic adolescent females can often lead to adverse long-term outcomes, including reduced academic achievement and impaired quality of life. This can cause many young women to become more socially withdrawn. The effects of social isolation and unaddressed mental health needs contribute to a vicious cycle of distress. Without timely and tailored interventions, many autistic adolescent females face ongoing challenges transitioning into adulthood, including difficulties with employment, relationships and independent living (Eaton, 2018).

Female perspectives and the issues surrounding diagnosis

The three main areas of autism diagnostic criteria outlined by the DSM are difficulties with social communication and interaction, relationship-building / relationship-maintaining and verbal / non-verbal communication. Symptoms thought to be experienced internally (e.g. social anxiety or depression), do not fit neatly into these categories. This is important to note, given that the prevalence of anxiety symptoms in adolescent females with diagnoses of both

autism and ADHD, and depression amongst males and females with both diagnoses, is higher than average (Accardo et al., 2024).

Autistic female presentations are known to correlate with those of non-autistic females (Head et al., 2014). For example, little difference is shown between the two groups in levels of empathy and sensitivity to others, although there may be a limited capacity to understand the nuances of more subtle aspects of communication, like, for example, a person's tone of voice. A consequence of this is that the potential for underlying anxieties to go unrecognised is exacerbated, and this may partially explain why autistic females have poorer mental health outcomes. Autistic females also appear to develop better sociability and friendship skills than autistic males, although there is some evidence to show that females are more likely to find ways to hide feelings of insecurity or vulnerability in social situations. However, among the scientific and neurodevelopmental perspectives on aetiology and diagnostics are studies that have detected differences between the sexes in brain functioning and genetics (Cridland et al., 2014).

The most contemporary autism research also makes us aware of a gender-bias when it comes to diagnosing autism, with males more likely to receive a diagnosis than females. Current estimates of the prevalence of autism in the UK place the male to female ratio at 3:1 and typically, recognition of autism in females tends to come 2-3 years later than males (*National Autistic Society*, n.d.). This could be problematic, as autistic individuals receiving later diagnoses are more likely to receive limited or delayed access to support if needed. Within the autistic community, diagnostic gender bias has been highlighted as an area that requires more research if mental health outcomes for autistic females are to be improved (Pellicano et al., 2014).

Reasons for the bias might link to continuing perceptions of autism based on 'outdated stereotypes and incorrect assumptions' that the condition is more prevalent in males (National Autistic Society, 2025). For example, it has been thought that females are less likely to revert to external 'stimming', or self-stimulating behaviours (e.g. recurrent or mechanical movements of the body or repetitive vocal sounds). However, it is now better understood that stimming can also occur internally (as a type of mental process), and therefore, may not always be apparent or obvious to others. Females who stim externally have been found to receive earlier diagnoses. Furthermore, an additional complication regarding diagnosis comes from the fact that autistic female presentations are not always consistent and can change in accordance with differing situations. This suggests the need for more thought and flexibility around the assessment criteria (Autistic Girls Network, 2025).

More recent studies indicate that interest in qualitative experiences of autistic girls and women is growing. Bargiela et al., (2016) interviewed late-diagnosed autistic women about various aspects of their past experiences throughout childhood and adolescence. Their narratives frequently outlined situations in which they felt misunderstood by professionals when seeking an autism diagnosis. Autism was frequently overlooked by medical professionals or misdiagnosed, which was thought to possibly be due to each woman's levels of self-awareness and intelligence. Most commonly, diagnoses of personality disorders were given before autism was considered. When it came to understanding how autism presented in these young women, professionals were generally experienced as lacking in awareness of female autistic presentations and initially making referrals for treatments targeting specific mental health issues, like anxiety or depression, rather than taking the time to understand which kind of support they required.

Most women in the study believed that receiving a late diagnosis had significantly impacted their mental health, contributing to the onset of depressive symptoms, anxiety and eating disorders. They recalled how their passivity and compliance throughout childhood fitted in with social stereotypes about girls being quieter and 'good', which often led to them being seen by others as 'shy' or the 'teacher's pet'. Rapid changes happened during adolescence, with attempts to fit in with peers backfiring or being misunderstood. Experiences of bullying and being labelled as different were common, alongside participants' struggles to fully understand peer routines and ways of life.

For many women, the eventuality of gaining an autism diagnosis seemed to bring a sense of relief and increased understanding of themselves. However, alongside this came resentment towards medical and educational professionals, who overall were experienced as unsupportive. Consistent reference was made to being frequently misunderstood and / or misdiagnosed when attempting to access support throughout childhood. This had exacerbated stress levels and feelings of isolation.

Following on from the above, there are now more studies focused on autism and females describing the impact of societal norms and culture on quality of life, commonly exploring issues around sense of self and experiences of being understood by others (e.g. Mo et al., 2022). Similar themes appear and echo accounts voiced within the female autistic community (Eaton, 2018; Hendrickx, 2015).

One of the earliest qualitative studies in this category was undertaken in Australia in 2013 and looked at the lived experiences of adolescent females and their mothers (Cridland et al.,

2014). Similar experiences were noted regarding diagnosis, with both mothers and daughters outlining the difficulties faced at the point of seeking a diagnosis as well as their experiences of not being taken seriously by the professionals encountered at different stages during the process. Having access to mothers' experiences enriched the data and provided understanding from a different perspective. These mothers spoke of feeling more challenged during their daughters' diagnostic journey than friends who were mothers of autistic boys. Additionally, their experiences of parenting autistic girls brought up female-specific anxieties around their daughters' management of puberty and sex-related issues. This seemed to directly influence parenting, highlighting how mothers tended to have a more hands-on approach with their daughters. In general, a sense of isolation was noted amongst the young women in the study, due to being 'surrounded by [autistic] boys' and by feelings of sexual and social vulnerability.

Autism and psychoanalysis: From controversial roots through a changing trajectory of psychoanalytic thought

Over the past century, historical concepts of autism viewed through a psychoanalytic lens have led to negative connotations about the suitability of psychoanalytic psychotherapy for autistic individuals in mental health settings. This is particularly true when thinking about the early linking of autism to deficiencies in early maternal care. Theoretical contributions from Bruno Bettelheim in the 1950s and 1960s and a small number of other psychoanalytic thinkers, gave rise to the view held by many over the subsequent decades that psychoanalytic psychotherapy can be unhelpful or even destructive for this patient group. Bettelheim (1967) popularised the concept originally coined by Leo Kanner, of the 'refrigerator mother', which outlined autism as a result of poor maternal care or 'cold mothering'. In his now outdated opinion, lack of maternal warmth led the child to turn away from seeking contact from its

mother. The result was a retreat into an autistic state, which he saw as a type of psychic defence (van Rosmalen et al., 2020).

In the early 20th century, Swiss psychiatrist Eugen Bleuler conceptualised the word 'autism' to describe what he thought of as a particular form of schizophrenia in childhood. His formulations in regard to autism pertained to an idea that the child carried 'infantile wishes to avoid unsatisfying realities and replace them with fantasies and hallucinations' (Evans, 2013). Bleuler had linked his concept to Freud's notion of 'auto-erotism' (1905), in which Freud described a very early, 'primary stage' of infantile sexuality. According to Freud, during this phase, the infant's tendency was to rely on parts of their own body (e.g. sucking their thumb) as a way to regulate and relieve anxiety. This process promoted the creation of unconscious phantasies in the mind of the infant, linked to aspects of the quality of their experience. Bleuler drew parallels with Freud's concept by describing the autistic state as one in which the infant also withdrew from external objects and focused more on the self and internal phantasy as a way to ease anxiety.

Consequently, the 'autism' label was taken up by psychoanalytic thinkers of the time, who were becoming increasingly interested in uncovering the roots of infantile psychopathology. Leo Kanner's interest in the children's parents fed into theories of autistic presentations as either a response to early stress situations, regression to an earlier infantile stage or a defense mechanism (Hobson, 1990; Mayes & Cohen, 1994). Autism was seen to be a condition only apparent during infancy and childhood, possibly due to the label of 'infantile autism' prescribed by Kanner (Evans, 2013). Studies of autism at this time were therefore largely directed towards children and the notion of autism throughout adolescence and adulthood seemed not to have been considered (Mesibov et al., 2000). It took many decades

and the Autism Act (2009) to dramatically change people's views on autism when it was made a statutory obligation in the UK for adult diagnostic centres to be provided by all local authorities.

Autism continued to be classified under the umbrella of childhood psychosis into the latter half of the twentieth century and a distinction between the two conditions did not arise until the American Psychiatric Association publicised the Diagnostic and Statistical Manual (3rd ed., 1980). From this point onwards, definitions of the essence of the condition began to focus on aspects of behaviour and deficits in communication. This led to increased interest and research in these particular areas (Koenig & Levine, 2011).

Leo Kanner's explorations and theories about autistic behaviours fed contemporary categorisations of autism. Diagnosis of autism has since centred on assessing communication, interaction and cognitive skills deficiencies and their contribution to developmental delay and restrictive or repetitive behaviours (Centers for Disease Control and Prevention [CDC], 2025). It is possible that Kanner's research also had some bearing on the continued interest in autism research within the fields of neuropsychology, neuropsychiatry and genetics.

Later developments in child mental health in the UK and in particular, the role of attachment, led by John Bowlby, a psychiatrist, psychologist and psychoanalyst, brought together leading scientific concepts and combined them with psychoanalytic theory. In essence, 'Attachment Theory' concentrated on exploration of the earliest caregiving relationship (in most cases the relationship between the infant and their mother), and the ways in which this relationship impacted an infant's developmental and emotional functioning (Bowlby, 1969).

Much of Bowlby's work centred on the anxieties he observed in infants who had been separated from their mothers in early life. His explorations tallied with contemporary psychology and ethological studies of attachment in animal babies, as well as other new discoveries about child mental health. Following the same line of thinking, Rene Spitz outlined the importance of developmental and emotional regression in many of the children growing up in Romanian orphanages in the latter half of the 1940s, which also contributed significantly to theories on child development and attachment (Music, 2017).

The development of attachment theory helped make it clearer that autism and attachment patterns were separate domains. This contributed to understanding that although communication style and ways of relating may be atypical, autistic individuals could develop secure attachments to caregivers (Rutgers et al., 2004). Attachment theory emphasised the importance of developing affect regulation in early relationships. Therefore, when viewed through an attachment lens, behaviours such as heightened anxiety and dysregulation in autism came to be understood less as autistic 'symptoms' and more as other forms of communication.

Contemporary views – later developments in psychoanalytic theory and practice

Frances Tustin: Autism and sensory experience

The British psychoanalyst, Frances Tustin, drew thinking away from blame-oriented theories, with concepts that took into account the psychological experiences of the autistic individual. She brought together formulations that did not view autism as a direct result of mismatches in parenting but as a developmental condition characterised by sensory phenomena and emotional vulnerability. Tustin emphasised the role of sensory phenomena in her belief that

autistic children experienced overwhelming sensations in the body. The sudden anxiety caused by physical separation from the mother's body (e.g. during birth) could be seen as an example of this. Tustin (1992/2021) posited that separation from the object could generate a sense of physical mutilation for the autistic child, as though they were losing a limb. She used the term 'autistic shell' to describe a protective psychic formation that an individual developed in response to overwhelming early experiences, suggesting that when separateness from the caregiver was felt as catastrophic or annihilating the child might defensively withdraw from emotional contact. The 'shell' became a sensory-based protection, functioning to block out the pain of separation and preserve a sense of continuity.

Tustin also put forward the idea that autistic children can come to rely on the use of 'autistic objects' and 'autistic shapes' to relieve themselves of these types of anxieties. These terms were created to describe types of self-devised sensory experiences. 'Autistic objects' (e.g. stereotyped or ritualistic behaviours) were seen to be 'hard' sensations used for strengthening the ego. They were thought not to have symbolic meaning but to function unconsciously, helping the child gain a sense of their own existence. 'Autistic shapes' were 'soft' methods used to self-soothe. This might, for example, be a child making patterns with their own breath or spit (1980, 1984). Tustin described how autistic shapes and autistic objects, when used as defences against anxiety, created an 'encapsulated' state in which the child could lose touch with the external world and have less ability to relate to others in more typical ways (1992/2021). Tustin saw autistic objects and autistic shapes as the predecessors to male and female and believed that the analyst had a part to play in helping these become unified for the child (Rhode, 2023b).

Tustin's work focused on the importance of creating a stable, predictable therapeutic environment for autistic children, proposing that experiences of intense anxiety and fragmentation can arise in response to unfamiliar or overwhelming stimuli. Tustin’s theories have been instrumental in shaping approaches to working therapeutically with autistic children, particularly regarding the need for attunement to non-verbal cues and establishing a safe, non-intrusive space. Additionally, Tustin drew parallels between aspects of autistic experience and anxieties characteristic of some neurotic states in non-autistic individuals, such as fear of losing a limb or of endlessly falling (1992/2021).

Donald Meltzer – Autistic barriers and dimensionality

Donald Meltzer expanded autism theory further within psychoanalysis in his considerations of internal landscapes and mental processes. To Meltzer, autism was seen to be a complex system for the mental management of distress, in which an internal ‘barrier’ served to block out painful or confusing thoughts. He believed that emotional communication and mentalisation were also impeded by a struggle to symbolise or represent thoughts and feelings.

In Explorations in Autism *(*1975/2018), Donald Meltzer outlined the state of psychoanalytic thinking on autism as it had developed by the 1970s. He suggested that for most neurotypical individuals, thoughts, emotions and relationships were experienced within a three-dimensional framework that encompassed not only depth, but differentiation of objects and emotions. In contrast, autistic individuals experienced a ‘flattening’ of psychic life into ‘two-dimensionality’, which challenged understanding of the layered quality of interpersonal relationships and the ability to engage in abstract thought.

Two-dimensionality was also thought to create a sense of confusion about separateness from the object and in perception of inside and outside in relation to the self. Sensory impressions and patterns, or repetitive actions were relied upon instead to establish order and predictability.

Meltzer also described types of primitive behaviours that were seen to be possessive or intrusive, e.g. The Claustrum (1992/2018). Adhesive identification (1975) described a notion of the autistic individual maintaining proximity to objects but without the usual depth of relational experience. This was seen as another form of defence mechanism, meaning that experience of relationships became flat and almost mechanical, rather than emotionally invested connections. Meltzer proposed that this reflected the two-dimensional psychic world and allowed an individual to form relationships without the risks and anxieties of deeper emotional involvement.

Both Tustin's and Meltzer's clinical work suggested that interventions with autistic individuals should prioritise building trust and emotional containment, avoiding intrusive interpretations or premature attempts to dismantle the individual's defensive structures. They both encouraged therapists to look beyond surface behaviours to understand the protective function of the autistic barrier and the deeper, often hidden anxieties that may be driving repetitive or ritualistic actions.

Focus on creating a stable therapeutic environment underscored the need for sensory attunement and respect for boundaries. Providing a consistent and non-threatening presence, could allow space for exploring new dimensions of thought, gradually facilitating the emergence of symbolic understanding.

Autism as a narcissistic structure and the capacity to tolerate separateness

Rhode (n.d.) described autistic states as involving a disturbance in the capacity to tolerate separateness and psychic differentiation. She focused on the psychological meaning of separateness and conceptualised that autistic children might struggle with the reality of discontinuity between self and object, due to a pull toward maintaining undifferentiated states of being and avoiding the pain of dependency and absence.

Rhode (2010) considered how in autistic states, the concept of mirroring (reaching the development of a stable sense of self through being psychically recognised within the caregiver's mind) may be compromised. This might be through constitutional vulnerability or relational difficulty but left the child uncertain about the ownership of their own experience, resulting in a fragile narcissistic structure in which the infant does not feel psychically recognised. Something of the self remains 'unclaimed' or 'unfound', marked by difficulty sustaining stable internal representations of others and a reliance on sensory experience to maintain a sense of existence. Clinically, the psychotherapist functions as a reliable internal mirror, enabling the gradual internalisation of being seen and known, and thereby strengthening internal structure.

Klauber (n.d., 1999), retained the idea of narcissistic withdrawal while placing greater emphasis on its adaptive and relational dimensions. She conceptualised autistic functioning as a retreat from experiences of overwhelming or traumatic relating, in which even minimal interpersonal contact may be felt as intrusive or destabilising. Narcissistic states, in this view, functioned as a protective solution rather than as evidence of constitutional deficit.

Klauber was particularly attentive to the countertransference experiences evoked in clinicians working with autistic children, including feelings of exclusion or helplessness. These responses were understood as communications of the child's internal world, in which the presence of another may be experienced as either persecutory or unbearably demanding. Her contribution represented a move towards more relationally-nuanced understandings of narcissistic organisation in autism.

Psychotherapy in contemporary times

Currently, psychoanalytic psychotherapists regularly work clinically with autistic children and adolescents within the NHS and there is growing interest in psychoanalytic autism research and theory (Acheson, 2023). Particular emphasis can be seen on measuring change through observation-based interventions with toddlers and parents (Houzel, 1999; Rhode, 2023a). Now, the idea of 'childhood autism' as the culmination of developmental regressions or emotional mismatches in early relationships with caregivers is extremely outdated. Modern psychoanalytic literature stresses the important role of early relationships in the shaping of the personality in a way that is broader in scope and builds in all types of experience, often drawing upon knowledge from other disciplines, like developmental psychology and child development research.

Psychoanalytic psychotherapists in ND teams aim to engage with the child in a way that takes into account the young person's stage of development, whether or not it relates in appearance to biological age. They will try to make meaning of the young person's emotional landscape and how this might connect to their particular modes of expression and pathological presentation. Furthermore, engagement with the patient in ways that connect with all aspects of communication is key, whether this might be verbal or non-verbal, expressed through the

body, action, stillness or silence. Typically, more time is dedicated to multi-disciplinary thinking in the period after a young person's referral to a neurodevelopmental service. Importance is placed on collective decision-making in regard to treatment pathways and when considering the needs of each family. What is on offer tends to be more 'bespoke', with every young person thought about in terms of their individuality.

The important function of the psychotherapist

Anne Alvarez integrated ideas from developmental psychology into psychoanalytic theory and her clinical practice to offer an active and emotionally attuned therapeutic method. Her work placed importance on the task of the psychotherapist to encourage the child towards improved awareness of human relatedness. She outlined three levels of therapeutic response, corresponding to variations in developmental and psychological states in autistic and developmentally delayed children (Alvarez, 2012).

Each level required different interventions to reflect the child's capacity for engagement, affect regulation and symbolic thought. A child at the first level may be pre-symbolic and lacking a fully developed sense of self or of others as separate beings. Their experience would be mostly sensory-driven and characterised by repetitive behaviours, withdrawal and an apparent indifference to interpersonal engagement. According to Alvarez, the therapist must 'loan their mind' to the child and structure interactions in ways that introduce meaning into what may otherwise feel like a chaotic sensory world.

At the second level, the child begins to develop better comprehension of difference and separateness, and their emotional world will be more organised, although they may still struggle to understand their own and others' thoughts, feelings, and intentions, or 'mentalise'.

Alvarez's interventions here aimed to strengthen the child's capacity to reflect on emotions and relationships, helping them link affect to language.

The third level was considered to be the equivalent of the typically practiced psychoanalytic work with patients unchallenged by developmental or cognitive needs. However, Alvarez's approach here emphasised the need to 'scaffold' a child's development through attuned intervention, rather than assuming traditional psychoanalytic methods.

Alvarez has encouraged psychotherapists to be more active and emotionally expressive when working with autistic children and adolescents and to form a bridge between the child's emotional and sensory worlds by avoiding abstract language. She also felt that autistic children may not always experience themselves as active agents in their environment and introduced the concept of 'reclamation' (1992), involving working developmentally rather than purely analytically with a young person. The idea was not just to uncover unconscious material, but to help the child develop capacities for affect regulation, agency, and meaning-making.

A single-case study (Alvarez & Lee, 2004) devised a method that measured a young autistic child's level of relatedness in intensive psychoanalytic psychotherapy over a period of four years. The child, 'Samuel' was under five years old. In conjunction with Samuel's psychotherapy, regular contact was made with Samuel's school and his mother also attended parent sessions on a regular basis. Assessment took into account both qualitative and quantitative data, which were a combination of the psychotherapist's summarised process notes and observations and video recordings. Process notes and observations included important aspects of the transference and countertransference and emotional content, whilst

quantitative data came from the video recordings. Areas of focus were on Samuel's general functioning, social relatedness, communication, play and levels of eye-contact. Some evidence of validity and reliability of data came through observation of samples of video recordings by a third party. Results showed an increase in Samuel's levels of relatedness over the four-year period, seen mainly through changes in quality and quantity of eye-contact, measured through analysis of both the qualitative and quantitative data.

Additionally, Alvarez, along with Sue Reid and others encouraged the development of psychoanalytic work with autistic patients in a London clinic. This led to important innovations in this field and broader thinking in regard to the experiences of young people and families attending clinics. Klauber (1999), for example, drew attention to the trauma experienced by families of autistic individuals through the experience of receiving a diagnosis, by describing how this trauma can be repeated in the process of retelling their circumstances over and over again with various professionals. She stressed the importance for clinicians to be mindful of the emotional impact of these traumatic experiences for families on the assessment and therapeutic process.

Similarly, Reid (1999) emphasised the importance of the assessment stage for autistic individuals referred for psychotherapy and their families and the need for this to be a longer and slower process. She encouraged psychotherapists to be more reliant on their observational skills during assessments to make meaning of the young person’s struggles and ways of presenting, both individually and within their family context. Reid encouraged therapists to be more reliant on their own countertransference as a way to make meaning of the young person’s internal states and to influence formulations. The assessment phase was

also outlined as a provider of containment for families, becoming for many cases an independent piece of clinical work that offered clarity and meaning to parents and carers.

The specific qualities of assessment in child psychotherapy were analysed by Petit and Midgley (2008) who explored the nature and function of assessment for psychotherapists working in CAMHS. They emphasise that assessment plays an important part in psychoanalytic psychotherapy and can have different formats. The main principles tend to be fixed but process, technique and reporting style may differ according to the psychotherapist or service.

They found that one of the main tasks of the therapist during assessment was to draw upon the observational skills honed during their training and pay close attention to the various aspects of a young person's internal and external environment. This might include exploration of the young person's anxiety defences as well as emotional and developmental factors, impact on the young person's management of external settings (e.g. their home and school environments) and relationship with the therapist. It was highlighted that assessment has many purposes other than gauging a young person's suitability for psychotherapy. The study brought to light the complexities of the psychotherapist's role in assessments and the delicacy in their task at this stage to offer understanding but without placing too much focus on the transference relationship.

Equality, diversity and inclusion

Before concluding this literature review, it was felt important to highlight some of the inconsistencies present within autism research and to briefly consider findings relating to

cultural and economic differences. Including these perspectives may help to emphasise the need for more accurate and culturally specific research in this field.

A 2023 systematic review (Bottema-Beutel et al. 2023) which assessed the standard of interventions for autistic young people in mid to late adolescence, found inconsistencies in both research design and outcome measurement in the majority of included studies. Furthermore, the potentially adverse effects on participants had not been considered in the studies, discrepancies that create complications when trying to accurately measure an intervention's efficacy and generalise results.

Similarly, a quantitative systematic methodological review in 2021 (Dickson et al) analysed the literature focused on the development of interventions to target co-occurring mental health difficulties in autistic children and adolescents. The authors drew attention to there having been a growth in this area of research over the last two decades, and that this has subsequently led to the formation of a number of evidence-based interventions. However, they found that despite the findings of several systematic and narrative reviews highlighting the efficacy of these treatments, they discovered a range of discrepancies, both in aspects of research design and in the categorisation of patient samples.

Most studies in the 131 projects reviewed, specified the types of co-occurring mental health issues amongst participants. Depression and anxiety, along with other internalising symptoms, were in the majority, followed by more externalised issues, most commonly relating to hyperactivity and disruptive behaviours. The ages of participants varied, with the majority being in upper latency and early adolescence. Young people at the age of transition into adulthood (between 19 and 25 years) were poorly represented, as were those from non-

Caucasian backgrounds. Additionally, although gender had been specified in all of the studies analysed, only 21.1% of participants on average was female.

Perhaps most interestingly, only a quarter of studies (28.2%) evaluated variations in participants' autistic presentations. The reviewers found that there were contrasts in the methods chosen to do this, meaning that there were limitations in the ability to accurately compare results of the studies. In addition to the discrepancies, it was noted that participants from ethnically and racially diverse backgrounds have been grossly underrepresented in autism research (Dickson et al, 2021). This creates a mismatch when looking at the reality of present-day referrals of autistic patients to child and adult mental health services. According to reports, over half of these referrals (up to 60%) are from ethnically underrepresented backgrounds (Brookman-Frazee et al., 2012).

There is very little evidence to describe differences in the prevalence of autism among racial or cultural groups. One of the largest studies undertaken within the last five years assessed the relationship between autism and socioeconomic and sociodemographic elements across the entire English state school system (Roman-Urrestarazu et al., 2021). 119,821 autistic students were identified within the sample and male to female ratio of autism prevalence within the sample was 4.32:1. Results showed that standardised autism prevalence was highest amongst black pupils (2.11%) and lowest amongst Roma and Irish travellers (0.85%), although it is not clear why there are such stark differences in prevalence between ethnic groups. It could be that cultural biases exist (conscious or unconscious) when it comes to diagnosis. Additionally, autistic pupils and those with both an autism diagnosis and additional special educational needs and disabilities (SEND), had higher levels of socioeconomic disadvantage than pupils without an autism diagnosis or SEND.

The above study also highlighted a difference between sexes in the levels of support autistic students received (through either an Education, Health and Care Plan [EHCP] or otherwise), within English state schools, with male students receiving more support than females (males / females with an EHCP 88.63% / 16.34% and males / females without an ECHP but receiving support 79.70% / 20.30%).

Current study

It is unfortunate that overshadowing the literature are explorations into the history of psychoanalysis and autism, as opposed to analyses of the efficacy of psychoanalytic psychotherapy with autistic individuals (Koenig & Levine, 2011). A backlash in the latter half of the twentieth century from families of autistic individuals against early psychoanalytic parent-blaming theories perhaps contributed to the dearth of new and more helpful research in this area over the years.

Despite this, there are many existing qualitative accounts of clinical work with autistic children and adolescents in psychoanalytic psychotherapy, which show positive developments regarding patients' emotional and relational landscapes over time (e.g. Alvarez, 1992). These accounts enrich our knowledge and understanding of the scope of psychoanalytic work with this client group and its potential benefits. However, most emphasis is on autistic children with significantly limited language and cognitive skills, and it remains the case that autistic females, particularly those in adolescence, rarely feature in the literature. However, there have been a few publications coming out, both academic and on the press, about the much higher presence of female autism and giving a wider understanding

of these issues, and which now need to be understood and integrated further into child psychotherapy practice.

This project, 'What can child and adolescent psychotherapists working with late-adolescent autistic young women tell us about the challenges and power of this approach? A Thematic Analysis' may therefore offer some insights into the essence of psychotherapists' interactions with female patients. As well as shedding light on some of the practical and theoretical elements of the role psychotherapists play in helping this client group after referral to CAMHS, it may offer new insights into the therapeutic relationship. Through analysis of unconscious elements within the work, as understood via psychotherapists' accounts, it may be possible to uncover important nuances of female experiences. As well as better understanding what the psychotherapist 'does', there is potential to understand how adolescent autistic females understand and relate to themselves and others and how that might shape their presentation. This may in turn be useful for shaping psychoanalytic work going forwards.

Research Design

Qualitative research

Qualitative research deeply examines and identifies key elements of experiences in the lived world. This type of research is most suitable for understanding processes, as opposed to quantifying size and extent of data as quantitative methods aim to do (Harper and Thompson, 2012). Despite their striking differences, the rich and expansive nature of qualitative approaches have also been useful for complimenting quantitative research (Braun & Clarke, 2014).

This study adopts an interpretivist epistemological stance, understanding knowledge as constructed through participants' accounts and the researcher's interpretative engagement with the data. By gathering data through interviews with psychotherapists, the researcher had scope to interpret stories of participants through their own perspectives, whilst at the same time, reflecting on their personal involvement in, and influence on, the research process itself (Hennink et al., 2020). An interpretivist stance aligns with psychoanalytic ways of knowing, in which knowledge is understood as relational and shaped by unconscious as well as conscious processes. The search for meaning involves a wish to interpret the reality of others in a way that offers 'warmth, openness and empathy' and gets as close as possible to their truth (Finlay, 2014).

Analysis of clinicians' accounts of their own practice was thought likely to reveal secondary themes relating to their patients, including aspects of the therapeutic relationship, the lived experience of autistic adolescent females in psychoanalytic psychotherapy and the states of mind encountered in the clinical work. The inclusion of unconscious processes aimed to

further enrich the findings and a qualitative approach therefore allowed for flexibility and deeper analysis of experiences.

Subjectivity and Reflexivity

As data-gathering itself happens within a context, it will vary according to each individual situation and will inevitably be impacted by the circumstances and situations of both the researcher and the researched. Qualitative researchers have highlighted the importance of reflexivity throughout the research process (Finlay & Gough, 2008). Being situated within a qualitative paradigm means that another researcher's findings on the same topic would be different to the discoveries laid out in this project. Awareness of the ways in which personal characteristics, experiences and outlook can impact efforts to be objective is key for successful and honest practice.

Therefore, the researcher felt it would be important to continuously reflect on their intersectional qualities, biases and personal and professional experiences. Throughout the process of undertaking this study, the researcher's own thoughts and reflections were continuously documented in a journal and were used as a way to understand their own positioning within the research and reflect on their general thoughts and experiences whilst undertaking the project.

Why Thematic Analysis?

Thematic Analysis (TA) as a qualitative research method, is regularly chosen for its potential to uncover and examine patterns within bodies of data. It has the potential to unlock both the evident and concealed elements within data, making it useful in psychoanalytic psychotherapy research, where complex subjective experiences and unconscious processes

need to be explored. TA benefits from being accessible and an approach that crosses epistemological and theoretical boundaries. It has been used extensively within the fields of psychology, social sciences, healthcare and humanities (Daly et al. 1997). As data analysis is not based in one specific set of theoretical principles, there is more potential for the identification of themes within a broader perspective. Once completed, a TA should highlight the most important areas of interest within a body of data, capturing the most 'affective, cognitive and symbolic' aspects (Joffe, 2012).

Braun & Clarke (2006) have outlined how thematic analysis allows for flexibility and permeability through interpretation of data. This gives scope to the researcher to continuously reflect on and adapt codes and themes as necessary throughout the process of analysis. They describe six phases of a typical TA:

- Becoming familiar with the data. This involves immersion in the data by reading and re-reading transcripts and noting down initial thoughts, reflections and impressions.
- Generating initial codes in a way that is systematic and stays applicable to the topic being researched.
- Searching for themes: Finding patterns within codes and gathering them into groups or themes.
- Reviewing themes. This involves assessing and reviewing themes by reflecting on their consistency to the data and research question.
- Defining and naming themes: Finalising each theme and being clear about their connection to the project title.
- Producing the report: Writing up findings from the themes identified through the data analysis and including data extracts to demonstrate ideas.

Limitations of TA

TA has been criticised as a 'poorly demarcated and rarely-acknowledged' method (Braun and Clarke, 2006), despite its aim to identify patterns and themes, rather than produce structures based on theory. Researchers have also regarded its lack of theoretical structure and inability to deeply interpret individual experiences as a negative aspect (Smith, 2015). Nowell et al. (2017) have also drawn attention to the potential for researcher bias when identifying codes and themes in data.

However, as a psychoanalytic psychotherapist, it felt important for the researcher to allow themselves to be subjective, whilst also being open and reflexive in thinking and approach. TA was deemed the most suitable method in this respect, especially considering the broad scope of the research question. Flexibility in interpretation was key, given the absence of patients' direct voices and the need to relay potential underlying meanings within the data. For these reasons, TA was chosen, as opposed to other methods, such as Interpretative Phenomenological Analysis (IPA), that are more concerned with interpreting lived experiences of individuals.

Data collection

1. Recruitment

In order to recruit participants for interviews, the researcher first made email contact with child and adolescent psychotherapists currently working in NHS neurodevelopmental (ND) services and teams, or who had worked in ND teams in the past. The researcher's own training experience within a specialist ND team enabled access to advice and

recommendations from colleagues about suitable clinicians to contact for potential recruitment. Given the small number of ND services for children and adolescents within the NHS, recruitment was not a hugely difficult task in practice.

Prior to any participants being recruited, the researcher conducted informal conversations with two experienced senior child and adolescent psychotherapists who had worked with autistic patients for many years within the NHS. This was for advice about the research topic and to help with planning the structure of interviews. An additional benefit from these conversations was a deepening of understanding of the evolvement of the practice of psychoanalytic child psychotherapy and autism within the NHS over the past few decades.

One of the most surprising aspects of these interviews was that both clinicians spoke of their very limited experience of offering interventions to autistic female patients during their working lives within the NHS (the latter half of the 20th century). On the other hand, psychoanalytic psychotherapy was regularly undertaken with autistic males. The researcher's understanding of the implications from these accounts, was that during this period, autistic females were rarely referred for psychotherapy in NHS ND teams.

This knowledge initially generated some concerns for the researcher about the ability to recruit enough participants with relevant experience for the project. However, this turned out not to be a problem, and all participants were recruited within the space of one to two months.

2. Interview questions

1. Can you say something about your patient's referral (including referral history, if known), and the impact of their mental health concerns on their day-to-day life and sense of identity?

2. Is there anything you can say about the impact of the patient's autism diagnosis on their sense of identity? (e.g. impact on self-image, friendships / partnerships, management of social or cultural expectations, etc).

3. How would you say your patient responded to psychoanalytic psychotherapy and how helpful do you think they found it? (Please include something about the transference / countertransference; their management of the therapeutic space and response to interpretations).

4. What were the biggest challenges or obstacles you / the patient faced during the course of the treatment? Were there ways in which you adapted your technique to respond to the patient's needs?

5. How (if at all) did gender feature in the work and have you noticed any differences between ASC-diagnosed female and male patients?

6. Is there anything you can say about your / your patient's relationships to the wider network (e.g. parents / family, external professionals, parent worker, MDT, etc)?

3. Sample size

When considering how to recruit for interviews, Braun and Clarke (2013) suggest that a minimum of 10 participants would be required for a typical university project or dissertation using TA, in order to gather a quality data sample. Due to the relatively small size of this study in relation to the average doctoral project and limited time for completion, this number was limited to six participants in total. It was thought that 6 would allow for diversity in clinical experience amongst participants. Eligibility criteria required participants to be qualified child and adolescent psychotherapists (CAPTs) with current or previous experience of working in an NHS neurodevelopmental team.

Participant characteristics:

- 2 newly-qualified CAPTs (under two years' experience post-qualification)
- 3 experienced CAPTs (between ten and fifteen years' experience post-qualification)
- 1 senior CAPT (more than thirty years' experience post-qualification)
- Age range: between 35 and 88 years.

Regarding other variables, there was an equal number of female and male participants recruited (three of each gender). In the UK, most NHS Child and Adolescent Mental Health Services (CAMHS) will see patients until they reach the age of 18, at which point they can be referred onto adult services. In this study, two participants worked in teams located within CAMHS and the other four were in specialist ND teams in which young people could be referred up until age 25. All six participants had more than three years' experience working as a psychoanalytic psychotherapist within at least one ND team or service. For the two newly-qualified participants, this included their years as a trainee CAPT.

4. Data recording and analysis

The data gathering process involved setting up semi-structured interviews, with participants given the option of either meeting in a familiar clinic setting or online. Two interviews took place in person and the other four were conducted online, due to participants' location or time constraints. Prior to their interview, each participant was given details of the process of recording, and a description of how their data would be managed during and after the interview.

In-person interviews took place in a confidential space within a clinical setting and participants who interviewed online were required to provide their own confidential space for the duration of the interview, where they would not be disturbed. All interviews followed the same format, with six open-ended questions, allowing for flexibility and depth of response.

Interviews were digitally captured using a voice recorder and then transcribed verbatim using Otter AI, after which pauses, emphasis and other features (e.g. coughs) were added to preserve aspects of the data that might be analytically meaningful.

The next stage of analysis involved coding the data through repeated reading of the transcripts to achieve familiarity and to identify significant codes across the dataset. Codes were iteratively refined throughout this process then subsequently reviewed and grouped into broader themes through an ongoing process of review and reorganisation.

At this stage, a decision was made to exclude two interviews from the final analysis. While these interviews contained clinically interesting material, their focus frequently diverged from the research question. Given the depth and richness of data present within the remaining four

interviews, it was felt that sufficient material was available to address the aims of the study without compromising analytical coherence. This decision was made carefully and with consideration of the potential implications for the project, with the final analysis therefore based on four interviews that were most closely aligned with the research question.

Research ethics

Formal ethical approval was gained via submitting a proposal to the Tavistock Research Ethics Committee (TREC).

Much thought was given to the choice of participants for this project. Although initially wanting to interview adolescent autistic female patients, this was discouraged by research training leads, as it was thought that the particular vulnerability of the chosen client group would place unnecessary ethical concerns on the project. This advice was followed and given the time constraints, a decision was made to focus on interviewing psychotherapists instead. The choice to interview only qualified psychoanalytic psychotherapists was purely down to the probability of participants having relevant experience of working with the chosen client group.

Consent

Consent was gained from all interviewees through signing of a participant information sheet, which clearly outlined all details of the project and areas relevant to potential participants. Participants were made aware that agreement to take part in the project was not a commitment to taking part if they had a change of heart and that they had the right to withdraw from the project at any stage, before, during or after interview.

Anonymity

Throughout the paper, all efforts have been made to eliminate any identifying names of individuals (participants and their patients) and places (e.g. clinical settings) referred to in interviews or within accounts of my own practice.

Findings

The aim of providing a full and in-depth account of therapists' experiences relies on the richness of the data gathered in interviews. As these interviews related to individual therapy cases, equal importance was placed on analysing patient information for better understanding of transference and countertransference phenomena.

Once all interviews were transcribed and coded, five themes emerged and from each of these, additional sub-themes could be created. The five overarching themes were then organised into the following categories (subthemes lettered and in brackets):

1. Autism can have different meanings.
2. Unstable relationships, identity and communication.
    a. (Building therapeutic relationships takes time)
    b. (Fragile sense of self and others)
3. The importance of unconscious communication.
    a. (Emotions are held in the body)
    b. (Therapists have deep-rooted feelings)
4. The need to offer flexibility and containment.
5. Endings and the complexity of letting go.

Each of these themes have been explored in more detail within this chapter, with reference to their relevant sub-themes. Extracts from participant interviews were included in the process of writing up findings, to broaden themes and give context to each topic.

Complex referrals and background

Additional aspects of patients' referral histories came to light during the process of data collection, and these factors were felt to have great significance to the study. It seemed relevant to begin this section with an overview of these themes. Having the freedom to base answers on experiences with one or more patients enabled interviewees to expand on their patients' psychotherapy journeys and explore aspects of the emotional content present within the work in more detail.

Patient history and referrals

Only one of the patients in the sample was believed to have received their autism diagnosis in early childhood (specific age unknown). In all other cases, autism had been diagnosed in late adolescence. The average age of diagnosis was 17, and this also happened to be around the same time as their psychotherapy referrals.

All young women in the sample were living with parents or carers. Four out of six lived with both parents / carers and two with only one. One parental couple was separated but continued to co-parent their children. All patients had at least one sibling, and one patient-sibling relationship was estranged. Ethnicities amongst the sample were varied: Four of the six families were of mixed European / non-European heritage, with areas spanning a wide range of continents. The other two females were of single origin (One European, one non-European).

Referral concerns were complex, with all females negotiating a variety of comorbidities spanning from moderate to severe. These included long histories of depression, self-harm,

suicidal ideation, anxiety, restricted eating, body issues / dysmorphia, OCD and extreme phobias. Patients also had other diagnoses in addition to autism, including ADHD and epilepsy. Two patients in the sample had additional learning difficulties, which in terms of the therapy, impacted certain areas for patients, like time management and organisational abilities.

Five of the six patients had been struggling with mental health issues throughout their childhoods, and most patients had experienced a period of intense psychological struggle in the period leading up to their psychotherapy referral. Some of the young women had been known to the NHS team where their clinician worked for a long time and all had accessed another psychological intervention prior to psychotherapy, either within the same service or externally. CBT and other more ‘structured’ interventions were the most accessed treatments prior to referral. Safeguarding concerns had culminated in the wider network referring one patient for psychotherapy. For another, psychotherapy came to an end due to a safeguarding disclosure, and this led to the young woman’s transfer to another specialist service for support.

Four of the six young women had complex and difficult histories, including involvement with social care. One young woman had been subjected to sexual abuse within the care system during early childhood, exacerbating the experience of trauma and feelings of loss and vulnerability associated with being separated from her caregivers. For the other females, experiences of physical or sexual abuse in either childhood or adolescence, carer neglect or physical / mental ill health had culminated in social care involvement. Interview narratives about these cases reflected patients’ and carers’ mistrust of services and professionals.

The education system had often been particularly difficult for many of the young women to navigate. This was despite some having been described as ‘high-functioning’, implying a sense of being psychologically robust. Participants reported that, in reality, many of these young women had experienced significant breakdowns in communication with educational settings, with some having rejected or spent extended periods out of education.

Experiences of bullying during childhood were commonly reported across the cases discussed by participants and most of the young women had struggled to form and maintain friendships with peers. Two patients had disclosed historical experiences of abuse that had not been reported to external authorities.

All cases had been in once-weekly psychotherapy, with two ongoing at the time of the clinicians’ interviews. These patients had been attending sessions for between one year and eighteen months.

Autism can have different meanings

The first of the overarching themes to be discussed considered the different ways an autism diagnosis or ‘being autistic’ could be understood and experienced by both the young women and their therapists. Psychotherapists remained attentive to the ways in which autism shaped both the young women’s navigation of everyday life and management of the therapeutic process.

Referring to an autism diagnosis could help some young women feel that external situations were more manageable and may have increased their confidence when expressing their

needs. Identifying as autistic could also support a stronger sense of being understood in everyday interactions, particularly in contact with services, as highlighted below:

She quite strongly advocates for her rights... with autism being a disability. So, I think this is something that she took as part of her personality and she's almost like protective of it (Therapist D).

I worked with a young person who was engaging with the housing services. And it was a really helpful sort of structure for them to be able to talk about their needs. You know... why a group home wasn't really appropriate. Why somewhere where there would be a lot of noise wouldn't be appropriate. Why lots of sort of continuous changes wouldn't be helpful for them. So, I think autism for their identity was really critical and helpful for constructing an idea of who they were in order to explain themselves to other people (Therapist C).

Alternatively, autism could feel confusing for some young women, as outlined by therapist A below. At other times, there were feelings that being autistic set them apart from neurotypical peers, such as highlighted by therapist C:

It was really hard for her to identify as autistic. I was the one like, bringing the autism, because my understanding was that she would not think herself as autistic. For many, many months, she wanted me to give her a diagnosis of anxiety. She wanted something that she could relate to, rather than something that felt a bit more abstract like autism (Therapist A).

So, it's really complicated, but the diagnosis is probably part of her feeling that something's really wrong with her, because that's something that she does talk about a lot… And that, you know, who'd want to help her?... Be her friend? (Therapist C).

For other young women, autism itself was not a particularly prominent narrative during sessions. This appeared to be more common among young women who had long been described in terms such as ‘high-achieving’ or ‘intelligent’. Other co-morbidities or physical illnesses might dominate narratives instead, as outlined by therapist B in this passage:

She seems more focused on her general difficulties. And maybe it's also because she's had this recent diagnosis of epilepsy, those aspects are more on her mind. And she's very worried about college… that's come up a lot [pause] So, I think she sees herself as a collection of problems or difficulties that are located in all these like difficult physical things that she's got… And interestingly, the autism hasn't really been spoken about at all (Therapist B).

Participants also described how efforts to broaden the way the young women thought about themselves could lead to moments of tension within psychotherapy sessions**.** For example, their attempts to highlight the young women’s strengths and capabilities or gently challenge fixed self-perceptions could sometimes lead to conversations closing down. The young women often experienced this as minimising the significance of their autism diagnosis and the difficulties associated with it. Participants found this dynamic challenging, as it could disrupt the flow of sessions and make it difficult to move the discussion forward:

I think there were times when she used the diagnosis as a way to avoid intimacy, or to enforce an idea that nobody ever gets her... you know. Nobody understands her. (Therapist D).

You know, 'I'm autistic, so I can't cope with this change'. Rather than it's been a break and it's been hard, emotionally difficult and hard to reengage... it's been very kind of dominated by this narrative that 'I'm autistic and so I can't do that' (Therapist C).

So, you might say something... give meaning, but they wouldn't see what you were saying, it would easily turn out badly and sound persecutory (Therapist B).

2. Unstable relationships, identity and communication

The second theme examined in greater depth how participants experienced their patients engaging with the therapeutic process. There were some similarities between aspects of the therapeutic relationship and the theme of identity within the work.

2a. Building therapeutic relationships takes time

The therapeutic space was thought to be anxiety-provoking for most young women, and participants, as noted below, reflected that time was needed for therapy to feel established and sufficiently safe for their female patients. This was possibly due to the intensity of individual focus and the expectation that they need not 'mask' in order to be taken seriously.

I think she does find it hard to be with me in a room and to have this… what you might think of as containing features. You know, someone's full attention. The same four walls,

the closed door, the quiet space. Actually, for her, I think that can be a little bit frightening (Therapist D).

I think that was very clear for [this] patient. I think it's clear and obvious in the family that she's the bottom of the priority. And it's hard for her to accept that she might be, certainly for that hour, my top priority (Therapist C).

As outlined below, lateness, missed appointments, and cancellations were common, particularly during the first year of therapy, and were often accommodated by therapists for substantial periods of time:

There is I think a kind of resistance to coming... I think her learning needs mean that she struggles with organisation and timing, and she is often late (Therapist B).

I was doing STPP with this young woman, and they stopped coming after a few sessions, maybe sort of five, six, something like that (Therapist C).

The week before, the week after the break, she would not turn up. Sometimes two weeks before. She wasn't able to think about that (Therapist A).

When thinking about potential meaning behind patient absences, participants tended to be analytic, although it could be challenging to explore these during sessions, as seen in the following quote from therapist B:

You know, it's so difficult when you work psychoanalytically and think about talking to people about being late. And what that might mean. And I think particularly for young people on the autistic spectrum, who can take things quite concretely that [lateness] immediately gets seen as not something to be explored, but as being told off, and then it's not really very helpful at all, is it?... so I've been very careful with it. (Therapist B).

These difficulties for the young women were often intertwined with broader anxieties about general life situations. As reflected in participants' narratives, transitions in life, such as moving from school to college or out of the education system, alongside exploration of independence, were observed as areas that evoked significant anxiety for some of the young women:

So, transition to secondary school was very tricky for her. She missed a lot of school. She had to repeat year 8. She had to re-sit her GCSEs (Therapist D).

One of the sessions we had was just utter despondency and dismay, and disappointment that she could see everyone else moving on, and she was here stuck (Therapist B).

We wondered about her ability to bring herself to a session after a few DNAs and mum not being able to bring her. And having that opened up and explored, I think, made her feel quite worried (Therapist C).

I did ask her, 'Now that you're 18, do you want our correspondence to go through your mum? Now that you have moved out, can we have your new home address?' And she would say 'No, no, everything must go through mum, because my mum remembers everything.' So,

there was this need to be the baby and her wanting to be... not wanting to separate from mum, basically (Therapist A)

Despite the challenges, participants observed that once the therapeutic relationship had become established and trust had developed, the young women often began to find meaning in the experience of psychotherapy:

I think she really appreciated one-to-one contact, you know, in our work. Ending with the previous CBT therapist, which I think was very hard for her - you know, the transition. Saying goodbye to the previous therapist, starting with me... I wonder if for her it's a little bit like catching up with something that was missed in her early experience in terms of maternal care. In terms of this kind of active presence there. Someone really putting her needs in front (Therapist D).

I was often talking about, especially like the second half of the journey, about getting in touch with the young version of her. And initially she was not able to think about anything, but then gradually, she was a bit more able to think about [that] (Therapist A).

2b. Fragile sense of self and others

Participants observed that some patients faced particular challenges when it came to thinking about their developing identity. Struggles around self-awareness, social identity and emotional processing could impact how the young women understood themselves and managed relationships.

As illustrated below, these dynamics were further complicated by the interplay of co-morbidities and issues such as sexuality, which became important areas of therapeutic exploration:

I feel like with her, for the bit I know, that she sees herself as a collection of problems or difficulties that are located in all these difficult physical things that she's got (Therapist B). *The complaints were about physical issues, physical illnesses and a kind of a link with the OCD... a link between real bruises and real felt body parts into something more sort of cerebral or emotional* (Therapist C).

I think there was something about sexuality that was not completely understood by her... by the family. I think most of the time this gravitated around this sort of not knowing what [identity] is. You know, sexual identity, identity in the family. And that has been the main thing (Therapist A).

Some young women were faced with ongoing uncertainty about where they fit, alongside confusion in negotiating multiple, sometimes contradictory aspects of identity, which generated significant anxiety. This was reflected in the following narratives by three participants:

I'm just thinking now... they were also diagnosed with DID (Dissociative Identity Disorder) and ADHD, and I'm wondering… I think autism was one of the more recent ones. But I might be wrong. But they had built up a sort of identity around their pathology, which again was quite a significant part of our work and presented them with problems, but also solutions to problems. And that has really been the crux of our work together, her identity.

And interestingly, you know, I was thinking about that the other day, because she still refers to herself as 'we'. And I think she does sometimes mean either her and her mum or her and one of her siblings. But there's certainly issues that she... she could refer to just herself (Therapist C).

In this case, this young woman wanted to identify as [mentions ethnic community]. She would pursue that sort of pathway... So there was this sort of play in her mind around identity, because she was clearly identifying with mum but unable to recognise it (Therapist A).

In terms of her sense of identity, I think they were intertwined with other aspects of her. So, the ASD was intertwined with the [cultural] part of her identity. With her sexual identity... with her sense of her body image as well (Therapist D).

As outlined in the passage below, peer relationships further shaped patients' developing identities. Some formed intense yet fragile friendships with other females, marked by cycles of closeness and breakdown, while relationships with males were sometimes experienced as more stable:

This is where the masking comes in, I think, because she was on a superficial level able to [have friendships]. *But she was unable to recognise genuine people, and she would end up in a lot of acrimonious situations... kind of difficult relationships with girls... friends. And I found it fascinating that she would turn up every couple of months with a new best friend* (Therapist A).

And then she went to a college, and it was very hard for her to find a place where she could fit in. There were a lot of issues around that. She experienced some bullying (Therapist D).

Family relationships appeared to occupy a central place in the internal worlds of many of the young women, several of whom seemed strongly attached and dependent, particularly in relation to mothers or female carers, as outlined below. Participants noticed shifts between dependence on maternal figures and feelings of frustration or resentment towards them, suggesting a complex and sometimes ambivalent relationship:

Mum sometimes brings her but the relationship between her and mum is quite strained. The young person feels that mum is very intrusive... she has to work quite hard to get her mum out of her mind (Therapist B).

And the fact that at nearly 18, she still would like her mum to come into the room. And to be dropped off... to be delivered in a way that you'd expect of a much younger child (Therapist C).

I think perhaps the biggest challenge in the work was this kind of enmeshed relationship between [the patient] and her mum (Therapist D).

[Patient X] who became actually sort of hyper-identified with mum, and sort of almost wanting to replace her (Therapist A).

Female therapists described moments where the sense of closeness felt especially intense, with elements of maternal or erotic transference emerging within sessions:

There was a passing erotic transference, which was quite interesting… But it seemed to be more of a testing the water. You know, what, what sort of person are you? And can I control the situation? (Therapist C).

I think this was all transference-evolved. Perhaps a more grown-up part of her as well, you know, wanting to meet someone really separate from her mum... to meet someone out there and have other important relationships. (Therapist D).

I felt a, a transference, perhaps a more... not erotic transference but a really, strong feeling of letting her down. I felt almost as if me and this ex-partner were one in her mind (Therapist D).

3. The importance of unconscious communication

This theme explores how therapists came to recognise and respond to subtle patient communications, both within sessions and across the wider network. Three sub-themes emerged: 3a. Emotions are held in the body 3b. Therapists have deep-rooted feelings, and 3c. The need to offer flexibility and containment**.** Together, these captured the emotional dimensions of the work for both patients and clinicians, alongside its practical demands.

3a. Emotions are held in the body

Participants emphasised the significance of the young women's body language, presentation and tone of voice as key indicators of emotional state and experience of safety within the therapeutic relationship. Subtle physical and vocal shifts were seen to

communicate anxiety that could not yet be expressed verbally. Participants described this in the following ways:

And interestingly... when she first comes in, she talks in this very high-pitched voice, like it's almost like a little girl's voice. And then, I can feel the tension. I never say anything about it, but I always kind of register it at a kind of more bodily level, and then after a while, when she calms down, it comes into a more normal register as the session goes on (Therapist B).

She's very kind of neat and tidy, and she'll sit quite still. And she will make very little eye contact. But her eye contact is different depending on how she feels. In the early days, you know, usual opening questions, she would use the same kind of monotone response to say things like, 'Erm...I don't know'. 'Erm… I'm not sure', but in the very same kind of tone and intonation... But I think it's also an expression of 'It's a hard question'. You know, 'It's hard for me to think about' (Therapist C).

Beyond tone and body language, the young women's bodies could be experienced as both empowering and vulnerable, as described by participant A below. The body could be used to assert agency whilst also being a source of confusion:

People started to pay attention to her body. And she started to think 'okay what am_I gonna do with it'? So, where this element of sexuality kicked in, no one knew what to do with it... The family got scared because she got scared (Therapist A).

I remember her coming to the session and talking about being catcalled and whistled at in the street. And she was quite excited about that. And the excitement was in relation to the fact that she managed to mask how much she was struggling in her life. She was struggling with school and learning and, you know, and masking… with her body (Therapist A).

In the statement from therapist B below, intimate interactions were described as having led a young woman into vulnerable or unsafe situations at times. Comments like this appeared to highlight how autistic young women could be particularly exposed to risk, which may have been due in part to difficulties in interpreting social boundaries and the intentions of others. Sexuality could also present a complex and sensitive area of therapeutic engagement, as outlined in the statement from therapist A:

One of the complicating factors for this young person was that there was fear of physical abuse from her boyfriend. She didn't want to pursue it any further and is still in a relationship with this young man (Therapist B).

There are pros and cons for a male therapist to work with a female patient... I think this area of sexuality, it was not fully explored. And I think it was a bit tricky for me to navigate her sexual phantasies as well, perhaps because I was scared that I would be part of them somehow (Therapist A).

3b. Therapists have deep-rooted feelings

The emotional depth of the work was often shaped by complex internal experiences, as Therapist D illustrated in the following narrative. Therapists' somatic responses reflected

the intensity of their attunement and appeared to resonate with their patients' struggles or experiences:

I remember she and I having this eye-contact, and a few times I found myself tearful, I don't know if she noticed or not, but I really felt tearful thinking about her. You know, what she's living with and how difficult (Therapist D).

I had this really strong feeling that perhaps I was not the right fit for her. That I was not good enough. I was not getting her. I really felt out of my depth. And I justified this by telling myself that it was because I hadn't worked with many girls on the spectrum... So, I was really dwelling with those thoughts in my mind (Therapist D).

And then also I think she had thoughts on her mind about is she a good enough patient to me? Is she Interesting enough? Which I think evolved over time (Therapist D).

Maternal and paternal countertransference emerged in participants' accounts, as seen below. For female therapists, this sometimes appeared to involve a wish to advocate for their patients and support the development of a more independent voice. For male therapists, feelings of paternal warmth could be accompanied by concerns about the young women's safety in their lives outside the therapy room:

I would say, I would have a sort of, a fairly maternal countertransference. So… the transference situation probably included a demand for an exploration of that relationship (Therapist C).

So, I think in the countertransference I felt quite a lot the sense of wanting to protect her, which I believe is a feeling, you know, this isn't, this was a parent projection. But at the same time, I wanted to protect her because I felt she was vulnerable (Therapist A).

4. The need to offer flexibility and containment

Participants occupied a range of roles within the work, alongside supporting the young women in psychotherapy. They frequently supported families and network professionals to better understand one another's perspectives, while keeping the young women's psychological difficulties in focus. Sometimes, the dynamics felt within the network were observed within the transference. These dynamics are illustrated below:

You know, she would look at the TA's CV... (and she believed that) they didn't take her ASD into consideration. So, this is something that we had to work together with the school to support. Members of staff to make sense of her difficulties and to find a way to address those issues that will come up in the school (Therapist D).

So, there was a lot of checking about who I was and what I was going to do and who I was going to share information with, and what kind of questions would I be asking about her and of the parents, and a concern that... you know, would they go into care? Which of course is pretty unlikely at that age (Therapist C).

Links with other professionals could have the secondary function of containing or reassuring clinicians, as outlined by therapist A below. Again, this seemed especially true when there had been a rupture in the therapy or breakdown in communication. The statement from therapist D below illustrates how these professional connections could also have a positive

impact on wider network relationships and support the smooth continuation of psychotherapy:

It took a while. First the task was to support the relationship with the TA, which we managed somehow with some networking meetings. And once that was more settled for her, I think she felt a little bit open to explore. You know, trust in the environment a bit more. There was a lot to do with trust (Therapist D).

There was always this sort of sense that is she safe enough to make a decision or will someone take advantage of her? So, I don't know if I addressed it in the therapy room, but this is what I would discuss in supervision [laughs] basically. [Pause] Especially when she was unable to tell me what she was going to do (Therapist A).

Similarly, peer support and supervision were seen to help participants process their responses and maintain a sense of perspective, particularly when patients struggled to engage with difficult material:

My colleague and I, you know, respecting confidentiality of the work, were trying to address this idea that when someone doesn't get you or when there is this kind of mismatch, then [the patient feels] 'that's it, that's over... It's finished!' But actually... difficulties, differences will be part of any relationship (Therapist D).

Attempts to explore experiences in a more traditionally psychoanalytic way, through interpretation or the introduction of new meanings, were occasionally experienced as overwhelming, and the flow of the session and sense of connection in the room could be

disrupted. Therapists described finding these moments challenging and spoke about the need to adjust their technique when appropriate, at times working in a less interpretative and more supportive way in order to re-establish a sense of safety and maintain the therapeutic alliance. The following passages illustrate these dynamics and how therapists used their countertransference as a guide in thinking about their patients' experiences:

I think with [this patient] it was more like... really slowing down the process and really navigating week by week. What came to my mind quite often was 'no memory, no desire', in terms of like really taking each session and making very, very, very gentle... very little connection. Because it would be overwhelming otherwise (Therapist A).

I think I held back transference interpretations far more than I might with another patient. I'm not sure that's because of her autism, or the fact that she was so ambivalent and found it hard to come consistently to the sessions (Therapist B).

It was a struggle to get to a more analytic space and to work within the transference situation. I more used the transference and probably more so my countertransference to inform on her state of mind, I think because of her difficulty to be more emotionally in touch, and to sort of verbally communicate her thinking. She was quite sort of fixed on what she talked about (Therapist C).

I felt I had to work in a way that... an unorthodox way of working. I had to be really flexible and go with my instincts. And I felt I had the freedom in the team to do it (Therapist D).

Some participants, such as therapist D below, described challenges in encouraging parents / carers to engage in work alongside their daughters' therapy. This was seen as a potential limitation, as it was felt that parent work could have provided valuable stability during the transition to adulthood and help strengthen both patient–carer and carer–clinician relationships:

Her mum was seen by colleague a few times, but it quickly broke down. Mum disengaged quite quickly. She became quite resentful at the parent worker. She felt... they didn't get her at all (Therapist D).

5. Endings and the complexity of letting go

For participants who had ended with patients, importance was placed in remaining mindful of emotional and relational boundaries, whilst also allowing space for young women to come to terms with the separation that lay ahead. Maintaining boundaries also enabled a continuing sense of safety and containment, especially as patients took more ownership of their narratives.

Therapists emphasised that endings were given extended time and often evoked complex emotions for the young women. These responses reflected both the depth of the therapeutic attachment and the difficulty of relinquishing a trusted space of containment and exploration, as illustrated below:

We took a bit of time, also because as you might understand working with autistic patient would necessarily imply giving them a bit more time when you, when you think about ending (Therapist A).

In psychotherapy, one needs to learn what's the best way to use it and explore how it can be helpful. I think she needed the time. So, it was really helpful being able to see her for three years (Therapist D).

In longer cases, particularly those extending beyond two years, young women were observed to increasingly explore their adolescent and sexual identities, sometimes initiating romantic relationships or engaging more actively socially. Some participants observed parallel developments in self-awareness and reflective capacity, with young women becoming better able to recognise their needs and articulate their experiences:

I think she was asking herself is she interesting enough? Is she pretty enough? What do people see when they look at her? Is she interesting enough to hold someone's interests so they will stay with her and not disappear? (Therapist D).

I think [the therapy] definitely enabled her to accept part of herself, you know. Not necessarily the autism... but get in touch with primary anxiety, you know, with the younger part of herself and acknowledge that there is a part of herself you can accept and you can carry on your life without feeling frightened about what's going on for you (Therapist A).

By the end of the work, psychotherapy appeared to be valued by the young women, although some felt anxious about facing future challenges without the therapeutic support they had

come to rely on. Endings could also evoke some difficult feelings. These points were outlined by therapist D. They also reflected on their own countertransference responses to ending the work:

This was the very end of our work, the very last session - [she said] 'I want to think about myself!' ... 'These are my mum's problems. I have other things I want to think about!' (Therapist D).

I think in the end of the work she was very angry as well. She wanted more and she was quite angry at me... something I had to work through as well. But, and then eventually she self-referred to a charity where she would get more talking therapy. And she said she's ready now to think about her past experience, the sexual abuse, this idea of meeting someone, falling in love. Now that she's in this place, she wants to explore this, which I thought was important (Therapist D).

So, it was very hard actually bringing [the therapy] to an end. It's… painful, yeah (Therapist D).

The data excerpt below illustrates how parents could also develop greater resilience through witnessing their daughters' progress in therapy. Therapist A described how one young woman's parents came to understand her needs more clearly and became better equipped to support her ongoing development:

The parent was really, really grateful for the work that we did, and they acknowledged how much therapy had helped [the patient] to be open with her parents. And to be more adult.

And parents gave up this idea that she was constantly in need, and she became more like a young woman to them. She was able to embody this sort of new identity. That sort of acrimonious rebellious adolescent relationship, that sort of eased a little bit. [Pause] They were more able to talk about things (Therapist A).

Alongside these developments, which were felt to be significant, there often remained a sense for professionals that the young women were still vulnerable in certain areas. This final excerpt captured this sentiment and how, despite the emotional challenges, one participant had witnessed their patient's development after three years of therapy. The slow, progressive nature of the work seemed critical in this respect:

I was thinking how, despite the challenges - because it was quite hard [laughs]... it was quite hard working with this patient. I do... I did feel quite rewarded, because I could see some sort of, I could see like a positive trajectory. Even though she was still posing a lot of anxiety. You know, a concern anxiety. A bit concerning to me and to the adults, you know. She sort of gradually was able to identify a bit more with the risk. Identify more with what was going on for her and notice stuff about herself, which I think wouldn't have been possible without the therapy (Therapist A).

Discussion

This chapter will provide a discussion and analysis of central themes within the data and findings. Some prominent ideas emerged, and it is hoped that this will improve understanding of the issues faced by both participants and their autistic female patients throughout the course of their therapeutic journeys. As this research has psychoanalytic underpinnings, concepts from theory will also be drawn upon to apply additional meaning to the data and as a way to analyse unconscious phenomena underlying the ideas.

Autism as identity and organising narrative

Study findings outlined the complexity with which 'being autistic' could be held in mind, appearing to hold contradictory meanings. For some young women it functioned as an organising framework that rendered experience more coherent. This was illustrated in the account of a patient negotiating housing services, where identifying as autistic provided a language through which her needs could be articulated and legitimised. The diagnosis seemed to serve as an ego-strengthening element, reinforcing self-advocacy and recognition by others. Similarly, the description of a young woman who was protective of her autistic identity, suggested that her diagnosis could be internalised as a valued aspect of her personality.

Tustin's (1992/2021) view of autistic phenomena being utilised as a protective 'shell-like' structure, may help to describe how the diagnosis itself could potentially have offered these young women a form of psychological self-preservation, highlighting vulnerability and dependency needs while at the same time, shielding other aspects of the self from exposure.

Autistic identity seemed more ambivalent for other young women, who found their diagnosis more difficult to identify with. The case who experienced her autism diagnosis as too abstract to meaningfully relate to and expressed a preference for an anxiety diagnosis instead, seemed to demonstrate this, as well as the young woman who identified more easily with her multiple physical diagnoses. It is possible that these identifications provided a greater sense of coherence where internal experience felt more fragmented. For example, anxiety or physical symptoms may have been easier to relate to due to their connection to more tangible or bodily experiences. This potentially offered a more accessible point of identification.

The autism diagnosis itself might be understood as reflecting an ‘encapsulated’ state, when strongly identified with or used as the main explanation for experience (Tustin, 1992/2021). From this perspective, identification with the diagnosis may sometimes have functioned as a protective structure, helping to guard against both vulnerability and overwhelm, whilst at the same time restricting the possibility of wider exploration.

Mirroring and narcissistic structures

Some aspects of the data may be understood in relation to psychoanalytic accounts that describe autism as a form of narcissistic organisation arising when early processes of mirroring and recognition are disrupted, leaving the developing sense of self insufficiently reflected and consolidated (Rhode, n.d., 2010). In such circumstances, there may be a pull toward maintaining ‘oneness’ with the object, to protect against the disruption that psychological separateness might bring.

Separation from caregivers, particularly mothers, was frequently described as complex and emotionally charged for the young women. Maternal figures occupied a prominent place in

their internal worlds, and the mother–daughter relationship often emerged as a recurring theme within the therapy room. Within this context, the therapeutic relationship itself may have come to represent a potential site of relational merging. Weekly separations between sessions, therapy breaks and therapy endings might have been experienced as difficult to tolerate, evoking major anxieties about separateness and a sense of 'falling apart'. These dynamics also appeared in many of the young women's experiences of difficult transitions, such as within the education system. Within the therapy space, they seemed particularly evident in work with female therapists, who may have been more easily experienced as available for psychological fusion.

Female therapists also experienced powerful maternal countertransference feelings (Klein, 1946), which may have partly reflected processes of projective identification, representing something of the young women's own anxieties about separateness and psychic disintegration. The wish to ensure that the young women remained engaged in therapy also gave a sense that the female therapists sometimes needed to actively 'reclaim' the young women within the therapeutic relationship, conveying through their persistence that there was a thinking other who was interested in them and able to hold them in mind (Alvarez, 1992). This was exemplified in the account of the young woman who struggled to grasp that she could be the therapist's sole focus during the session.

Descriptions of intense, 'all-or-nothing' friendships with female peers also illustrated this pattern, suggesting a relational template organised around fusion rather than mutual differentiation. The quality of these attachments appeared adhesive and two-dimensional, (Meltzer, 1975), where there seemed to be difficulty internalising a stable, separate other.

Related to this, some aspects of the therapeutic setting itself appeared challenging for the young women. Participants described how the open-ended nature of psychoanalytic psychotherapy, and its emphasis on exploration, could initially feel unsettling. The boundaried, one-to-one space, usually understood as containing, seemed too exposing for some young women. It is possible that previous engagement in more structured therapeutic approaches, such as cognitive behavioural therapy (CBT), with its clear framework and greater sense of predictability, had enabled a sense of control and stability. Where early experiences of mirroring and containment had been fragile, the relative ambiguity of psychoanalytic work and requirement for the patient to tolerate the therapist as a separate thinking object, may have felt particularly challenging.

Paradoxically, however, it is precisely the reliability of the therapeutic frame that can offer the possibility of developmental movement. It could be understood as enabling the conditions under which separateness can gradually be tolerated. Over time, repeated experiences of separation followed by return may potentially enable the therapist to become internalised as a more stable object.

The difficulty of recognising the therapist as a separate thinking object appeared within the clinical material itself, as with the young woman who frequently referred to herself as ‘we’. The therapeutic encounter, which requires the coexistence of two separate minds, may have evoked anxieties about fragmentation or loss of connection. Additionally, this concept might also explain why the therapist’s independent thoughts or interpretations could sometimes feel intrusive or destabilising for most young women and contribute to moments of withdrawal or shut down within sessions. In a similar way, the reluctance of some families to engage in

parent work may have reflected anxieties about the introduction of a 'third' into what was functioning as a tightly bound relational system.

Unconscious communication

Psychoanalytic theories of autism have long emphasised the primacy of sensory, bodily and pre-symbolic communication in the absence of verbal symbolic capacity. Participants described coming to rely less on explicit verbal communication, and more on subtle shifts in the young women's tone and posture, or their own emotional responses as indicators of the young women's states of mind. In work where verbal symbolisation is limited, the therapist's embodied and emotional responses may become a helpful source of analytic knowledge (Klauber, 1999).

Participants described observing how anxiety could be communicated through bodily channels, suggesting that affect was often registered somatically before it could be mentalised. By working sensitively to receive and reflect on the young women's emotional communications, therapists were often taking in experiences that had not yet been fully processed by the patient. In Bion's (1962) terms, these may be understood as 'beta elements', or raw emotional states that cannot yet be thought about or symbolised. Through a stance similar to maternal reverie, therapists attempted to hold and process these elements and gradually help patients transform them into thoughts and feelings that could be more psychologically managed. Over time, psychotherapy appeared to offer a containing space in which overwhelming or unformulated experiences could begin to acquire meaning and become available for reflection.

Engagement with professionals

As well as pacing the therapy and being attuned to patient anxieties and identity states, there were additional tasks for therapists that extended beyond the consulting room. One example of this was how they could take on the role of facilitator, becoming the key link between female patients and their families and wider professional networks. Making these links helped to shift narratives around the young women, enabling them to be better represented within their environments. This was especially true when external relationships had broken down (e.g. in educational environments), which was common in nearly all cases.

For patients who spoke of feeling misunderstood, therapists taking on the facilitator role seemed to positively impact their experiences of being heard and seen as individuals with emotional lives, as opposed to just carriers of behavioural symptoms. By ‘connecting the dots’ between patients’ observable behaviours and their underlying emotional and relational difficulties, therapists encouraged deeper understanding of patients’ identities within networks. This enhanced the therapeutic alliance and encouraged more open and empathic dialogues between families and professionals.

Engaging with other professionals also provided some therapists with an additional level of containment. These participants noticed that the dynamics of their patients' relationships with other professionals often echoed transference patterns towards them in the therapy room. Recognising this parallel gave these participants a broader perspective on their patient’s internal worlds and allowed for more integrated formulations and responsive interventions. Collaborating with colleagues also helped the therapists to recognise complex projections, which most commonly related to feelings of being powerless or not good enough for their female patients. Supervision played an important role in helping therapists process these dynamics, whilst having an additional holding function for therapists. For example, one

participant explored in supervision how their feelings of confusion and sense of persecution in sessions were states that mirrored their patient's own unconscious anxieties. Supervision therefore also became a space for 'reverie' and enabling unprocessed emotional content to be transformed into insight and meaning (Bion, 1962).

Endings

Endings in psychoanalytic psychotherapy are widely understood to be significant and emotionally complex. Within this study, therapists emphasised the importance of helping patients approach the ending of therapy in a way that felt containing and thoughtful, rather than abrupt or seemingly rejecting. Allowing space to process the ending was thought to be essential in supporting patients to manage the feelings that separation could evoke.

Time emerged as an important factor in the work. Participants described how longer treatments, often extending over three years or more, allowed trust in both the therapist and the therapeutic frame to develop gradually. Through this sustained process, patients could feel increasingly held in mind. As trust strengthened, therapists observed meaningful changes, including reduced anxiety, greater emotional stability, deeper exploration of personality and a gradual movement beyond a fixed identification with diagnostic labels.

This development may also be understood in relation to Klein's (1946) description of movement toward the depressive position, where ambivalence and loss can be tolerated and the object can be experienced as both loved and separate. In one account, a patient's ability to express anger towards the therapist at the point of ending could be understood as signalling developmental progress, suggesting that the therapeutic object could now survive attack while remaining meaningful. This also reflects the broader developmental challenges of

adolescence, where the push for autonomy can sometimes coexist with anxieties about loss and dependency.

Reflexivity

Throughout the research process, the question of the researcher's position, particularly as a non-autistic person researching a topic so deeply rooted in autistic experience, emerged as a source of considerable internal conflict. This 'outsider' status raised important questions about authority, representation, and the ethics of speaking *about* rather than *with* those whose experiences form the substance of the inquiry. The researcher became acutely aware of how this positioning risked perpetuating a wider pattern within autism research, wherein autistic female voices remain marginalised or entirely absent. This tension was particularly pronounced given the commitment in this thesis to recognising and amplifying aspects of the autistic female experience through the minds of psychotherapists who have built therapeutic relationships with them. This is something that sits in contrast to the historical underrepresentation of this group within this field.

While the exclusion of autistic young women from direct participation in this study was deeply regrettable, it was not a decision taken lightly, nor without reflection. It stemmed from a combination of practical and ethical constraints. The small-scale nature of this project, alongside time limitations and the procedural requirements of gaining NHS ethical approval, rendered direct access to this group unfeasible within the timeframe. When working with a population considered doubly vulnerable through the intersection of mental health and disability, these complexities become even more pronounced. The researcher thus found herself in a difficult ethical bind: to proceed with indirect data collection via clinician narratives, or risk not addressing the topic at all. This dilemma illuminated a recurrent tension

in psychoanalytic and qualitative research: the impossibility of ever fully resolving the question of who gets to speak, and for whom.

This challenge was further compounded by the researcher's dual identity as both a clinician and an academic. While clinical practice offers a rich and nuanced lens through which to make sense of unconscious processes and relational dynamics, it also imposes its own limitations. The therapists interviewed in this study, like the researcher, are embedded within a particular epistemological framework that privileges internal worlds, symbolic meaning, and intersubjective process. Consequently, the data produced is inherently partial. It reflects one perspective, shaped by psychoanalytic assumptions and filtered through the minds of professionals trained to interpret, contain, and respond to unconscious communications. This is not to suggest that such a perspective lacks value; rather, it raises important questions about the nature of truth in qualitative research and the ethical imperative to acknowledge what is left unsaid or unseen.

The act of writing itself became a reflective space where the researcher was repeatedly confronted with the question of how language both reveals and obscures. In reviewing literature and engaging with clinical narratives, a troubling pattern began to emerge in which autistic women were frequently portrayed primarily through the lens of their diagnosis. In the researcher's opinion, this risked dehumanising these young women and stripping them of the rich particularities of their individuality. The researcher became increasingly aware of how even well-intentioned research can inadvertently sustain this dynamic and reinforce the very isolation it sought to avoid.

It is understood that these reflections do not resolve the ethical and epistemological tensions inherent in this project. Rather, they are offered as part of an ongoing process of reflexivity that recognises the limits of the researcher's gaze, and the inevitable partiality of any knowledge produced. In this sense, the discussion is not simply about what was found, but also about how the conditions of finding shaped, constrained and sometimes silenced what could be known.

Another important aspect of reflexivity in this research has been the ongoing attention the researcher has given to their own intersectional identity and lived experience, and how these have shaped the development of the project. This has been apparent both practically and psychologically. The process of writing this thesis did not occur in a vacuum, but was deeply informed by the researcher's personal history, cultural background and class position. Coming from a background that has often been 'othered' within dominant academic and clinical discourses, the researcher found that questions of belonging and legitimacy frequently had to be worked through, sometimes explicitly and sometimes more subtly as the thesis came together.

This sense of marginality, or of not always having been heard, brought with it both vulnerability and strength. It contributed at times to self-doubt on the one hand and on the other, a fluctuating sense of confidence in navigating an academic space that can feel implicitly exclusionary. It also cultivated a heightened sensitivity to dynamics of inclusion and exclusion within the research itself, particularly in relation to whose voices are amplified and whose are omitted. The risk of unwittingly reproducing silencing, particularly of autistic young women, became a deeply personal concern. There was a strong internal pull to ensure that this research did not position itself as speaking for others in ways that might be

experienced as undermining or objectifying. However, also an understanding and negotiation of the fact that in its very nature, the project will inevitably be experienced in these ways by some.

Psychoanalytic thinking offers a way to stay close to such tensions without prematurely resolving them. The researcher became increasingly aware of both her own unconscious processes in the research, and those possibly operating within the field more broadly. These included anxieties about difference and representation, as well as the psychic costs of inhabiting a space of perceived authority while remaining attuned to one's own experiences of marginalisation. Writing, in this context, became an act of negotiation between personal history and professional responsibility, between speaking and listening, between knowing and not knowing.

Being mindful of these complexities made the task of writing slower and more emotionally laden. But it hopefully also enriched the process. The awareness of difference, and of how it is felt and enacted, became a critical lens through which the entire research process was viewed, helping to shape a thesis that strives to remain accountable to both the subject matter and the wider ethical questions it evokes.

1. The complexity of language

Language is never neutral and carries with it a history, an agenda, and implicit values. The terminology frequently used to describe autistic experiences, particularly those of females, makes this very apparent. The term *'masking'*, for instance, commonly used to refer to the ways in which autistic girls and women manage social interactions, initially appeared to offer a useful descriptive shorthand. Yet, on closer reflection, it raised ethical and conceptual

concerns. The word itself carries negative connotations, suggesting inauthenticity or even deception, implying that behind the mask lies a 'true' self being deliberately concealed. For a psychoanalytic clinician, attuned to questions of identity, defence, and the unconscious, this framing appears to risk pathologising behaviours that may in fact reflect adaptive strategies developed in response to social exclusion or misattunement.

This concern extended to broader questions of diagnostic and clinical language. The prevailing use of the term 'disorder' in reference to autism, as codified in diagnostic manuals, likewise felt problematic. It echoed a deficit-based model that positions autism as something inherently 'wrong' or that needs to be fixed or changed. It was felt that terminology such as this can shape not only how individuals are perceived by others, but how they come to understand themselves, which felt challenging to sit with.

Such considerations became particularly fraught in relation to the overlapping discourses of autism and psychoanalysis, which is a domain marked by a complex and often controversial history. The researcher engaged deeply with literature, such as Sue Reid's work (1999), that critically examines how language such as 'treatment' in the context of working psychoanalytically with autistic patients, has contributed to misunderstanding. Within psychoanalytic practice, 'treatment' typically denotes a therapeutic engagement with an individual. Yet, when situated in the context of autism, the term has often been misunderstood to imply an aim to 'cure' the condition itself. This misunderstanding has been a source of mistrust between the autistic community and psychoanalytic practitioners over time, a dynamic the researcher was acutely conscious of not reproducing.

Another layer of complexity arose in the way autistic female traits are framed within both clinical discourse and wider cultural narratives. Qualities such as being socially adept, articulate, or able to ‘fit in’ with peers are often cast in a positive light, frequently described as strengths. However, listening to the narratives of autistic women, whether through direct accounts in the literature or via the clinicians who work with them, reveals a strikingly different picture. These so-called strengths are often experienced as burdens, e.g. as exhausting, alienating performances that delay diagnosis and reinforce a sense of disconnection from one’s inner life. This divergence between external valuation and internal experience required the researcher to think carefully about how language might inadvertently reinforce harmful norms, particularly those that celebrate conformity at the cost of authenticity.

These reflections on terminology demanded that the researcher remained in a continual process of self-questioning: Whose language am I using? What histories and assumptions does it carry? And what might be the unintended consequences of that language on the very individuals this work aims to support?

In this way, reflexivity became an indispensable tool, not only for ethical and methodological integrity, but as a means of holding space for uncertainty, contradiction and ambivalence. The writing of this thesis thus became a process of negotiating not just what to say, but how to say it, and of recognising that the words chosen, and the frameworks used, both reflect and shape the realities they seek to describe.

Strengths and Limitations

One of the principal strengths of this study lies in its focus on an under-researched intersection of clinical practice and patient group: psychoanalytic psychotherapy with adolescent autistic females. Despite the growth in interest in neurodiversity and autism research in more recent years, there still remain much fewer studies centred on a psychoanalytic approach. By giving space to the voices of experienced psychoanalytic psychotherapists, this research contributes to the sparse literature that considers how psychoanalytic technique can be meaningfully adapted and employed with neurodivergent adolescents. This may be particularly true of adolescent autistic females who have been underdiagnosed and misunderstood in clinical and research settings (Bargiela et al., 2016; Lai & Baron-Cohen, 2015).

A further strength lies in the researcher's dual role at the outset of this project as a psychoanalytic psychotherapist in training and clinician working within an NHS neurodevelopmental service. This insider perspective enabled engagement with the data in a way that could draw on clinical experience to inform analysis and interpretation. The additional opportunity gained through training across both a neurodevelopmental team and a more generic CAMHS setting allowed for comparative reflections on team dynamics, service structures, etc. This was felt to enrich the understanding of how psychoanalytic practice can be held, or at times compromised, within differing multidisciplinary environments.

Additionally, the researcher benefitted from access to rich psychoanalytic thinking, both theoretically and experientially, through engagement with senior psychoanalytically-minded supervisors and educators during the training process. This theoretical grounding enhanced the opportunity to make sense of unconscious dynamics and countertransference phenomena

within participants' narratives, and to contextualise these within the broader psychoanalytic literature.

It is hoped that the study might also hold practical relevance for clinicians beyond psychoanalysis by offering insight into how adolescent autistic females may present in psychoanalytic psychotherapy. It may be of further benefit by giving a sense of how therapeutic technique and service design might be adapted to support autistic females more effectively. The findings may be especially helpful in NHS settings, where the focus can be overshadowed by diagnostics and limited psychotherapy provision, resulting in a clinical population that continues to be underserved and misinterpreted.

A principal limitation of this study was the inability to include the direct voices of autistic adolescent females. The absence of their voices arose due to ethical constraints and time limitations and meant that the study only accessed the therapeutic encounter through the lens of psychoanalytic psychotherapists. While this offered rich insight into clinical processes and therapist experiences, it inevitably limited the scope of the findings. Without the perspectives of the young women themselves, the study can only represent one side of the therapeutic dyad. A follow-up study focused on the lived experiences of autistic adolescent females in psychoanalytic psychotherapy would be a valuable future project. This would allow for a more wholesome and inclusive understanding of the work with this client group.

The study's sample size can be seen as both a strength and a limitation. Although adhering to the recommended guidelines for a doctoral thesis within the remit of the researcher's training organisation, the small number of participants restricts the generalisability of its findings. Insights gained through the collection of interview data only reflect the unique experiences of

a small group of therapists working in specific contexts. As such, the findings bring to light valuable understanding of participants' experiences. However, data cannot be assumed to represent the broader population of psychoanalytic psychotherapists, nor the experiences of autistic adolescent females more generally.

In addition to this, the complexity of psychoanalytic work introduces limitations in how fully certain phenomena can be captured through reflective narratives. Much of the material discussed in psychoanalytic psychotherapy, such as unconscious phantasy and shifts in transference / countertransference during sessions, belongs in a domain that is mostly intangible. It is therefore almost impossible to articulate with accuracy what is worked with in the room, even to experienced practitioners.

Another limitation is that the important subject of intersectionality was deemed too large to delve deeply into in this project. This is an area that remains underexplored within the context of therapeutic work with autistic individuals, as well as in psychoanalysis in general. The way autism is perceived often varies significantly across cultural and socioeconomic contexts. Diagnoses of autism are becoming less stigmatised in many communities, yet differences remain in understanding the condition, as well as in access to diagnosis and appropriate intervention. A more thorough exploration and analysis of intersectionality may be a necessary way of ensuring that therapy is both accessible and effective for diverse populations.

Furthermore, as a non-autistic researcher, the researcher acknowledges the limitations in being able to fully grasp the embodied and everyday experiences of living with autism.

Personal challenges relating to the researcher's consideration of this, and outlined in the section on reflexivity, resulted in slower progress on the project than anticipated or desired.

Finally, the research might have benefitted from deeper exploration of the role of trauma and early deprivation in the lives of the young women discussed by participants. While this was acknowledged in participants' reflections, a more focused inquiry into the potential impact of relational trauma on psychic structure and therapeutic engagement could have further enriched the findings. For example, the particular vulnerabilities that were seen to arise for the female patients in the early phases of therapy might be better illuminated and allow for therapists to offer additional more focused techniques to support engagement.

Implications for practice

Findings of this study appear to strongly support the argument for long-term, open-ended psychotherapy for adolescent autistic females. The experiences of participants working within neurodevelopmental teams that offered extended psychotherapy provision to age 25 highlighted how positively this impacted outcomes for autistic females. In this environment, therapists had more capacity to work at the pace of the individual and having more time helped to strengthen the therapeutic alliance and ease patient anxieties around endings. However, as this is a small qualitative study and only offers therapists' perspectives, the results cannot be generalised or assumed to relate to all clinical situations.

Winnicott (1960) noted that in order for the true self to emerge, the environment must be both reliable and non-intrusive and this seemed to be evidenced in the cases in this study. The findings seemed to highlight a reliable and emotionally attuned relationship was needed and

that without this, adolescent autistic females in the sample may have risked remaining trapped in cycles of constant dysregulation and self-directed aggression.

It is important to consider the fact that so many autistic females are only referred for psychotherapy when they have reached a significant level of psychological distress. This is often during late-adolescence and often subsequent to many prior interventions. This delay in accessing psychotherapy might mean that there is a time-limited window for treatment within NHS CAMHS, which typically ends at the age of 18. Data from this study outlined some of the pressures this can bring to both patients and therapists. Just as the therapeutic relationship begins to deepen and psychic defences are able to be broken down, discharge from the service becomes imminent. This can not only threaten the potential to achieve positive outcomes but might also have the effect of replaying themes of abandonment and rejection for patients.

Furthermore, a parallel may be made to the wider clinical literature that highlights how autistic females are rarely identified as neurodivergent until relatively late in adolescence and frequently late-diagnosed due to their capacity to conform superficially to neurotypical expectations (Hull et al., 2017; Lai & Baron-Cohen, 2015). By this stage many have been exposed to repetitive experiences of feeling unheard and unheld, which can lead to higher-than-average levels of distress and much poorer mental health prognoses.

Conclusion

These findings may have implications for how neurodevelopmental pathways are organised within NHS services, particularly when considering the needs of adolescent neurodivergent females and continuity of care into early adulthood. In the cases discussed, access to

psychotherapy appeared to support psychological and developmental progress. The study also highlights the importance of a shared understanding within multidisciplinary teams about the role psychoanalytic psychotherapy can play in neurodevelopmental services. Greater collaboration between professionals may support both patient care and clinicians working with the emotional complexities of this work.

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Appendices

Appendix 1: Trust ethical approval

From: Academic Quality

Sent: 12 May 2023 16:53

To: Jenny Adejayan

Cc:

Subject: RE: TREC Application - Minor Amendments Requested

Dear Jenny,

I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee (TREC) your application has been approved. This means you can proceed with your research.

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

For information governance purposes and in line with the Trust policies, please be advised that in order to conduct research/interviews using online video conferencing you must contact TEL team (telsupport@tavi-port.nhs.uk) to set up a zoom account.

With regards to privacy, please ensure that meetings with yourself and your participants are conducting in a safe environment and that confidentiality is maintained.

Your updated TREC form is attached.

If you have any further questions or require any clarification do not hesitate to contact me.

May I take this opportunity of wishing you every success with your research.

Best wishes,

Appendix 2: Public Facing Documents

Participant information sheet

Dear

I am writing to you as I am about to begin my research as part of my doctoral training as a child and adolescent psychotherapist at the Tavistock and Portman NHS Trust and would like to invite you to take part in my project.

The working title of my research is: **What can child and adolescent psychotherapists working with late-adolescent autistic young women tell us about the challenges and power of this approach? A Thematic Analysis**

I would like to recruit qualified child and adolescent psychotherapists who have delivered (or are currently delivering) a course of treatment of at least 3 months to one or more adolescent females with an autism diagnosis in CAMHS.

Treatment may have been once-weekly or intensive.

Specific research aims:

- To gain insight into the mental health needs of young women with a diagnosis of autism who are in psychoanalytic psychotherapy.
- To gain insight into the treatment journey of this patient group within CAMHS and relation to their subsequent referral for psychotherapy.
- To explore whether gender has been relevant to patients' treatment journeys and experience in psychoanalytic psychotherapy or CAMHS.

- To find out clinicians' views on whether psychoanalytic psychotherapy has been helpful to these patients and their families, and if so, which aspects have been most beneficial and why.
- To learn something about the states of mind of late-adolescent females entering CAMHS by considering aspects of clinicians' experiences during treatment, for example consideration of the transference and countertransference experiences during sessions.

Participants will be asked to take part in a semi-structured interview, lasting approximately 60-90 minutes. Interviews will be audio recorded and subsequently analysed.

If you would be interested in taking part, please refer to the participant information sheet attached.

With thanks,

Jenny Adejayan

Participant consent form

The Tavistock and Portman
NHS Foundation Trust

Participant Consent Form

ProfDoc Research Project Title: **What can child and adolescent psychotherapists working with late-adolescent autistic young women tell us about the challenges and power of this approach? A Thematic Analysis**

Name of the Researcher: Jenny Adejayan

Project sponsor: Tavistock and Portman NHS Trust

Ethical permission obtained by TREC.

Please tick the boxes on the right below:

I______________________________________voluntarily agree to participate in this research project.	
I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that I am agreeing to participate voluntarily, and I am free to withdraw, without reason, at any time up to two weeks after the interview has been completed.	
I understand that the interview will be recorded and transcribed as described in the participant information sheet.	
I understand that my name and personal / identifying information linked to my participation in this project will be anonymised and held securely by the researcher.	
I understand that all data which I contribute will be destroyed no later than 5 years after the study has been written up.	
I understand that whilst every effort will be made to anonymise the interview provided, there is a possibility that I will recognise some of my own quotes used in the final piece of work	
I understand that it is my responsibility to anonymise any examples referring to cases I choose to discuss during the interview.	

I understand that the findings from this project will be published in the form of a Doctoral Research Thesis and that it may be referenced in future academic publications or used in presentations.	
I am aware that the interview can be stopped by me at any time, should I feel any emotional upset and that during the process of being interviewed there may be some risk of discomfort.	
I am aware that should I need time post-interview to debrief or discuss any of the topics referred to, this will be provided.	
I confirm that the above statements have been understood and that I consent to being a participant in this research.	

Participant's Name (Printed): ___________________________________

Participant's signature: ____________________________ Date: ____________

Contact details:

Researcher: Jenny Adejayan Email:

Supervisor: Elena Della Rosa Email:

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

Debrief letter

Dear

I wanted to thank you for taking part in my research project **What can child and adolescent psychotherapists working with late-adolescent autistic young women tell us about the challenges and power of this approach*?* A Thematic Analysis,** and for your contribution. I hope that, like me, you found it an enjoyable and interesting experience.

I am aware that sharing information in this way can be a challenging and emotional process and hope that you will be able to access support through your personal network of colleagues, or your supervisor / manager, if required. However, if this is not possible or there are further issues you would like help with, please feel free to contact me using the details provided at the bottom of this letter.

Additional help can be obtained via the Association of Child Psychotherapists:

Telephone: 020 7922 7751

Email: admin@childpsychotherapy.org.uk

By post: The Association of Child Psychotherapists, CAN Borough, 7-14 Great Dover Street, London SE1 4YR.

If you have any concerns about my conduct as researcher during the interview process, or at any time during the study, please do contact me:

Email:

My supervisor:

Email:

Or [redacted], Head of Academic Governance and Quality Assurance

With kind regards,

Jenny Adejayan

Tavistock and Portman NHS Trust

120 Belsize Lane

London

NW3 5BA

Telephone: 020 7435 7111

Appendix 3: Sample of data analysis process