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ORIGINAL RESEARCH

The experiences of autistic adolescents in a dialectical behaviour therapy programme: a qualitative study utilising thematic analysis

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Abstract

Autistic adolescents are at higher risk of self-harm, suicidal behaviours, and emotion dysregulation compared with their non-autistic peers. Dialectical behaviour therapy (DBT) is an evidence-based treatment for self-harm and suicidal behaviour with emerging literature of the application of DBT for autistic populations. Despite this, no qualitative research has investigated the experiences of autistic adolescents of standard DBT. Therefore, this study aimed to explore autistic adolescents' experiences of non-adapted DBT. Ten adolescents who had or were seeking an autism diagnosis, and were in a DBT programme, completed semi-structured interviews. Qualitative data from the interviews were analysed using reflexive thematic analysis. Themes were generated for each objective. Objective 1 included themes about the lived experience of autistic adolescents accessing DBT, including: 'The impact of invalidation', 'Fostering acceptance and understanding', 'What does autism mean to me?', and 'Autism and mental health difficulties'. The themes regarding Objective 2 were about the experiences of the various modes of DBT and were organised by each client-facing mode. Objective 3 included themes highlighting the experience of utilising DBT skills in daily life, which included: 'Barriers to skills use', 'Supporting skills use', and 'Skills practice or masking?'. Finally, Objective 4 included themes regarding the recommendations participants had for optimising DBT for autistic people: 'Improving written materials' and 'General accessibility advice'. These findings suggest for DBT therapists to embody cultural humility, curiosity, validation, and flexibility when building neuro-affirmative competencies for supporting autistic individuals. Results are discussed in relation to the application and acceptability of DBT for this group.

Key learning aims

(1) Recent publications (e.g. Keenan *et al.*, 2023) have explored the experience of autistic adults accessing DBT and highlighted the need for clinicians to work collaboratively with clients and make reasonable adjustments to improve autistic adults' understanding and adherence to DBT.
(2) To date, no qualitative studies have explored the experience of autistic adolescents accessing the Rathus and Miller (2015) Adolescent DBT model. The current study explores the views of autistic adolescents on how autism is discussed and considered by clinicians when supporting them to access different components of DBT when describing the strengths and barriers they experience.
(3) Adopting a bottom-up approach, we identify key themes from adolescents' perspectives on how to support them to access and engage with different DBT components, ranging from making environmental adaptations to meet individual sensory needs to improve accessibility, to providing

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more opportunities for personalised learning using neuro-affirmative examples that can improve generalisability of skills in everyday life. We provide recommendations for clinicians to consider on ways of adapting the process and content of DBT to increase accessibility and engagement for autistic adolescents in treatment.

Keywords: adolescent; autism; dialectical behavioural therapy; mental health; neurodiversity

Introduction

Autistic adolescents[1] are at higher risk of mental health difficulties compared with their allistic peers (Bougeard *et al.*, 2021; Lai *et al.*, 2019; Micai *et al.*, 2023). Furthermore, autistic people are three to five times more likely to engage in suicidal and non-suicidal self-harming behaviours (Blanchard *et al.*, 2021; Geoffroy *et al.*, 2022; Newell *et al.*, 2023; O'Halloran *et al.*, 2022), and they are seven times more likely to die by suicide (Hirvikoski *et al.*, 2016). There are a number of factors associated with this higher risk, including interpersonal factors such as loneliness and unmet support needs (Cassidy *et al.*, 2018; Hedley *et al.*, 2018; Lipinski *et al.*, 2022) and intrapersonal factors including rumination, camouflaging burden, and emotion dysregulation (Arwert and Sizoo, 2020; Cassidy *et al.*, 2018; Costa *et al.*, 2020; Richards *et al.*, 2019). Many autistic individuals experience co-occurring alexithymia and have difficulties with emotion recognition (Milosavljevic *et al.*, 2016). Difficulties with emotion regulation, as a key risk factor to mental health difficulties, are also higher in autistic adolescents compared with allistic groups (Conner *et al.*, 2020; Mazefsky and White, 2014; Restoy *et al.*, 2024); autistic youth are four times more likely to have clinically elevated levels of emotion dysregulation (Conner *et al.*, 2020). Additionally, autistic adolescents may be more likely to rely on maladaptive regulation strategies (e.g. emotion suppression) compared with adaptive strategies (e.g. cognitive reappraisal; Samson *et al.*, 2015).

Emotion regulation difficulties are implicated in the development and maintenance of a wide variety of mental health difficulties, self-harm, and suicidal behaviours (Hu *et al.*, 2014; Kraiss *et al.*, 2020; Rogante *et al.*, 2024; Sloan *et al.*, 2017; Weissman *et al.*, 2019; Wolff *et al.*, 2019). Therefore, emotion regulation is considered a key transdiagnostic treatment target for many different mental health disorders across various intervention models (Gratz *et al.*, 2015; Gross, 2015; Sloan *et al.*, 2017). Given the elevated rates of difficulties with emotion regulation in autistic populations, and the role it may play in increasing self-harm and suicide risk, emotion regulation is considered an important focus for interventions seeking to improve outcomes for autistic populations (White *et al.*, 2021).

Furthermore, it is important to acknowledge how environmental factors may further contribute to the development and maintenance of emotion dysregulation in autistic individuals. For example, the Biosocial Theory posits that emotion dysregulation arises from the interaction between one's inherent emotion vulnerabilities and growing up in an emotionally invalidating environment (Linehan, 1993). For many autistic individuals, experiences of being socially excluded, misunderstood, bullied by others, and facing stigma associated with autism diagnosis may be common from a young age (Pearson *et al.*, 2023; Pearson and Rose, 2023). Pervasive and persistent adverse social events from childhood to adulthood can lead to high levels of internalised stigma amongst autistic individuals with regard to their autism diagnosis and autistic identity (Cooper *et al.*, 2017; Davies *et al.*, 2023), which in turn contributes to high levels of camouflaging or masking where individuals try to hide their autistic traits in order to 'fit in' to society (Hull *et al.*, 2017; Pearson *et al.*, 2023; Pearson and Rose, 2023), much akin to self-invalidation (Bemmouna and Weiner, 2023). The impact of negative autism identity and high levels of social camouflaging have both been linked to elevated levels of mental health difficulties amongst autistic individuals

[1]We will use identity first language in our paper as this has been shown to be preferred by members of the autistic and autism community (Kenny *et al.*, 2016).

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(Cooper *et al.*, 2022; Hull *et al.*, 2021). In light of intersectionality, women and girls, those with higher cognitive abilities, and ethnic minority groups are at particularly risk for diagnostic overshadowing, where difficulties experienced that may be accounted for by autistic traits are misattributed to mental health difficulties or other conditions, and result in under-diagnosis of autism in these groups (Gupta *et al.*, 2025). Taken together, it is important to consider how environmental and self-invalidation may influence how autistic individuals make sense of their lived experiences, contribute to the development and maintenance of emotional dysregulation and mental health difficulties (Weiner *et al.*, 2025), and for such experiences to be acknowledged and discussed where appropriate to inform treatment delivery (Lei *et al.*, 2024a).

Considering the high risk of self-harm and suicide, emotion regulation difficulties, and experiences of environmental invalidation in autistic populations, a report by the UK National Health Service (Murdoch *et al.*, 2023) suggested that the use of mental health in-patient and high-intensity services by autistic people had risen by over 50% between 2017 and 2023. Autistic people also experience barriers to accessing effective mental health support, including (but not limited to) lack of specialist training and resources that lead to low confidence and competence in clinicians in working with this group (Maddox *et al.*, 2020; Maddox and Gaus, 2019; White *et al.*, 2021), poor accommodations/adaptations to interventions, and longer waiting times (Camm-Crosbie *et al.*, 2019; Cleary *et al.*, 2023; Dickson *et al.*, 2021; Tint and Weiss, 2018), all of which can exacerbate the risk of this population engaging in self-harm and suicidal behaviours whilst having poorer access to good quality care (Kato *et al.*, 2013). Studies have suggested that using reasonable accommodations such as the use of concrete and concise examples and instructions, fewer open-ended questions, use of visual aids, incorporation of focused interests and sensory sensitivity considerations (Huntjens *et al.*, 2024; White *et al.*, 2021), having generic clinical competencies, and having tailored content such as improving emotion awareness to reduce the potential impact of alexithymia on emotion dysregulation (White *et al.*, 2021) can all improve quality of care provided to autistic individuals (Weiner *et al.*, 2025).

One particular evidence-based intervention for reducing emotion dysregulation, self-harm, and suicidal behaviours is dialectical behaviour therapy (DBT). DBT is considered a leading evidence-based cognitive behavioural intervention for improving these difficulties in young populations (Johnstone *et al.*, 2021; Kothgassner *et al.*, 2021; Mossini, 2024). DBT seeks to increase and generalise capabilities to regulate emotions and related areas of dysregulation utilising five modes of treatment: individual therapy sessions, group skills training, between-session telephone coaching, therapist consultation team meetings, and environmental interventions (Linehan, 1993; Miller *et al.*, 2010). DBT utilises a number of principles, including: zen-based practices, behaviourism, exposure, skills training, problem solving, dialectics, an underpinning biosocial model, and cognitive modification (Linehan, 1993). This principle-based structure allows for flexibility to tailor support to individual needs and allows for accommodations for minoritised groups (Camp, 2023; Phillips *et al.*, 2024). This flexibility, alongside its focus on the transdiagnostic treatment target of emotion dysregulation, is thought to make DBT an ideal candidate for supporting autistic populations with emotion regulation and self-harm-related difficulties (Bemmouna and Weiner, 2023; Huntjens *et al.*, 2024). The biosocial model of how emotion dysregulation develops (Linehan, 1993) is thought to be applicable to autistic populations, such that environmental invalidation stems from early adverse experiences and invalidation from familial and societal systems, which result in internalised ableism and may increase social camouflaging and self-invalidation. These experiences potentially interact with emotional vulnerabilities that may stem from a biological vulnerability to emotion regulation as well as autism-related risk factors, such as social communication differences, sensory differences, and alexithymia, which further increases the risk of emotion dysregulation developing (Bemmouna and Weiner, 2023).

A growing number of studies have explored adapted versions of DBT. These often include adaptions to the five modes of DBT (Bemmouna *et al.*, 2022; Huntjens *et al.*, 2024) or to the

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skills-training component only (Hartmann *et al.*, n.d.; Lee and Arora, 2023; Ritschel *et al.*, 2022) for adult autistic populations. These interventions often included adaptations discussed above (e.g., (Weiner *et al.*, 2025; White *et al.*, 2021), with a particular focus on making mindfulness tasks and instructions more concrete and precise; working on social anxiety before participants joined skills group; integrating sensory profile assessments and adaptations; providing clear scheduling; using specialist interests to increase motivation; providing support for between-session practices to help with executive functioning difficulties; more visual elements when teaching skills; and integrating stimming into self-soothe and emotion regulation (Bemmouna *et al.*, 2022; Hartmann *et al.*, n.d.; Huntjens *et al.*, 2024; Keenan *et al.*, 2023; Lee and Arora, 2023; Ritschel *et al.*, 2022). These studies suggest promising findings regarding feasibility, acceptability, and changes in self-harm, suicidal behaviours, and emotion regulation difficulties. The one randomised controlled trial to investigate the efficacy of adapted DBT for autistic adults found that suicidal behaviours and depression decreased significantly compared with treatment as usual, although the differences between conditions in suicidal behaviours was no longer statistically significant at the 12-month post-intervention follow-up (Huntjens *et al.*, 2024). No known studies have explored these adaptations in adolescent populations.

Few studies have investigated the outcomes of autistic populations in standard DBT which has not employed systematic adaptations for these groups. One study explored the effectiveness of non-adapted DBT by comparing routinely collected clinical outcomes of a DBT programme for autistic and non-autistic adolescents (Phillips *et al.*, 2024). This study suggested that autistic adolescents experienced improvements in self-harming behaviours, borderline personality disorder symptoms, emotion regulation, and in-patient bed days by the end of DBT, and that there were no statistically significant differences in these changes compared to their peers without an autism diagnosis. While this study tentatively suggests no significant differences in treatment effectiveness based on clinical outcomes, it does not provide information on the subjective acceptability of the standard DBT programme to autistic adolescents. Qualitative studies exploring autistic adolescents' experience of standard DBT may offer insight into ways the treatment can be optimised to improve any issues around acceptability, given the reported barriers to accessing psychological interventions (Camm-Crosbie *et al.*, 2019; Dickson *et al.*, 2021; Murdoch *et al.*, 2023; Tint and Weiss, 2018). This would also inform future accommodations and potential adaptations to the model. Therefore, this service evaluation sought to understand the following experiences of autistic adolescents in a national DBT programme for adolescents in the UK:

(1) What lived experience do autistic adolescents bring with them when accessing DBT, in relation to how they perceive their autism diagnosis and co-occurring mental health difficulties?
(2) How do autistic adolescents experience different components of DBT (individual sessions, skills groups, telephone coaching), reflecting on strengths and limitations?
(3) What are the experienced barriers and motivators in accessing or utilising DBT skills in daily life?
(4) What recommendations do autistic adolescents have on ways to adapt the DBT programme to cater to their needs?

Method

Service context

The National and Specialist Child and Adolescent Mental Health Service (CAMHS) DBT service at South Lnodon and Maudsley NHS Foundation Trust (Camp *et al.*, 2023a; Smith *et al.*, 2023) accepts referrals from Tier 3 Community CAMHS and Tier 4 Adolescent In-patient Units/ Specialist services at both local and national level. Drawing on evidence-based DBT for adolescents (Rathus and Miller, 2015), with some adaptations for implementing in the NHS (see

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Camp *et al*., 2023a for further explanation), the service supports adolescents aged 13–18 years old with pervasive emotion dysregulation, self-harm, suicidal behaviours and associated mental health difficulties. During this study period, the DBT programme included: up to 9 months of weekly individual sessions with adolescents; 21 weekly skills group (lasting around 6 months including breaks between modules) conducted separately for both adolescents and parents/carers; between-session telephone coaching for adolescents to promote generalisation of skills use into daily life; and a weekly team consultation meeting for therapists to enhance motivation, capability and adherence to the treatment manual. Parents/carers were allocated a therapist that acted as parent/carer worker, with whom they could meet for individual session and contact for telephone coaching to promote their own skills practice and support for their child. Joint family sessions and other adjunctive interventions were provided as needed.

This service context provided DBT to autistic and allistic adolescents, and their families/carers, was not specifically adapted for autistic young people. However, therapists to varying degrees would have integrated aspects of diversity into the biosocial model formulation and other aspects of the intervention where deemed appropriate. These accommodations are not systematically implemented. In addition, sensory needs were integrated into the PLEASE skill teaching to consider sensory vulnerabilities to emotions, into the self-soothe skill teaching to consider soothing sensory input across the eight senses, and fidget toys were included in the skills groups to encourage exploration of utilising these as regulation aids in group.

Participant recruitment

Using purposive sampling, we invited adolescents within the service who either had or were in the process of seeking a clinical diagnosis of autism spectrum condition to participate in this qualitative interview study after completing the DBT skills groups (i.e. the first 6 months of treatment). Autism diagnostic information is collected at the point of referral and baseline assessment and does not from part of the inclusion/exclusion criteria for the young person to access DBT care within the team. This was to ensure that all adolescents had attended the majority of their DBT treatment to provide reflections across all components of DBT offered within the service. Ten of the 12 invited adolescents completed the interviews (see Table 1 for demographic and symptom information as noted on clinical records), and two adolescents chose to withdraw from the study before participating in the interview due to time constraints. Nine of the 10 adolescents had confirmed clinical diagnosis of autism. One adolescent was on the waiting list and seeking autism diagnosis at the time of participating in the study, and self-identified as autistic.

Materials

Interview topic guide

The first author developed the interview topic guide (see Appendix 1 in the Supplementary material) to gain insight into autistic adolescents' experiences of receiving DBT, and the topic guide was reviewed with the first participant in the study to ensure that the questions were easy to understand and acceptable to autistic adolescents. We were interested first in how autistic adolescents understood autism and perceived their own diagnosis, such as how adolescents would describe navigating their own identity in relation to autism. We asked adolescents to reflect on all different aspects of DBT, including individual therapy, skills group, telephone coaching, and their overall experience of being able to discuss autism during DBT.

Measures

All participants completed the Structured Clinical Interview for DSM-V Axis II Personality Disorders, borderline personality disorder (BPD) subscale at initial assessment to examine traits related to BPD, and the Screen for Child Anxiety Related Disorders to assess anxiety symptoms;

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Table 1. Adolescent demographic information at baseline ($N = 10$)

	***M* (*SD*)**	Range
Age (years)	17.10 (0.54)	16, 18
Symptom severity		
SCID-II (borderline personality symptoms)[a]	6.22 (1.99)	3, 9
SCARED Total (anxiety symptoms)[a]	54.89 (5.80)	46, 63
MFQ-C Total (depression symptoms)[a]	49.78 (9.31)	37, 63
DERS Total (emotional regulation)	135.1 (11.17)	120, 157
Sex assigned at birth	***n***	**%**
Male	0	0
Female	10	100
Gender identity	***n***	**%**
Male	1	10
Female	5	50
Non-binary	3	30
Other/unknown	1 (she/they)	10
Sexuality		
Bisexual	4	40
Gay	1	10
Heterosexual	1	10
Pansexual	1	10
Queer	1	10
Other/unsure	2	20
Ethnicity		
Black or Black British – African, Caribbean, or any other Black background	2	20
Asian or British Asian – Bangladeshi, Indian, Pakistani, or any other Asian background	1	10
Mixed: White and African	1	10
White – British or Irish	5	50
White – other	1	10
Looked after children	2	20
Autism diagnostic status		
Confirmed clinical diagnosis	9	90
Waiting list for seeking diagnosis	1	10

All demographic information and measures were collected at assessment, before treatment began. SCID-II, Structure Clinical Interview for DSM-IV Axis II Personality Disorders (scores $\geq$5 meet the diagnostic criteria for borderline personality disorder or emotionally unstable personality disorder); SCARED, Screen for Child Anxiety Related Disorders (scores $\geq$25 may indicate the presence of an anxiety disorder, and scores $\geq$30 are more specific); MFQ-C, Mood and Feelings Questionnaire-Child (higher scores out of 66 indicate more depressive symptoms, scores $\geq$27 may indicate the presence of depression); DERS, Difficulties in Emotion Regulation Scale (higher scores out of 180 suggest greater problems with emotion regulation). [a]$n = 9$.

the Mood and Feelings Questionnaire-Child version to assess depression symptoms; and the Difficulties with Emotion Regulation Scale to assess emotion dysregulation (see Appendix 2 in the Supplementary material for more details on each measure).

Procedure

All adolescents received an information sheet that explained the aims and procedures of the study and provided informed consent prior to taking part in the interview. All interviews were conducted via Microsoft Teams video call between January 2023 and January 2024. During each interview, the interviewer took field notes to facilitate question scaffolding, and all video recordings were transcribed. Interviews lasted 30–45 minutes, and adolescents received a £15 gift voucher upon completion. The first and second authors participated in data collection. One interviewer (J.L.) was a female psychology trainee clinician in the team with extensive experience of conducting qualitative research with autistic adolescents at the doctorate level and supervised the second interviewer (A.S.) who was a female assistant psychologist with a bachelor's degree in psychology also with experience of conducting qualitative research at the undergraduate level. Neither of the two interviewers identified as being neurodivergent, although one interviewer (J.L.)

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has worked extensively with autistic children and adolescents in both clinical and research capacity for 9 years. To ensure the adolescents were familiar with the interviewers but did not have potential competing interests that may inhibit their ability to share their opinions, we ensured that interviewers may know adolescents from DBT skills groups through group facilitator role but were not the young person's individual DBT therapist. Both interviewers participated in data analysis. All transcripts were checked by both interviewers to ensure accuracy, and no repeat interviews took place. We considered ways to ensure accurate representation of autistic adolescents' views during feedback to the wider clinical team (none of whom identified as neurodivergent), and we decided to code primarily the explicit surface meanings (i.e. semantic features) of the interview data to avoid misinterpreting underlying assumptions of meanings (i.e. latent features) of the data.

Analysis

Following the Braun and Clarke (2006, 2013) method to complete reflexive thematic analysis, we (the first and second authors) primarily coded the semantic features of the interview data. We first familiarised ourselves with the data through transcribing, reading and re-reading the transcripts. Throughout the analysis, we aimed to centre the discussion on participants' lived experiences and understand their perspective on DBT without superimposing any existing frameworks on their responses. At the same time, as researchers, we adopted a critical realist stance (Fletcher, 2017) and evaluated whether autistic adolescents' perceptions of when and how autism was brought into conversation and informed DBT adaptations ('experiential' sphere) may have influenced their own experience of accessing and engaging with different components of DBT ('actual' sphere), and in turn related to the Social Model of Disability (Chown *et al*., 2017) where disability is a function of poor adjustments and adaptations that are not meeting individual differences and their unique needs ('real' sphere).

Using NVivo version 14, we went through three iterative rounds of independent coding of three to four transcripts each time and met to discuss our interpretations of the transcript that led to our coding of the data. Rather than assessing inter-rater reliability, we examined similarities and differences in our codes and reflected on our own position and interpretation of the transcripts in relation to our own professional experiences of supporting autistic adolescents, to allow both authors' perspectives to be reflected in the final reporting of results through theme generation. The first author approached the study as clinician-researcher with experience working with neurodivergent adolescents in DBT. Together with the research team, we were able to draw on our understanding and experience of delivering DBT in different capacities to hypothesise how different therapy components may have presented unique strengths and challenges when meeting the needs of autistic youths. We were able to shape follow-up questions and direct the interview towards eliciting helpful recommendations from the participants on ways that DBT can be made more accessible and beneficial for other autistic adolescents. We approached the interview with a neuro-affirmative approach by clearly stating how each autistic adolescent's opinions can bring about meaningful change and evoke reflections within the clinical team to enhance our ability to best support neurodivergent youths.

After iterative rounds of reviewing each transcript together and discussing codes, we reached agreement on the final set of themes and subthemes. As suggested by Braun and Clarke (2021), we did not use data saturation as an indicator for when to stop data analysis. Instead, as part of reflexive thematic analysis, we viewed coding as a process that continuously evolved and developed through discussions between the two coders, and were not derived from a fixed framework (Braun and Clarke, 2021). To gauge clinicians' understanding, interpretation and feedback on key themes identified from the data, preliminary study findings were presented at the Society for DBT in the UK and Ireland 2024 Conference. Questions and feedback from the diverse audience at the conference highlighted that the final themes need to explicitly state direct clinical implications on meaningful adaptations of DBT to cater for the needs of autistic adolescents and

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clearly outline ways to strengthen neuro-affirmative practice in DBT when supporting autistic adolescents. The last author also supported in reviewing and providing feedback on theme structure, boundaries, and clarity to ensure that clear clinical implications can be drawn out from described themes. We report the full qualitative procedure using the COREQ Checklist (Tong *et al.*, 2007) in Appendix 3 of the Supplementary material.

Results

Adolescents' demographic information is provided in Table 1. We summarise the overall thematic structure in Table 2. To maximise clarity in highlighting how feedback from adolescents can inform clinical practice across different components of DBT, we divide our analysis to specifically address each of the four questions stated in our service evaluation aims, which reflect: (1) understanding autistic adolescents' lived experiences; (2) understanding autistic adolescents' experience of accessing different components of DBT; (3) broader considerations for DBT skills use; and (4) general feedback on meaningful adaptations. We discuss the key themes within each section using narrative synthesis and illustrative quotes that are summarised in Table 2.

Question 1: What lived experiences do autistic adolescents bring with them when accessing DBT?

Autistic adolescents reflected on how they navigated their autism diagnosis in relation to personal identity, recognising strengths and differences that stem from autism, and their understanding of how autism may influence their experience of co-occurring mental health difficulties. We summarise these experiences into four main themes (Table 2a).

Theme 1: The Impact of Invalidation

First, autistic young people spoke about the experience of chronic invalidation from their environment, where people may have either dismissed, misunderstood, or conveyed ableist views such as '*ohh, you don't seem that autistic*' (B2) when speaking to autistic adolescents about their diagnosis. The diagnostic overshadowing of autism and neurodiversity by other conditions such as anxiety and low mood meant that many autistic young people experienced missed or late diagnosis and did not receive the support they needed in a timely fashion or may have received little input about what autism means post-diagnosis. Young people also spoke about the impact of internalising chronic invalidation from others. Adolescents spoke about how being told by many others that they do not have autism made it harder for them to recognise those traits in themselves and actively pursue a diagnosis. Even when a diagnosis has been confirmed, autistic adolescents spoke about the ambivalence and mixed feelings regarding whether they viewed autism to be part of their identity, and the impact of having an on/off relationship with their diagnosis on their ability to accept themselves fully for their individual differences. Autistic adolescents also talked about the impact of this self-invalidation on feeling like they must mask and hide their differences in social settings.

Theme 2: Fostering Acceptance and Understanding

First, autistic adolescents described that receiving an autism diagnosis was often the beginning of feeling understood and validated by others, as the diagnosis offered a lens for them to reflect and make sense of their past lived experiences in the context of neurodivergence, especially negative social interactions with peers as well as sensory differences and meltdowns. Autistic adolescents also talked about the importance of embracing neurodivergence as a form of individual difference and forms an important part of who they are in everyday life. Autistic adolescents felt empowered through the process of diagnosis disclosure to bring about wider systemic change and acceptance.

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Table 2. Summary of themes and subthemes including quotes from adolescents ($n = 10$)

Theme	Subtheme	Quote
(a) Autistic young people's lived experiences		
The impact of invalidation	From others: • Societal ableist views • Challenging diagnostic process • Diagnostic overshadowing • Lack of support	• 'A lot of it came from like outside invalidation … I guess why like I felt so upset. When, people like invalidated my autism, whether it was like being ohh, you don't seem that autistic or use like outdated terms regarding to like higher or lower spectrum.' (B2) • 'There's like a social idea of what autism is, and it's not typically how it's presented with me … whenever I told people that I have autism they're like, no, you don't. I'm like, what do you mean? They are just like well you don't act like it, and it's like you don't know a way to act like you have autism. And like you were really smart. And I was like, ok, lots of famous scientists had autism. I just didn't like that … I think they were trying to compliment me, but it came across as very ableist. I was like, you can be smart and have autism.' (D4) • 'My first assessment I had done, I was told I only had autism traits and that's all it was. But then you're either autistic or you are not, you can't say that I'm in between, that doesn't make any sense. So I did end up having to fight for my diagnosis. I also have ADHD. My presentation is different compared to if I only just had autism.' (A1) • 'Because prior to that (autism diagnosis) I had been diagnosed with anxiety and depression. But I always suspected that there was like not something more wrong with me, but there was something more there.' (B2) • 'Because my mum, she's very much taboo about mental health, even though I do have like mental health struggles … and I have been in CAMHS for the last five years, but because they were labelling it as like mild autism … She (my mum) just completely disregarded it.' (I9)
	Within self: • Harder to self-identify • On/off diagnosis acceptance • Masking	• 'When I was initially diagnosed or before that, I think there's maybe and this is probably the same with lots of people like internalised ableism about it, maybe a little bit about. Oh like thinking, oh that's just like what really stupid people have or something …' (G7) • 'When they first brought it up, I was like, I don't see that at all. But after kind of researching it, I was like, actually, I really do quite identify with this … and I think it's been kind of a weird journey for me because I never, it was never soemthing that I thought about until I was 15.' (H8) • 'I would say I have like an on and off relationship at the time I accepted and I'm like yeah, that's who I am. Some of the time I don't … I'm not the biggest fan of labels.' (F6) • 'A lot of the time during school I would have to mask like there are times where cause I go mute at times, which is also linked to autism and I would just have to force myself to speak because you know, the teachers don't understand that.' (B2)
Fostering acceptance and understanding	Diagnosis and self-learning: • Diagnosis = validation • Make sense of lived experiences • Neurodivergence = individual differences	• 'When I was diagnosed with autism, it just felt like a breath of fresh air … things just started like clicking in place … so everything just started like making sense to me and … honestly, it helped me get a better understanding of myself.' (B2) • 'I've always felt different and other people have always been able to tell that I'm different. So I have been picked on, I have been bullied and then I've also had people have really standards for me when they're standards that I can't meet and it's been quite unfair … I got my diagnosis after I was kicked out of school.' (A1)

(*Continued*)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
	Diagnosis disclosure promotes system change: • Disclosure facilitates understanding • Therapist needs to understand who I am • Everyone's responsibility to self-educate	• 'It was very helpful to just learn about it, like everything and then it just made so many things make so much more sense because when I was younger, I never really like understood why I was having meltdowns about like time and stuff … certain things, it helped me understand that a lot more.' (J10) • 'For me it's just the way my brain works and how that's different to neurotypical people.' (C3) • 'I don't see autism as like a disease or anything, I really dislike the people that are trying to find cures for it because it's not a disease.' (D4) • 'I find that it's part of my everyday life and it's like intrinsic to who I am and the way I do things and my being comfortable with that.' (F6) • 'When my school knew I was autistic, they changed their attitude completely to how I was learning and the social situations I was in. Which it was a bit weird, just cause they didn't really understand it at first, but then when I explained it a bit more in detail to them how it affects me, they were a lot more like they were able to give me the support that I need basically.' (D4) • 'Even if you are a therapist, there's always more to learn about autism. If you've only met one autistic person, you've only met one autistic person. I just felt like there's definitely way more training and understanding that needs to happen … If someone really understood what the young person was talking about, again autism affects everyone differently, I think it could help with finding the best fit therapist.' (A1) • 'I think it's important that they like get the full picture of what is going on, because if I didn't mention it then it would be quite a bit harder for them to properly understand me, cause I think and react to social situations differently, especially since there's a bit of social aspect of DBT with group. And I find those kinds of interactions a bit more difficult.' (D4) • 'I think if you bring up autism in your initial assessment, it can also help maybe match the person to the therapist, maybe a therapist who is more aware of autistic challenges?' (C3)
What does autism mean to me?	My strengths: • Creativity • Empathy • Depth of knowledge • Honesty • Goal-driven • Detail-oriented	• 'So I study art and I've always just really loved art and I pick it up really easily and nobody in my family is an artist or anything like that … I just could it and all the time I get people asking me like how you do these things … and I think it's because of the way that I view things and I look at the world and stuff in it in a slightly different way to other people, and I can translate that into art … I view the world completely differently to like other people because I'm autistic, maybe it's actually because of this.' (H8) • 'Cause for me I struggle a lot with social cues. When I'm talking to somebody else, I always make sure to tell them like whether I'm joking, whether I'm being serious.' (I9) • 'I've had my life goals planned out since I was 8 years old.' (J10) • 'I quite like the fact that I am an honest person and that I always know that I'm at least telling what I believe to be true.' (J10) • 'I get like so excited and even like to this day, I retain a lot of knowledge from it.' (B2) • 'I'm very methodical and also very observant of things I want to observe.' (E5)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
	My differences: • Emotion processing • Sensory needs • Social communication differences	• 'I find it really hard to show my emotions or show the appropriate emotion …' (E5) • 'Noises can be very distracting and I can't tune them out. Bright lights like fluorescent ones. I'm not the biggest fan of textures. I'm quite sensitive too especially with food. I don't eat a lot of food cause of textures.' (C3) • 'I find social communication quite hard. Especially in social situations, there are places that are scary to me because there are lots of people there.' (F6) • 'I can't tell like if I'm having a conversation with somebody, if they're getting like angry or like, I don't know, annoyed. It just puts me off from talking to people to the point like after my diagnosis I became very socially withdrawn … I don't really leave my house anymore because I just find like communicating with people so difficult.' (I9)
	Both and… • Hyperfocus • Logical reasoning • Social learning	• 'I will like fixate on one thing for ages … and then I sort of decide I don't like it anymore. My interests can be really intense in things, they are really random things as well. That can become quite exhausting for me sometimes.' (H8) • 'I think because I'm very overly aware socially, even though that can be exhausting. Sometimes I think I definitely notice a lot more than other people would, because I put so much effort into like learning about sort of social cues and reading people and stuff like that … that means I get to be there a lot of the time to support my friends and it's quite helpful now because I do read into it too much.' (H8)
Autism and mental health difficulties	Anxiety and autism overlap: • Need to understand autism first • Late diagnosis increases vulnerability • Masking is NOT the same as anxiety • Impact of social anxiety	• 'I definitely was open about my autism diagnosis, but I think it's more that at the time I didn't really think how those two things like my emotions and autism could be linked together. And it took me a bit of like discovering that autism is directly linked to emotions, cause of how autistic people see the world and stuff … I feel like if it was, if the link between autism and emotion, especially emotional dysregulation was brought up earlier to me, a lot of things would like click faster in my head … with certain things, because for me my anxiety is quite linked to my autism as well with like overstimulation and feeling overwhelmed. So I feel like if that was brought more to my attention it would make a lot more sense with me.' (B2) • 'So I don't know and I really haven't been getting like help for it or like learning how to like navigate like life in this way. So it's just kind of a diagnosis that it's kind of detached for me because I don't really know what to do with it.' (I9) • 'I have quite a bit of social anxiety. It's because I never know what a situation's gonna be like, and I have to like, anticipate loads of different things … I get quite stressed out with going out cause I don't. I never know what's gonna happen … I've planned ahead cause it's like worst case scenarios that I'm more planned for. Like it's very very rare that will happen.' (D4) • 'I kind of knew what I was doing, but I didn't know that it had a name for it. And part of me thought it was just because of my anxiety and wanting to fit in because of anxiety. But then when I was learning about like camouflaging and masking it kind, I felt like it was more than anxiety.' (J10)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
	Interaction between autism and mental health: • Autism is who I am, NOT the cause of all my difficulties (emotion dysregulation is!) • Self-harm related to sensory differences?	• 'I was actually really pleased that my autism wasn't brought up so much because for me, as soon as I got that diagnosis with CAMHS and even before that, everything was just pinned on autism … and for such a long time, I just fought with CAMHS. I kept telling them, I don't think it's because of that. I understand my autism, I understand the traits that I present with and it's not there. So I'm telling you it's not and they just wouldn't listen … I think for the first time that I think part of the reason as well why it wasn't really brought up that much (in DBT assessment) because even though autism can cause emotional dysregulation and things, it's not something like I don't view it as being related to autism. Because I can sort of trace it back to like other things that have happened, and I explained all of this to DBT and they were really understanding of that. They actually looked at it in a different way. And so thanks to that, I've actually been able to come a lot further because it wasn't just like, oh, you know, you're autistic. That's why it's like they've actually put in a lot of effort to sort of look at the root causes of it, which has definitely helped me.' (H8) • 'I know that DBT is more for emotion dysregulation, that's the problem I have, I don't know if it's related to autism or if it's just a separate problem.' (D4) • 'Non-autistic people don't realise is the link between self-harm and like sensory issues … in autistic people self-harm can be really linked to like being dysregulated or like sensory overload … When my occupational therapist said that to me about how linked the self-harm and like being overwhelmed is like it was quite eye opening to me, it's like some autistic young people might not even know it.' (C3)
(b) Autistic adolescents' experiences of different components of DBT		
DBT component	Theme/subtheme	Quotes
Individual therapy	When/who/how to bring up autism? • Helps to clarify the context (who I am and affects everything I do) • Not always relevant • Autism in relation to emotion dysregulation	• 'I guess the conversation was brought up quite easily because every aspect of me is autistic, so it's just I can't really run away from it.' (E5) • 'It was something that we always acknowledged as being there, but it was never really something that I felt I needed any help with.' (H8) • 'A lot of my sessions were like mainly focused on dealing with suicidal ideation and anxiety and lack of motivation, so autism was barely brought up.' (B2) • 'When you are doing chains and stuff like it's never brought up as an option, in like the vulnerabilities or in the prompting event, there's never really the option of like sensory overload, or like being dysregulated in like an autism sense, not just like a mental health sense … me and my therapist have talked about it a lot, like how it can make other things with my mental health more difficult?' (C3) • 'I don't really experience the impulsivity side of emotional dysregulation because my autism really keeps me in check. I really stick by rules and things like that. Autism definitely makes me more vulnerable to emotional dysregulation … I definitely understand more now about how autism could potentially affect that as well.' (H8)
	How lived experiences are understood: • Validation and invalidation from the clinician • Facilitates self-understanding	• 'I think if I brought it up, she always like acknowledged it and validated it … for prompting events if I said it was soemthing to do with being overwhelmed or overstimulated, she always like validated that and tried to put things in place that would help with that, so I think my therapist's been great with it.' (C3)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
		• 'I've had many times where I have been explaining like I have a certain experience because of my autism and it's just an autistic experience that I have and my therapist has never heard of someone with autism having such an experience. It's a little frustrating. She doesn't understand how it links in with my autism or how it's an autism thing.' (A1) • 'It [autism psychoeducation] wasn't even learning about it for me, but just learning about it in general, which was really helpful.' (J10) • 'In sessions when we talk about different things and like my specific emotions, why I feel the way I do. Then I kind of realise that it's about my autism almost.' (E5)
	Importance of practising skills 1:1	• 'I do find it quite hard, like I do have to ... like my 1:1 sessions, we do have to go through skills over and over again for me to know how to use them or to understand how they work and like that kind of stuff.' (A1)
DBT skills groups	Social communication differences and impact on relationships: • Not understanding implicit social rules • Impact of social anxiety • Feeling connected with others	• 'I found it difficult to kind of read social situations, because I don't know any of these people and outside of a group I would see them as my peers and I normally would not share anything like that with them. But then because we were in a group like I could share that. So I think that was a little bit strange for me at first.' (H8) • 'I've actually never left the group when I've been struggling because I don't physically feel able to because of my social anxiety, I get worried about what other people will think. So I physically feel stuck.' (A1) • 'Knowing a lot about one interest, it helped me bond with one person in my group quite well. That kind of make me want to go to the first two rounds of group because I knew shew as going to be there and we got along well and I felt more comfortable when there was someone that I can sit next to all the time and talk to.' (J10) • 'I felt a bit awkward about it at first, cause I didn't know if I was the only person who is neurodivergent in group ... I feel like in Group because there was another autistic individual there with me, I feel like both of us felt more like open to asking questions, we felt more comfortable with it, I felt like that was a strength ... I think it took the other autistic individual to bring it up first to be like ohh I'm not the only one in Group who is struggling with autism.' (B2) • 'Seeing other people of similar ages and like similar things because I made one really good friend, that was really good.' (G7) • 'I do feel quite isolated in group, I definitely feel like I lack more social skills than the rest of group, I don't always know when it's my turn to speak or if I should speak, and I really struggle with those things and I don't really see anyone else in the group struggle the way I struggle and that feels quite isolated.' (A1)
	Impact of lived experiences on group dynamics: • BOTH speaking up about my experiences AND acknowledge individual differences • Feeling othered/invalidated by others or invalidated others by mistake	• 'We spoke about [autism] sometimes in Group, but it's always a young person that brings it up.' (A1) • 'I don't really wanna like make anyone upset or feel like invalidated because a coping mechanism works really well for them, but it doesn't work for me.' (D4)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
		• 'It's not really specific to someone in the group, but in ae there are other autistic people in the group and they can relate to it rather than it being like well you are autistic, so you have to do it this way rather than make it more general, I guess.' (E5) • 'I think if people hadn't laughed, it would have been a bit easier to just be like, that wasn't cool, but because everyone reacted the complete opposite to me, should I be laughing as well? Am I overthinking? Am I responding like inappropriately? … Everyone's very different, but everyone seems to have very similar views and I'm just like that does not work and it's really awkward having to be cause they don't force you to speak if you don't want to, but there's a bit of pressure for you just because it's encouraged that you like share with the group and you are there for a reason. So when I have a complete opposite idea than everyone else, I feel really bad. It makes me feel really uncomfortable because everyone does soemthing completely opposite to me, and I'm here saying that doesn't work at all for me … I've been labelled as the Devil's advocate by a few people in my group, I have a habit of completely disagreeing with something someone said or like saying how this isn't effective for me personally, I never say it's effective for everyone.' (D4) • 'I'm very bad at hiding my opinions and emotions and I also have a very strong sense of right and wrong or like moral code. So if someone in Group is doing something that I consider bad or wrong, I will really struggle to just like not involve myself or not hide my disgust or whatever … to me, a rule is a rule, you've gotta follow the rule. If you don't follow the rule, you know that's wrong. That's upsetting.' (C3)
	Group materials and teaching: • Worksheets do not acknowledge neurodivergence • Role-plays not personalised	• 'I don't think they were giving like an alternative way of doing soemthing. I don't think they've said if you are autistic, which is also fine, because obviously lots of people either aren't diagnosed, or maybe share traits that aren't autistic and stuff. So then it leaves a lot more like open …' (G7) • 'I mean looking back at the worksheets, you know some of them are quite generalised, it's just like black and white thinking. It's very heard to change that if that's been your entire, that's how your brain is wired, that's not easy. I don't know if there is an alternative, if there was then it wasn't discussed.' (E5) • 'Maybe on the worksheets or something, because especially maybe for emotion regulation kind of things … It's a bit different with autism, for me anyways.' (J10) • 'I don't want to ask if I need clarification on something … it's just like the social situation, you don't want to hold everybody back who understands when you are asking a question and like having to then go back through it and then like wasting time … during group I didn't practice any of the skills, I just take the handout home and came back the next week.' (F6) • 'With the role plays and stuff, it's just one situation when there could be different situations … I don't find it that helpful.' (A1)
	Role of facilitators: • More actively manage group dynamics • Literal use/interpretation of language • Second facilitator to check in	• 'Maybe the facilitators have been more aware about how it wasn't just affecting the two people who were in the argument … but just being maybe a bit more aware that like it will impact other people in the group as well … kind just maybe having one person dealing with the people arguing, and then the other two just checking on people … I find it difficult to

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Table 2. (*Continued*)

Theme	Subtheme	Quote
		tell people when I'm struggling, but if someone checks on me then I'm more likely to tell them how I'm feeling.' (D4)
		• 'The facilitators shouldn't have a visible reactions, even if they found it funny … they are the adults in the room and the responsible ones … It made me feel worse that they also reacted in the same way …' (D4)
		• 'In group sessions like whereas one person explaining and then another person can be going around like making sure like everyone understands like actually and that's how it's going? Checking like everyone is ok, do you understand? Do you want me to explain it again? Do you want a break? Those things are really helpful …' (F6)
	Sensory differences: • Environmental considerations • Lower demand and self-sooth box	• 'I feel like with the group there should have been a bit more of a like introducing yourself kind of thing. If we weren't immediately like you all have emotional dysregulation, talk about that. I kind of wish we had a chance to properly get to know everyone that'd be like I like this, I do these subjects at school … it doesn't have to be like a lot, but it would be nice to know a few things about other people.' (D4)
		• 'In group we were provided like a lot of things to fidget with … that wasn't really a lot of pressure to talk, as long as you provided the reason, everyone in Group was really understanding and it was a nice environment to be in.' (B2)
		• 'It's quite noisy, and there's the stuff on the table, sensory stuff, I can find it quite distracting if everyone's like fidgeting with stuff …' (C3)
		• 'Space it was very cramped in … there wasn't even like room to move in your chair kind of to get a little bit, just to like regulate yourself a bit better, that was difficult.' (G7)
		• 'Informal and a bit less intimidating, it's kind of just more fun …' (G7)
Telephone coaching	Social demands impact on accessibility: • General anxiety around telephone calls • Lack of structure for information processing • Lack of information to interpret social interaction	• 'I despise phone calls … I just can't see them. Having to throw the idea of phone calling someone when I'm already in a bad state of mind or like I need help would me fell worse about it … I think it's also social anxiety. I don't really know how I sound down the phone like it could sound really weird or sometimes they might not be able to understand what I'm saying properly.' (D4)
		• '[Therapist] did try to message me and being like how are things send me a message … there was lots of encouraging, to be honest I tried it then and it wasn't that bad.' (F6)
		• 'I think it's very important that there's conversation and like no pressure, they are not expected to say everything because it's hard conversation to have with people.' (D4)
		• 'I just didn't wanna cross any like boundaries … and I really struggled like talking about how I was feeling and even in sessions like I would sit there for ages … There was too much anxiety going into like how to use phone coaching and like what I was supposed to say and how I was supposed to use it … what exactly am I supposed to say?' (F6)
		• 'I definitely think there could be like a structured way of how phone coaching should work … like it could be the young person calls up and explains the situation, and then what the therapist is supposed to do and I feel like it would be easier if it was structured …' (A1)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
		• 'Maybe like knowing the questions they are gonna ask, and then expanding on that, because I struggle a lot when people ask questions I'm not prepared for.' (I9)
		• 'When you are talking to someone on the phone, it's not like you can read or try and read their emotions. If you mishear something or if they can't hear you, then you have to repeat it and it's just so you have to think so much mor than when you are talking to someone in person ...' (E5)
	Fear of negative evaluation or invalidation and being misunderstood: • Anxiety around who will pick up the telephone • Will they understand me or make it worse?	• 'You are supposed to call the mainline if your individual therapist doesn't answer. I find that very daunting and I haven't been able to do that. It's like the uncertainty of who's going to answer the phone. It might be someone I know or it might not be someone that I know ... They don't particularly know what I'm like, what my life is like. So if I tell them the specific scenario of what's going on, they might not understand they might make me feel even more frustrated.' (A1)
		• 'I'm just having to repeat everything all over again after working so hard to say it in the first place. I'm not gonna do that. I'm sorry.' (F6)
		• 'When it comes to therapy, you know your therapist isn't gonna judge because that's their job. But I don't know. I just have a lot of like internalised anxiety when it comes to talking about my feelings and especially because phone coaching ... you are meant to use it when you are in like a state of distress. I don't really know if I want like somebody like seeing me in that state.'
	Timing of telephone calls: • Forgot to ring • Too dysregulated to ring • Out of office support	• 'I think [my therapist] was a bit worried at the beginning that maybe I was struggling with phone coaching, but it's genuinely just like I would just forget. If I was in a situation where I really needed support or something, I definitely would call her.' (H8)
		• 'I wouldn't notice my emotions and they would all kind of build up later in the day. So by the time phone coaching was available it would be too late.' (B2)
		• 'It would be so amazing if there was even just one person who would be available on the weekend or soemthing? Had their phone on them and even though it might not be your therapist, just say there would be someone to like contact would be helpful.' (G7)
		• 'The main times that I would want to have like contacted like someone who I actually know has been in like out of hours times which is difficult ...' (G7)
	Messaging more than telephone calls?: • Visual stimuli enables more time for processing • Edit/change responses • Access to individual therapist	• 'So instead of like phone coaching, I guess I'll text my therapist or somebody else instead because I just find it easier to speak that way because when you are texting, you actually have time to formulate what you are saying. Just easier for me ... because when you text, you don't have to like hear or see another person's reactions.' (I9)
		• 'When I'm typing I kind of have a bit more of chance to see what I'm typing ... even though I can't get tone over text, I can read the message and try and guess their tone and then formulate an appropriate response without having to like worry too much ... With texting I can read it through and be like that's not the right thing to say, I wanna say this. I can articulate my point a lot better.' (D4)
		• 'I'm just not good at communicating with text and stuff, I always thought that was awkward.' (J10)
	Therapist and environment: Background noise cause sensory overload	• 'I think be wary of background noise ... if the therapist is in quite like a loud space, that could be very difficult. If you are hearing some of it on the phone, I find that horrible.' (C3)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
(c) Skills use and generalisation		
Barriers to skills use	Too abstract: Harder to grasp with lack of clear instructions	• 'If you use skills it's because you want to use them and you have to get to a point where you actually want to. But in my mind, because I'm very methodical and matter of fact, sometimes I don't understand the point of using them and I just, no one really explained the point. Why am I doing this? Even though there is a reason why, but in the moment you are not really thinking of why and then you become very tunnelled. There's just tunnel vision, and you know it's black and white again … There's no grey for me, and I think that's the issue with skills is that you have to find a grey area.' (E5) • 'I don't like mindfulness or like wise mind, just stuff that you need to like intuitively do. I find it hard to do things if there's not like instructions.' (I9)
	Poor generalisability: I understand it, but I don't know how to apply it	• 'With Acting Opposite, I understand it, but it's like the little parts of it, you know like the sort of body language and stuff I just don't think about it, just doesn't enter my head at all that like actually maybe how I'm sitting is conveying a certain emotion and I need to change it. That's something that I haven't' gotten used to … if you are feeling sad, then your instinct is to like withdraw. I'm good at you know actually doing the complete opposite of that, but it's the smaller details of it that I just can't get a hold of.' (H8) • 'Like all the skills I can tell you everything, but like when it comes to like applying, I find it a lot harder and like I can regurgitate the information but like do I understand all of it like not necessarily.' (F6) • 'Skills and techniques especially for an autistic person, is in like a state of distress or in a meltdown. It's very hard to take yourself out of the situation and be like, oh yes, this is time to use a skill, because you have very like tunnel vision, it's just so overwhelming … I just find it so hard to like adapt them to any situation.' (I9)
	Motivation and past misconceptions about skills	• 'Finding the motivation to do it is like a skill in itself really, because it's quite draining to go and put ice in a bowl if you are sad.' (E5) • 'I never believed in mindfulness until … like halfway through DBT, I guess like now I can just concentrate, like I can ignore my unhelpful thoughts and I can concentrate on the helpful ones if that makes sense.' (A1) • 'I think I definitely had like a bit of a prejudice with mindfulness because the way that it had been taught to me before and I didn't find it very helpful at all. I just thought it was like, just rubbish.' (H8)
	Demand on social communication skills: • Check the facts/GIVE: perspective taking • GIVE: eye contact	• 'Check the facts, that I really struggle with because I just catastrophise everything … I never really thought to check the facts before, like I would just wholeheartedly believe whatever it was that I was thinking was going to happen … I think it helps me, even though I struggle with sometimes I will go back over the situation and think this isn't helping me at all but it helps if I go over it with someone else. A lot of the time I'll actually check in with like my friends or my family and say like what do you guys think about this situation? Because I'm quite open with them anyway, so a lot of the time they do, we know all of the facts and so they can even tell me if like actually maybe what I'm feeling is valid or maybe ok, you are

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Table 2. (*Continued*)

Theme	Subtheme	Quote
		overthinking this. So to hear that from somebody else I find really helpful. But I struggle with it on my own.' (H8) • 'Especially like in terms of autism and with the skill GIVE. That skill really wants you to put yourself into someone else's shoes, which a lot of autistic people can struggle with.' (B2) • 'But GIVE almost negates, it just almost cancels it out for me cause what I'm doing feels unnatural … almost like don't do that and be like this when I'm trying to make a point to someone.' (E5) • 'There's one where it's like ohh you should make eye contact. We spoke about how that might be difficult for me … I find that it doesn't really take into consideration like social situation and social communications and like everything and like it just presupposes that everyone is like already, like comfortable or able to.' (F6)
	Sensory differences: • TIPP: sensory differences • Mindfulness: sensory overwhelm, emotion regulation	• 'I get very overwhelmed by sensations, so I feel like distress tolerance skills really helped with that.' (B2) • 'I definitely try and notice how I'm feeling in my body and like any sensations and stuff that I have. I try and break down situations because there's a lot of times where I will get secondary emotions.' (H8) • 'Autism doesn't like prevent me from doing any of those skills, like with the ice diving – I always have to have a towel ready cause I can't be soggy.' (C3) • 'My focus was really hard for me … mindfulness is just hard because I can't keep my brain like on focus on the task at hand because my brain is always wandering.' (F6) • 'Because you are meant to do it when it's quiet and there's no noise and it's just my mind's always racing other places. I'm always thinking about stuff. It's hard.' (I9) • 'Usually like an autistic person just can't really tune those out, like they don't have that capacity, so they are already very aware of those things like almost like no need to point them out again.' (C3)
Supporting skills use	Clear rationale and bespoke tailoring	• 'The whole time we've kind of just decided that it'd be better to work on just a couple of skills and actually remember them than trying to learn lots of them and not remember any of them.' (G7) • 'If someone's brought up the fact that they think they might struggle with autism, then just helping them apply the skills because it will be a bit different for them and just helping them understand how it might be different and how they can apply it differently than what the worksheet might say.' (J10) • 'I feel like explaining the rationale behind skills cause I feel like that will help a lot more and so autistic individuals can really understand why these skills will help and so you know, really sink in better and someone will be more likely to use it. So I feel like that can definitely help.' (B2)
	Clear structure and plan: • Act Opposite: clear guide on what to do • Mindfulness: Observe, Describe • Cope Ahead: reminder for skills use	• 'Act Opposite is very helpful … I try and do it more with my actions of not hiding away, you know trying to do more actions. It's the actual actions that you are doing, like actively trying to participate and not seclude yourself. That's what I take form the act opposite skill rather than the whole project your body language into a positive way.' (C3)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
	• Interpersonal Effectiveness: structured social response	• 'Act Opposite is one I use a lot in terms of like social situations because I get disheartened in social situations very quickly … and if I didn't use Act Opposite, I feel like I'd just stay in my room all day, so it's very helpful. I have to be in my mind a lot telling myself you are going to do it. That's very helpful …' (J10) • 'Even if I'm not struggling, I like to just sit back and sort of see all my thoughts go by and pay attention to what's going on around me. Just feel like almost it gives me a little breather because everything can be really over-stimulating sometimes. I think I get really caught up. So it's nice to just take a little step back and that's been probably my most used skill out of all of them.' (H8) • 'I don't know what skill I should be using cause I'm just too overwhelmed. To know which one is the right one to be using in that moment, Cope Ahead plans are quite helpful.' (A1) • 'I know the DEAR MAN made it easier for me to ask for things because I can be quite a blunt person as well, because DEAR MAN focuses on both parties, that structure made it easier for me to focus on myself and keeping myself happy while also keeping the other person happy and them understanding my side of things.' (B2) • 'Because I'm autistic, I absolutely loved that it gave me, like a structure about it. I definitely used that in situations with people, but I think just sort of breaking it down a little bit even if I'm not doing the full DEAR MAN, I think it's definitely helped me to understand how to word things better.' (H8)
	Building positive relationships with self and others: • Check the facts: validate self and others • Interpersonal skills; offer advice to others	• '[check the facts] I think that's quite helpful because I just forget that may not be the actual intention behind soemthing or that I'm just seeing it from my own point of view …' (G7) • 'If someone's said something and I'm like oh they hate me and then I just try and tell myself it was actually just a joke they made. They don't hate you. They just made a joke and you are insecure about what they made a joke about, yeah.' (J10) • '[GIVE] two things that I think I really struggled with, like trying to be sort of a bit more empathetic and a bit more gentle in the way that I go about things … I think part of the reason that was because of my autism, like I just didn't pick up on things a lot of the time. So that really helped me because I've become more aware of like who I might actually affect other people.' (H8) • 'Honestly I think with my interpersonal relationships I use skills like for other people more than I do for myself. So like the advice I get in like DBT and stuff with the skills I'll tell my friends who are in like high stress situations to do that instead. I'll use the skill with them so it helps them as well as helping me I guess.' (I9)
	Autism strengths: hyperfocused attention and logical reasoning	• 'I like check the facts because I can really you know, pros and cons, I like that it's logic and it's fact and it's not predictions or anything like that, it's what's happened.' (E5) • 'I think it would be easy to use because I'm like a very factual person and I think I'm always kind of checking the facts because I don't like being super upset about something when I shouldn't, like if it's unnecessary.' (I9) • 'I quite like radical acceptance as my favourite one because it's straight to the point really.' (E5) • 'I think they've said a lot if I describe situations like you've really accessed your wise mind as I don't think I did. I think I just rationalised it cause I like rationalising things and I like logic.' (D4)

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Table 2. (*Continued*)

Theme	Subtheme	Quote
Skills practice or masking?	Is it skills use or masking? • Mindfulness: personality mask? • Act Opposite: hiding?	• 'I just don't understand the idea of changing my mindset almost so just it's very hard to switch into wise mind or even the other minds. Because it's very unnatural to me to do that. So I guess mindfulness is like trying to put on almost like a mask … trying to put on some sort of personality that isn't really me because I'm trying to be either Zen when I'm really not a Zen person.' (E5) • 'I don't understand why you would act opposite, I know I understand why but like in terms of just real life, it just feels odd to act opposite to the way you are feeling. If you want to embrace the feeling, there's so many different paths. It's quite confusing.' (E5) • 'Act Opposite, just sometimes you are told like ohh, you know, just put on like a positive face and mask and stuff. And I'm like, I don't know what that means. I am putting on a positive face. This is my positive space face, you know project your body language into a positive way, because my positive body language doesn't really … it is masking for me.' (C3)
	Using skills to mask how I feel: • Use more discreet skills so others can't see and hide how I feel	• 'I suppose in public, I remember … you know like certain things aren't acceptable in public and I need to try and be OK. But I also don't wanna draw any attention to myself. Then in front of friends and stuff I just suffer in silence … I guess like people around me aren't noticing how much I'm struggling as much because … I have more skills to use to try and hide it.' (A1)
	Skills can also help me assert myself: • DEAR MAN: Establish boundaries – both firm AND polite • FAST: identify and uphold personal values	• 'One of the things I found about DEAR MAN was people always had like a positive reaction to it, which was helpful in giving me the confidence to be able to use it again … This is good because it had a balance of stern but also polite, because I always have to think about my priorities, if it was like maintaining the relationship or like my own needs. To me, it kind of felt like a good balance in between the two. Because I'm always awful at picking my own needs over the relationship … That was my favourite one because my whole life I've never been able to set boundaries with people and I get used a lot and like manipulated and stuff.' (J10) • 'One thing that I really struggle with was kind of the idea of FAST and being able to like uphold my own wants and needs and stuff like that. It literally took me the entirety of the therapy, it wasn't just something that I picked up. I took me so long to be able to like actually, number one, identify those things and number two, like uphold them. But it's soemthing that I definitely found myself doing now, and it's just made such an impact on my entire life I think.' (H8)
(d) Recommendations and adaptations		
Theme	Subtheme	Quotes
Improving written materials	Worksheets – use to maximise learning opportunity! • Writing things down helps information processing/memory • Allow individuals to work through sheets • Summary skills sheet	• 'You know how the worksheets they've got lots of like spaces to write stuff. I feel like we didn't really ever do much of the stuff on there, we just talked about it and it would have maybe been good to do more of the structured activities where they are written down … because then it's a lot easier to come back to it, because then you know you've already got an example and stuff because each sheet we've talked about them, but then I couldn't' have written down anything … lots of skills they are meant to be used in the moment but I can't just think of the answers on the spot … I have to write it out beforehand and then quite

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Table 2. (*Continued*)

Theme	Subtheme	Quote
		often I'd prefer to like text someone or so I can read what I've got … not remember how like just not being able to process things quickly enough.' (G7) • 'The worksheet is good, but like a lot of the time they can be like a lot of information … you guys can like highlight the key bits of information and stuff.' (I9) • 'I really liked the structure of it and like it just helped me pay attention with the break … and then the worksheets when we work through them and you do the homework, I like that aspect.' (J10) • 'I was trying to look through the contents page and I was like it would be really good if they had it all on one A4 page with what the skill is and then like just an one line summary just to prompt.' (G7)
	Be mindful of literal use of language: Use Neurodiversity DBT handbook	• 'Sometimes I do take things quite literally or like I'm saying, like I'm focusing on the language, on my understanding of that and not the actual content itself, or sometimes I may be not understanding of what's being said or I just act like I am … There's also a DBT handbook for autism, and like things are explained a bit more carefully.' (F6)
	Be creative! (e.g. diary cards)	• 'It's actually easier to see … and then there's spaces to add in your own things and stuff. And obviously you can just type them out, I print them on sticker pages …' (G7)
General accessibility advice	Understanding autism from the get-go: • Self-learning is key • Ask, and ask again!	• 'Everyone learns the same skills, but everyone will like use them differently or like they'll use them in different situations, because everyone's different.' (D4) • 'I think maybe in like pre-treatment, in the beginning, that's how you know there would be like a clear framework for how the rest of the session go because you have had this conversation whereas if you didn't have the conversation then that individual could be struggling and like you wouldn't even know.' (F6)) • 'I would say just checking in with that person as soon as they start and sort of seeing if there's anything in particular that they would find helpful or I think for one thing that I sort of wish that I had before DBT was kind of helping to understand my autism a little bit more because that's something I really just did on my own. I'm still learning new things about autism.' (H8)
	Common adaptations: • Sensory differences • Planned breaks • Adjust session lengths • Session reminders • Clear agenda	• 'Make that option open to bring in like a toy or something and also because I know a lot of autistic people really struggle with eye contact, mentioning that you don't have to make eye contract because a lot of people see a lack of eye contact as you know, not respectful. And it really sucks because you know, I could be really listening to a conversation and really involved with it, but not make eye contact.' (B2) • 'The waiting room. It's noisy and jam packed. It's quite stressful. Maybe allow people to go into the room as soon as they arrive. So it's not so overcrowded in the waiting room.' (C3) • 'It takes me a long time to process things and stuff … so maybe extending it and then having a break in between or just extending it and no break, because I'll get more from it because like that one hour, I need extra time, I will also take me a while to get comfortable and then by the time that I'm comfortable like time has passed already and then it's the end of the session and we've not done that much in it. I'd say in the beginning like that thing should be outlined like how

(*Continued*)

Table 2. (*Continued*)

Theme	Subtheme	Quote
		someone processes information and how long it takes them, that will depend on how long the sessions are.' (F6) • 'Sometimes I would totally forget that if I had like an online session or something, I would have to get my mum to remind me because my memory's really bad.' (H8) • 'One thing I've also found very helpful with my therapist is when we have our individual sessions, she always sets like an agenda of like what we are gonna do.' (C3) • 'I feel like if there was almost like an itinerary or something like that . . . tick boxes, you can tick it off once you've like done that bit and then it has the times of everything and break then hopefully group will stick to that itinerary. So you actually learn skills and then things don't get overwhelming.' (E5)
	Manage (social!) anxiety: • Clear structure to reduce uncertainty • Anonymised slips for Q&A • In-person, online, messaging	• 'It's a way to get comfortable with your DBT therapist and like to speak about things that aren't just DBT related and form that rapport like before, like you then start talking about like things are really personal to you and like just talking about random things for us.' (F6) • 'I would use it [write down on an anonymous little slip my question], that would be useful.' (F6) • 'That's why I chose to come into DBT instead of like having online because I just always really struggled with online therapy and stuff.' (J10)

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Adolescents spoke about how explaining the diagnosis meant peers, school systems, and even clinical therapists may develop a better understanding of their needs and highlighted that everyone should view it as their personal responsibility to improve autism knowledge and understanding, rather than always having to rely on the autistic young person's account, as each autistic person may be very different.

Theme 3: What does Autism Mean to Me?

First, autistic adolescents embraced many strengths that they associated with their neurodivergence. For example, viewing the world through a different lens can evoke creativity, and many drew on their lived experiences of social communication differences that allowed them to have more empathy and be more open and honest in their communication with others to avoid misunderstanding. A few adolescents also talked about being able to develop a depth of knowledge for areas of focused interests, be very goal-driven when they put their minds to a task and have detail-oriented processing that helps them to be methodical and observant. Second, autistic adolescents also noted differences associated with autism, such as finding emotion identification, expression, and processing to be more difficult than others, having a range of sensory differences that can limit various aspects of their daily lives, and having stark social communication differences that can make it harder for them to interact with others. Finally, adolescents talked about how the boundary between strengths and differences might be blurred. For example, hyperfocus and learning social cues can both have advantages in developing deeper learning and build empathy with others. At the same time, these can prove to be exhausting at times when over-used. Recognising strengths and differences can be helpful to support the autistic adolescent build a more holistic image of their autism identity.

Theme 4: Autism and Mental Health Difficulties

First, autistic adolescents talked about both recognising the importance of understanding what autism means for them, and felt like the post-diagnostic support they received may not always be adequate and they can be left to navigate their diagnosis alone. Poor understanding of how autism and late diagnosis combined can increase their vulnerability to developing co-occurring mental health difficulties, as well as prolonged diagnostic overshadowing as certain behaviours such as masking may be misattributed to anxiety. Social anxiety was particularly common in this sample and was associated with both intolerance of uncertainty in social situations and not always knowing how to respond. Second, autistic adolescents spoke about how validating it was when autism was both considered as a vulnerability factor, and to have emotion dysregulation identified as the main target for treatment in DBT. Understanding emotion dysregulation and associated self-harm behaviours and urges within the context of autism can be helpful, as one autistic adolescent was able to relate self-harm to sensory overload associated with autism.

Question 2: How do autistic adolescents experience different components of DBT?

Autistic adolescents reflected on each DBT component, which they directly came in contact with, namely individual sessions, skills group, and telephone coaching, to consider how autism was brought into the sessions and influenced accessibility of DBT content in different settings. We highlight the strengths and difficulties experienced by adolescents in each of the different components in DBT (Table 2b).

Theme 1: Individual Sessions

First, given that many adolescents experienced both environmental invalidation and internalised stigma associated with autism in everyday life, adolescents spoke about the when, who, and how

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conversations about autism were initiated in individual sessions to bring such lived experiences into conversation. For some, conversations emerged naturally as discussions about social situations or emotion dysregulation provided opportunities to consider the role that autistic traits (such as social communication and sensory differences) might play. Others felt that although it was acknowledged, the focus of sessions was around emotion dysregulation and not always related to autism *per se*. Understanding emotion dysregulation in the context of autism also helped some adolescents better understand why they responded to situations in certain ways, and how autism can increase vulnerability to emotion dysregulation. Second, adolescents talked about mixed experiences of validation or invalidation from therapists when they shared their lived experiences. Some therapists advocated for environmental adaptations to be put in place to accommodate for sensory differences, providing functional validation. Others may have brought in more preconceived notions of how autism might affect someone that came across as invalidating to the adolescent. Nonetheless, having the opportunity to discuss autism facilitated adolescents' understanding of self and their emotional experiences. Finally, adolescents valued individual sessions to provide opportunities to clarify and practise skills in a person-centred way and consolidate learnings.

Theme 2: Skills Groups

Autistic adolescents described how autistic traits can have a direct impact on how they experienced the social setting of DBT skills groups that have a direct impact on their learning, as well as perceived relevance and application of DBT skills when accounting for their social communication and sensory differences. First, adolescents reported that social communication differences meant that they found it harder to understand implicit social rules in group, which perpetuated and exacerbated social anxiety. For some, having a shared interest or knowing there was another autistic young person in group helped foster social connection. For others, noticing how one's social communication differences stood out from others made the experience more isolating and anxiety provoking. Second, adolescents talked about the process of sharing lived experiences with others, and the impact on both group dynamics, and oneself. Double empathy difficulties arose where both autistic and non-autistic adolescents may be more likely to misinterpret each other's perspectives. Autistic adolescents often noticed that they experienced the world differently that meant skills practice did not always work in the same way as it did for non-autistic adolescents, and balancing sharing their perspective without invalidating or demotivating other people can be hard. Autistic adolescents reported feeling upset and needed to call out when group rules were not respected. Noticing visible differences in one's reactions compared with others (e.g. taking a joke literally and feeling offended when others were laughing) also led adolescents to feeling othered and invalidated by group members. Third, adolescents spoke about how group materials and method of teaching using role-plays often failed to include or highlight neurodivergence, and adolescents did not always feel able to seek clarification for fears of holding back the group and standing out for not understanding the worksheets. General guidance on skills use were less applicable to autistic adolescents' personal situations, which led to reduced motivation for skills practice outside of group. Fourth, adolescents wanted the role of facilitators to be more hands-on in terms of managing group dynamics, and to maintain a neutral stance when responding to adolescents in the group (e.g. not laugh at jokes as some autistic adolescents may have taken this literally and did not find it funny). Adolescents wanted a second facilitator who actively checked in on each person's understanding of materials being shared, to give more opportunities for clarification without having to ask questions oneself. Finally, adolescents spoke about the need to consider how the environment may impact on each person's sensory needs. For example, noisy and smaller spaces can increase one's vulnerability to experience sensory overwhelm. Even adaptations such as providing fidget toys can be perceived to be helpful by some,

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and distracting for others. Helping adolescents familiarise themselves with each other and the environment can make the setting feel less intimidating and more accessible for participation.

Theme 3: Telephone Coaching

Overall, autistic adolescents found telephone coaching to be particularly challenging and less used throughout therapy. First, adolescents found the social demands of making a telephone call too inaccessible. The uncertainty of how telephone conversations will unfold is exacerbated by having very minimal social cues to assess the therapist's reactions, and adolescents reported not knowing how to effectively communicate their situation across. Second, when there was no guarantee that telephone coaching would always be directed to your individual therapist, adolescents talked about feeling exhausted to think they will have to explain their situation to someone new, and what if the new team member misunderstands them and makes them feel worse through invalidation. Third, practical challenges around making telephone calls included forgetting to ring, or only remembering when one is already very dysregulated and no longer able to use the telephone, as well as wanting to use telephone coaching outside of office hours when it was not available. Fourth, in general, many adolescents commented that texting provided a helpful alternative as visual information processing allowed one to communicate more effectively, although others found this awkward and still not knowing how to structure one's responses so not to sound inappropriate. Finally, adolescents wanted therapists to be more mindful of their environment when taking telephone coaching, as background noise can be distracting and cause sensory overwhelm.

Question 3: What are the barriers and motivators to skills use in everyday life?

Autistic adolescents spoke about the difficulties of generalising skills to everyday life, and also practical tips that increased accessibility to certain skills, sometimes drawing on their autistic strengths. For skills such as mindfulness and emotion regulation, adolescents also talked about how some skills practice felt like masking or hiding how they felt. We summarise their experiences into three key themes (Table 2c).

Theme 1: Barriers to Skills Use

First, adolescents talked about abstract skills that lacked clear instructions made the skill harder to use, especially if one did not understand the rationale behind skills use. Second, understanding the skills did not always translate to generalising skills use to personal everyday situations. Third, individual differences in motivation to practise skills often differed, and sometimes lack of motivation stemmed from having unhelpful pre-conceived misperceptions of skills from previous therapy, which have been taught outside of a formal DBT programme. Fourth, adolescents noted that some skills, such as check the facts, and interpersonal skills like GIVE, often had pre-requisite social communication skills that autistic adolescents found difficult. For example, checking the facts and being able to put oneself into other's shoes often required perspective taking, which was easier to do with the support of family members or their therapist, but harder to do independently. Some skills such as GIVE also explicitly asked for eye contact, which can be uncomfortable for some autistic adolescents. Finally, adolescents talked about the need to consider sensory difference when teaching and using skills. Although many found distress tolerance skills such as TIPP to be helpful in managing sensory overwhelm, being mindful of individual preferences for sensory components such as temperature, having water on one's face, and managing such aspects ahead of skills practice can make the skill more accessible for use. Understanding how attentional differences may also form part of neurodivergence that can interfere with mindfulness practise is also important, such that observing external surroundings can contribute towards sensory

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overwhelm, when the adolescent may be trying to shut off certain cues to better focus one's attention on the task at hand.

Theme 2: Supporting Skills Use

First, adolescents talked about how having a clear rationale on why a skill can be helpful and working together with their therapist to tailor skills practise based on individual's needs made it easier for the adolescent to remember and be more willing to practise the skill. Second, adolescents noticed that some skills came with clearer instructions, such as carrying out opposite actions to urges to avoid (Act Opposite) and having structured ways to think through social interactions (e.g. DEAR MAN). Writing a clear Cope Ahead plan and focusing on rehearsing a few skills well also reduced the burden on having to remember which skill to use in difficult situations. Third, adolescents were able to use skills to effectively improve their relationships both with oneself and with peers. For example, using Check the Facts helped autistic adolescents to notice when they are catastrophising, and both self-validate one's distress, and consider different missing perspectives. Interpersonal effectiveness skills were reported to be particularly helpful for autistic adolescents who drew on them to support other people, sharing their skills when noticing others in distress, and fostering stronger relationships with others. Finally, autistic adolescents talked about how strengths associated with autism, such as hyperfocused attention and logical reasoning, made some skills easier to use than others, such as being able to describe the facts in a rational way (e.g. Mindfulness Describe skill and Check the Facts), and this was noticed by therapists who considered adolescents to be accessing their Wise Mind when they relied more on logical thinking, which may have been more reflective of Reasonable Mind.

Theme 3: Skills Practice or Masking?

First, autistic adolescents found some skills to be less intuitive, mostly around trying not acting in line with one's emotions (i.e. Act Opposite). One adolescent found switching between different states of mind to be unnatural, and that Wise Mind almost felt like they were trying to put on a persona of being calm when that did not match how they felt. For others, Act Opposite – especially aspects related to monitoring one's facial expressions and changing one's body language – felt more like masking and hiding how one felt; whereas taking actions instead of avoiding felt more helpful and brought about noticeable changes in one's mood. Second, autistic adolescents spoke about how using some discreet skills in public might hide how one's feeling as to not stand out, and this meant that other people may be less able to identify when they are struggling, and skills contributed to masking one's difficulties in public. Third, autistic adolescents also noticed that interpersonal effectiveness skills, especially learning to identify one's own values and upholding them (FAST and Wise Mind Values), and learning to effectively assert oneself without coming across as disrespectful, were really valuable ways to help one become more authentic in one's social interactions. Learning to put one's own needs first rather than always focusing on maintaining the relationship when the latter meant masking or disregard for self-respect were also helpful skills as the antithesis of masking.

Question 4: What recommendations do autistic adolescents have on adapting DBT to better suit their needs?

Adolescents also offered recommendations on ways to improve session materials to facilitate learning, as well as general tips on ways to increase accessibility to different treatment components. We review each of the two themes below, and quotes are summarised in Table 2d.

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Theme 1: Improving Written Materials

First, adolescents spoke about the importance of using worksheets to provide structure to skills sessions, allowing individuals to work through materials in their own time given differences in information processing speed, and use the written guide to reduce burden on working memory and being easier to relate the skill to personal circumstances through examples. Second, adolescents talked about how sometimes language can be taken quite literally, and facilitators can benefit from paying attention to resources, drawing on adapted neurodiversity-based materials where possible, to reduce misunderstanding. Finally, adolescents wanted to be involved in co-creating resources that were clearer and appealed to them visually, such as re-designing diary cards.

Theme 2: General Accessibility Advice

First, adolescents talked about the importance for mutual understanding about a young person's individual differences to be established between therapist and young person, and the importance of checking in with the adolescent early on in pre-treatment to ensure adaptations and accommodations can be put in place from the get-go. Second, adolescents noticed several helpful adaptations during their time in DBT, such as allowing clients to bring fidget toys and explicitly stating that eye contact is not mandatory, finding much quieter spaces over lunch for autistic adolescents to socialise in, having flexible session lengths that accommodates for learning differences, and having clear session agendas. Third, adaptations around managing anxiety (especially in social settings) can also help increase engagement, such as prioritising rapport building during pre-treatment with therapist, providing more anonymised ways for question asking during group to reduce attention drawn to oneself, and offering a range of meeting modalities to suit the adolescent's preferences for accessing therapy.

Discussion

This study aimed to evaluate autistic adolescents' experiences of accessing DBT within a National and Specialist Child and Adolescent Mental Health DBT service in the UK. Unlike previous studies with autistic adults and adolescents that often involved an abridged or adapted version of DBT being delivered in a shorter time frame, all adolescents in the current study received the full adolescent DBT programme (Rathus and Miller, 2015) over the course of up to 9 months, in a routine clinical service rather than part of a clinical trial. The findings from this study largely resonate with previous studies that evaluated feasibility and acceptability of DBT in autistic adults and related adaptations (Bemmouna *et al*., 2022; Bemmouna *et al*., 2023; Bemmouna and Weiner, 2023; Huntjens *et al*., 2020; Keenan *et al*., 2023). We begin by summarising autistic adolescents' lived experiences prior to entering DBT to consider the interplay between external and internal invalidation on emotion dysregulation, before contextualising adolescents' experiences of accessing different components of DBT and recommendations for adaptation (summarised in Table 2d) considering current literature.

For many autistic adolescents, the long road to receiving an autism diagnosis was riddled with invalidation experiences stemming both from professionals, such as diagnostic overshadowing, and from family and wider society that often hold ableist views (Wilson *et al*., 2023). The subsequent internalisation of ableism and having a mixed relationship with accepting one's own diagnosis meant that many autistic adolescents had mixed levels of understanding of what autism meant for them. Nonetheless, most adolescents were able to name several differences and strengths that summarised how autism impacted their everyday life, and having an important understanding of one's own needs enabled adolescents to engage in conversations around

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vulnerabilities associated with emotion dysregulation and co-occurring mental health difficulties. Autistic adolescents' experiences resonated with the biosocial model of emotion dysregulation outlined by Linehan (1993) and adapted by Bemmouna and Weiner (2023). Participants noted the importance of including autism in the biosocial model as important context for their experienced invalidation and potential vulnerabilities to developing emotion dysregulation. A dialectic emerged in that many autistic adolescents found having the opportunity to explore and understand the reciprocal relationship between autism-related vulnerabilities and co-occurring mental health difficulties such as social anxiety to be helpful, and at the same time were clear that they viewed emotion dysregulation to be the main difficulty that needed intervention and should not be overshadowed by their autism diagnosis (Mazefsky and White, 2014). For this reason, participants highlighted several useful skills and therapy content for decreasing difficulties with emotion dysregulation, and particularly with developing interpersonal effectiveness skills.

The interaction between autistic traits and emotion dysregulation has been explored in literature (Dell'Osso *et al.*, 2023), where emotion dysregulation can negatively impact social functioning; exacerbate intolerance of uncertainty in relation to anxiety and depression; and is also in turn impacted by co-occurring alexithymia, cognitive inflexibility, and rumination. Although previous studies have highlighted the importance of considering alexithymia in relation to emotion dysregulation especially for autistic individuals (Bemmouna *et al.*, 2022; Bemmouna *et al.*, 2023; Bemmouna and Weiner, 2023; Dell'Osso *et al.*, 2023), interestingly, autistic adolescents in the current study did not refer to alexithymia *per se* in relation to either autism or emotion dysregulation. This may reflect the absence of psychoeducation and explicit assessment and discussions of how alexithymia may impact on emotion regulation processes with autistic adolescents within the service. It may also be that differences in emotion awareness capabilities did not feel particularly pertinent to how these autistic adolescents experienced DBT. Many spoke about the influence of sensory overload as a key contributor to emotion dysregulation, and the importance of including autism as a multi-faceted vulnerability factor during behavioural chain analysis for understanding self-harm and other high-risk behaviours.

Autistic adolescents' experiences of different components of DBT resonated with previous findings from adult studies. Examples include: using individual therapy sessions to have in-depth personalised skills practice (Bemmouna *et al.*, 2022), the importance of managing social dynamics within skills group to reduce social anxiety as well as environmental adjustments to meet individual differences in sensory needs (Bemmouna *et al.*, 2022; Ritschel *et al.*, 2022), and drawing on concrete explanations to encourage skills practice (Bemmouna *et al.*, 2022; Keenan *et al.*, 2023; Ritschel *et al.*, 2022). Social anxiety and intolerance of uncertainty were frequently cited as barriers to accessing skills group and telephone coaching, and autistic adolescents noted that having clearer agendas and structured conversations can reduce some uncertainty to ease anxiety, a benefit that may be generalised to all adolescents accessing treatment. Given that adolescence marks a period of heightened sensitivity to peer rejection (Blakemore and Robbins, 2012; Foulkes and Blakemore, 2018) and that many autistic individuals may experience prolonged and persistent invalidation from others, it was important to see from autistic adolescents' perspective how skills group provided a microcosm that had unique boundaries and set-up that can be particularly anxiety provoking.

Autistic adolescents experienced a double bind where often being one of the only neurodivergent individuals in group, they felt both 'othered' when they struggled to relate to shared experiences of social chit-chat and skills use amongst other group members, and invalidated when their unique perspectives may be misunderstood by others. The latter resonates with the Double Empathy problem (Milton, 2012; Milton *et al.*, 2018; Milton *et al.*, 2022), where the communication may break down across neurotypes when both parties struggle to see things from the other's perspective. This was especially evident in the current service evaluation project which was conducted in a routine clinical care setting, and autistic adolescents accessed clinical care in the same service as non-autistic adolescents, which is reflective of most clinical services

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outside of autism specialist settings. Potential fear of negative evaluation from others can maintain social anxiety over time, as autistic adolescents may continue to monitor both oneself and others to try and come across well in groups (Clark and Wells, 1995), which may also overlap with masking one's autistic traits and not drawing attention to oneself (Lei *et al*., 2023). Having group facilitators that actively scaffold conversations around how individual differences, including neurodivergence, may affect skills practice might offer a neutral space for sharing individual perspectives without singling anyone out based on their minoritised status (Camp *et al*., 2023b; Lei *et al*., 2024b). If possible, having the second facilitator to actively check in on each adolescent to answer questions may also bypass the burden of having to share in the wider group, and reduce the impact of social anxiety on access to skills learning in a group setting. On the other side of the dialectic, where autistic adolescents were aware of other autistic adolescents in skills group, this was seen as beneficial for increasing connection with similar others, similar to findings from the experiences of other minoritised groups in DBT (Camp *et al*., 2023b; Lei *et al*., 2024b), and also findings on the benefit of within-neurotype social interactions to foster peer relationships for autistic adolescents (Chen *et al*., 2021).

Finally, adolescents provided additional recommendations to DBT adaptations that are outlined in Table 2d. Many of these resonate with prior adaptations outlined in DBT such as using visual materials, making teaching more concrete, accounting for individuals' differences in information processing speed, practical adjustments to session lengths and breaks, personalisation of therapy materials, building routine and minimising uncertainty to manage anxiety, preparatory work to reduce social anxiety related to skills group, and environmental accommodations to suit individual differences in sensory needs (Bemmouna *et al*., 2022; Hartmann *et al*., 2019; Huntjens *et al*., 2020; Keenan *et al*., 2023; Ritschel *et al*., 2022). Autistic adolescents were especially mindful that their voices do not represent the lived experiences of everyone, and the key is for therapists to explore with each autistic client their individual preferences, strengths and differences, and make accommodations from the get-go to ensure the autistic adolescent feels safe and comfortable to engage in treatment over time. This is congruent with the principle-driven nature of DBT. Adolescents highlighted that continued conversation about adjustments and accommodations throughout DBT is key, as individuals may develop a better understanding of their autism and related needs over time. Such conversations were experienced as validating and the actual implementation of accommodations as functionally validating, which may serve to reduce the impact of the invalidation they have received from their environment (Bemmouna *et al*., 2023). Additionally, participants often cited barriers to seeking clarification on content or having the potential to misinterpret abstract information, therefore therapists likely need to check in on their understanding in all modes of DBT to appropriately scaffold capability development. This requires therapists to balance delivering DBT with fidelity, while shaping the principles to fit the needs of the clients, effectively to help clients work towards their life-worth-living goals.

Strengths and limitations

A strength of the current study is that it reflects feedback from autistic adolescents receiving a comprehensive DBT programme offered through a CAMHS in the UK, rather than participants in a clinical trial that may be specifically adapted for autistic individuals (Bemmouna *et al*., 2022; Huntjens *et al*., 2020; Ritschel *et al*., 2022). The findings from the current study may therefore be more relatable to the experiences of autistic young people accessing routine care in child and adolescent mental health settings outside of autism specialist clinics.

Limitations of the current study are also related to the non-autism specialist nature of the included DBT service. For example, due to restraints on service resources, we were not able to complete formal assessments of individual sensory profiles as recommended by Bemmouna and colleagues (2022) that would have been beneficial to understand sensory needs from the get-go. Similarly, unlike weekly consultations and supervision that took place to monitor DBT adherence

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to fidelity, conversations around autism and its overlap with emotion dysregulation both at assessment and throughout the intervention was not standardised across team members, and individual differences in adolescents' accounts may reflect different therapists' understanding of neurodiversity and approach to adopting a neuro-affirmative practice within the team. Additionally, any accommodations made in the DBT programme were not systematically monitored or recorded. It is also important to state that although an autistic adolescent helped the first author evaluate and pilot the interview questions, and that the first author has around 10 years of experience in working with autistic children and adolescents in clinical, research, and community settings, none of the authors or team members identified as autistic, and were unable to offer a first-hand insight into neurodivergent perspectives. Although it was not within the scope of the current service evaluation project due to time and resource restraints, we acknowledge that having the opportunity to work more closely with autistic young people throughout the conceptualisation of DBT evaluation to data analysis and interpretation could have strengthened the current paper, and adopting a participatory framework may have addressed power imbalances that may have been present in the current study (Beck and Naz, 2019; Jennings *et al.*, 2018).

Clinical implications and future directions

In our study, we highlight both adolescents' lived experiences of their diagnostic journey and what autism means to them in relation to mental health difficulties, as well as reflecting on their experience of accessing a comprehensive DBT programme. We hope such insights and recommendations summarised in Table 2d and throughout the paper can inform therapists to consider ways of improving their neuro-affirmative practice from assessment and formulation stage, first recognising the importance of striking a balance between acknowledging, understanding, and validating each autistic young person's unique profile of autism-related strengths and difficulties, while also not falling into diagnostic overshadowing and emphasising the role that autism plays when working on emotion dysregulation if this does not resonate with the autistic adolescent's lived experience. This may include collaboratively considering the role of autism-related differences in the dialectical biosocial model and in behavioural chain and solution analyses, to understand vulnerabilities and consider accommodations in skill implementation.

The importance for therapists to have a good understanding of autism and related characteristics and how they may influence emotion dysregulation may serve as a guide that pre-empt areas for exploration together with autistic adolescents to formulate and chain their difficult experiences while accounting for context. Dialectically, this is to be balanced with self-education so that therapists do not over-rely on minoritised individuals to educate them about their minoritisation, similar to recommendations for other minoritised groups in DBT (Camp *et al.*, 2023b; Lei *et al.*, 2024b). Utilising such a guide with clinical sensitivity and flexibility will ensure that each autistic adolescent's personal experiences is met with validation, to reduce the impact of the invalidating environment (Bemmouna *et al.*, 2023). Therapists need to factor in how an autistic adolescent's personal relationship with their autism diagnosis and identity may also play a role on their willingness to explore such areas openly in DBT. Considering strengths and differences and discussing autism in relation to their experience were reported by the participants as ways that DBT could be used for this goal. It is important for therapists to also improve competency on how to engage in conversations with autistic adolescents related to autistic identity, social camouflaging, autistic strengths and differences and navigating the relationship between autism diagnosis and one's co-occurring mental health difficulties (Lei *et al.*, 2024a; Lei and Nocon, 2024).

In addition, the participants name several accommodations that can be made to the delivery of DBT while adhering to the original principles, which are highlighted in other literature (Bemmouna *et al.*, 2022; Hartmann *et al.*, 2019; Huntjens *et al.*, 2020; Keenan *et al.*, 2023; Ritschel *et al.*, 2022), and are likely useful to implement in DBT programmes supporting autistic people.

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These include, but are not limited to, concrete instruction/explanations, sensory accommodations, additional support for social anxiety, increased structure and clarity ahead of time in all modes of DBT, including neurodivergence in teaching examples, personalising therapy materials, scaffolding generalisation, and the use of visual information to aid teaching. Noticing no one size fits all, we emphasise the need for therapists to embody cultural humility and curiosity to explore with each autistic client how to best tailor DBT to suit their unique needs, tapping into their personal strengths, and support autistic individuals to better understand their emotion dysregulation and lived experiences in the context of autism, to champion neuro-affirmative practice and foster positive autism identity where possible. It is additionally pertinent for therapists to be aware of their allistic biases and seek to reduce the potential for unintentionally oppressing diversity related to autism when teaching skills and concepts which were originally developed within societal contexts that privileges allistic behaviour. Thus, to not reinforce oppressive practice and invalidation of diversity.

Key practice points

(1) We highlight autistic adolescents' voices in accessing a comprehensive DBT programme in a non-autism specialist Child and Adolescent Mental Health service in the UK, drawing attention to individual differences in their relationship when navigating autism diagnosis, and personal reflections across different components of DBT to share recommendations for intervention accommodations.
(2) Adolescents suggested several recommendations for making DBT accommodations, including using concrete language, checking understanding and providing clear rationale for skills practice, using diverse and neuro-affirmative examples, offer time and space for individualised practice to support skills use generalisation, social anxiety preparation work to facilitate skills group attendance, and environmental considerations to accommodate individual sensory differences.
(3) We emphasise the need for clinicians to embody cultural humility, curiosity, validation, and flexibility when building up personal competencies in neuro-affirmative practice to support autistic individuals within the social model of disability.

Supplementary material. To view supplementary material for this article, please visit https://doi.org/10.1017/S1754470X25100305

Data availability statement. Please contact Dr Jake Camp for data access requests.

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Author contributions. **Jiedi Lei:** Conceptualization (lead), Data curation (equal), Formal analysis (lead), Funding acquisition (equal), Investigation (lead), Methodology (lead), Project administration (lead), Supervision (lead), Validation (lead), Visualization (lead), Writing - original draft (lead), Writing - review & editing (lead); **Abigail Sanders:** Data curation (equal), Formal analysis (supporting), Investigation (supporting), Methodology (supporting), Project administration (equal), Writing - original draft (supporting), Writing - review & editing (supporting); **Jake Camp:** Conceptualization (supporting), Methodology (supporting), Project administration (supporting), Writing - original draft (equal), Writing - review & editing (equal).

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Competing interests. Jake Camp is an Associate Editor of *the Cognitive Behaviour Therapist*. They were not involved in the review or editorial process for this paper, on which they are listed as an author. Jake Camp also provides and receives payment for training in DBT. The other authors have no competing interests to declare.

Ethical standards. This is a service evaluation project with the primary aim of improving service care quality. Ethical approval for this project (as determined by the NHS Health Research Authority Descision Tool) was provided by the South London and Maudsley NHS CAMHS Clinical Governance Committee. All procedures in the study were in accordance with the ethical standards of the institution and the 1964 Helsinki declaration and its later amendments. All authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

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