Psychological interventions for autistic adolescents with co-occurring anxiety and depression: Considerations linked to autism social identity and masking.

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Abstract

Background: Adolescence marks a time of increased vulnerability to developing mental health difficulties. Recent literature has pointed towards both risk and protective factors that contribute to the development and maintenance of co-occurring mental health difficulties amongst autistic adolescents. For example, autistic individuals may mask their autistic traits to fit in with neurotypical peers, but prolonged masking may negatively influence the development of one's autistic identity and increase vulnerability to developing mental health difficulties.

Method: In this commentary, we focus our efforts on highlighting how 1) autistic identity and 2) masking behaviours may be considered within a holistic and person-centred formulation to guide treatment for mental health difficulties in autistic adolescents. In current clinical practice, mental health practitioners may not explicitly enquire about potential construct overlap between these autism related factors and other cognitive and behavioural factors that perpetuate mental health difficulties.

Results: We propose a series of assessment questions that clinical professionals may use when developing a shared understanding with autistic adolescents of how they perceive the relationship between autism and co-occurring mental health difficulties.

Conclusion: Our goal is to support clinical professionals to consider ways of integrating advances in autistic identity and masking literature in autism to inform the assessment and formulation of co-occurring mental health difficulties when supporting autistic children and young people.

Key Words: Mental health, Camouflaging, Masking, Identity, Adolescent, Formulation

Community Brief

Why is this topic important?

It is now well established that autistic people are at disproportionate risk for having co-occurring mental health conditions but there is limited high quality research on mental health interventions for this group. Much research has aimed to adapt mental health interventions developed based on psychological models which do not account for the features of autism. For example, psychological models emphasising on how one's thinking, and behavioural patterns maintain mental health difficulties may fail to contextualise them as autistic individuals' responses to living in a predominantly neurotypical environment. There appears to be a disconnect between emerging topics such as autistic identity (one's personal and social identity in relation to being autistic) and masking (suppression of one's autistic traits in order to "fit in" with non-autistic peers) which can either increase risk/vulnerability to developing mental health

difficulties or buffer against emotional and social distress, and clinical assessment and practice when supporting autistic individuals to navigate mental health interventions.

What is the purpose of this article?

This article focuses on highlighting how the interaction between 1) autistic identity and 2) masking behaviours should be carefully considered when clinicians examine interactions between autistic traits and co-occurring mental health difficulties, leading to more person-centred treatments and shared understanding. In current clinical practice, mental health practitioners may not explicitly enquire about the relationship between one's autistic experiences and other cognitive and behavioural factors that perpetuate mental health difficulties.

What personal or professional perspectives do the authors bring to the topic?

We are a group of clinical psychologists working with autistic children, young people, and adults in the UK. We have also conducted research into the areas of masking and autistic identity.

What is already known about this topic?

We know from research that prolonged and persistent social masking and having a negative autistic identity can increase autistic individual's vulnerability to experiencing autistic burnout, as well as experiencing negative mental health outcomes over time. However, to the best of our knowledge, incorporation of masking and autistic identity into routine assessment and formulation to understand autistic individuals' experiences of mental health difficulties is very inconsistent in clinical practice.

What do the authors recommend?

We propose a series of assessment questions that clinical professionals may use when developing a shared understanding with autistic individuals of how they perceive the relationship between autism and co-occurring mental health difficulties. Our goal is to support clinical professionals to consider ways of integrating advances in autistic identity and masking literature to inform the assessment and formulation of co-occurring mental health difficulties when supporting autistic individuals, starting in childhood and adolescence.

How will these recommendations help neurodivergent adults now or in the future?

We hope this recommendation will contribute towards how clinicians can work together with autistic individuals to ensure formulation of mental health difficulties incorporates their personal understanding of and relationship with autism. Through identifying links between autism and maintenance factors incorporated within psychological models of anxiety and depression, we hope that interventions can be better adapted to acknowledge and account for autistic individuals' experiences in a more person-centred way.

Autistic individuals experience a high prevalence of co-occurring mental health difficulties across the lifespan.[1] However, there is limited evidence available on adapting psychological treatment for co-occurring mental health difficulties in autistic individuals. A key developmental phase for the emergence of mental health difficulties is adolescence,[2] defined as the "phase of life between childhood and adulthood from ages 10 to 19".[3] From a biopsychosocial perspective, adolescence marks a phase of heightened vulnerability to developing mental health difficulties. Biologically, the adolescent brain is particularly sensitive to heightened emotional responses in the context of peer rejection given the slower maturation of prefrontal cortex that governs top-down emotion regulation and decision-making.[4-5] Psychologically, adolescence marks a phase of uncovering one's sense of self and discovering self-identity in society through one's evolving interests, values and goals, and difficulties in navigating this developmental phase may give rise to role confusion in society.[6] Socially, adolescence is a turbulent phase of changes in relationships, growing independence from family and turning to peers for social support, and can be particularly challenging for autistic young people with social communication differences.[7-8] Furthermore, the development of self-awareness and understanding of other minds exist in the context of interpersonal interactions. Milton (2012) emphasised the double empathy problem of autistic individuals existing in a world where non-autistic viewpoints dominate. For example, differences such as in autistic movement and speech[10] can be interpreted negatively by non-autistic individuals, and when non-autistic individuals struggle to interpret facial expressions of autistic people this can exacerbate negative evaluation of social communication in autistic individuals.[11] Repeated experiences of being invalidated through the neurotypical lens can contribute towards a greater cognitive dissonance between "who we (autistic individuals) *are,* who we *want* to be, and who we feel like we *should* be in order to satisfy society".[12 (pp45)]

More than half of all serious adult mental health difficulties start by the age of 14 years amongst non-autistic individuals, with anxiety and depression being some of the most prevalent and chronic co-occurring mental health conditions.[13-14] It is therefore important to understand how to best assess, formulate and adapt existing interventions to treat anxiety and depression amongst autistic adolescents. In the UK, treatment guidelines outlined by National Institute of Health and Care Excellence (NICE) on supporting autistic young people under the age of 19[15] only highlight the need for making practical adaptations to CBT such as increasing use of visual and written materials, incorporating parent/carer in treatment, increasing structure of the session and incorporating autistic young person's special interests if possible. However, there is little guidance on how clinicians can effectively assess and formulate the mental health difficulties in the context of the features of autism when working with autistic young people.

In one qualitative study exploring experiences of 130 autistic young people aged 16-25 years accessing mental health services in England, young people stated that they lacked a clear understanding of the relationship between their

mental health symptoms and autistic traits.[16] It is crucial that autistic young people and their mental health practitioners develop a clear, individualised shared formulation to aid understanding of their mental health difficulties. At present, it is common for autistic young people and adults to receive an autism diagnosis with no follow-up or opportunity to learn about autism and understand and incorporate this diagnosis into one's self concept.[16] Practitioners may lack adequate training and experience in understanding how autism presents for different subgroups (especially autistic traits in girls and gender diverse people) and are unable to provide adequate support that may result in missed autism diagnosis or confusion for the autistic individual trying to make sense of their experience.[17] Clinicians not knowing "where to start" may increase avoidance of discussing autistic traits in mental health settings, and inadvertently contribute towards feelings of shame amongst autistic individuals about their diagnosis and increase internalised stigma.[17-18] In a recent qualitative study that explored the experiences of young people from diverse ethnic, racial, and cultural (ERC) backgrounds in accessing mental health support, young people emphasised the importance for clinicians to actively create space within therapy for the young person to discuss how they perceived their mental health difficulties in the context of their ethnic, racial, and cultural identity.[19] Modelling acceptance through listening to and validating young people's lived experiences was particularly important for therapeutic alliance, and such conversations allowed clinicians to approach treatment delivery with greater ERC sensitivity, and enabled young people to navigate a more positive personal identity in daily life.[19] Extrapolating from ERC diversity to neurodiversity, providing a safe space to increase discussions about autistic identity and lived experiences in clinical settings may also support autistic individuals to develop a more authentic sense of self.

One systematic review highlighted that strategies employed by autistic adults to cope with stigma can often result in an unhelpful "double bind".[20] For example, some acknowledged that concealing and masking their autistic self-prevented them from living an authentic life, whilst disclosure of their diagnosis can also resulted in invalidating comments from neurotypical peers that challenged their sense of autistic identity.[20] In contrast, others acknowledged reconstructing their personal and social identity. This could occur through positive reframing; attributing their unique strengths to being autistic and recognising how the autistic community provides them with a sense of belonging can be a more helpful way of coping with stigma.[20] For example, autistic people report feeling better understood by and more able to be their authentic selves when around other autistic people, in contrast with the pressure to conform to non-autistic communication styles when interacting with non-autistic family and friends which can negatively affect how autistic people feel about their autistic identities.[21] Thus, it may be easier for autistic people to reframe their identities when they are situated within any community that accommodates and accepts communication differences and provide a sense of belonging.

Recognising the powerful interactions between identity and masking (whilst acknowledging that environmental factors are also critical) may contribute towards developing a shared formulation on understanding the overlap between autism and co-occurring mental health symptoms. We will draw on recent literature in autistic identity and masking to assess how such constructs may be important for clinicians to explicitly assess and formulate to inform treatment adaptation when working with autistic adolescents and adults. We acknowledge that there are many other important factors, such as the need for professionals to simultaneously work on advocating for systemic change that fosters a culture of acceptance of neurodiversity, which are beyond the scope of this commentary. The position of the current perspective piece is to help clinicians working with autistic individuals to maintain awareness of the double empathy problem, by fostering curiosity and maintaining humility, and actively seeking information from autistic individuals to understand the interaction between their autistic identity and personal experiences of mental health difficulties. This is not to underestimate or ignore the importance for wider systemic work, and rather highlights how clinicians may be best placed to model acceptance of neurodiversity. Clinicians should aim to support the autistic individual to develop a more holistic understanding of their mental health difficulties in the context of their lived experiences and identify where systemic change is needed to foster greater sense of acceptance and social inclusion that enables the autistic individual to live more authentically. Here, we highlight the importance of assessing and formulating links between masking, stigma, and social identity when conceptualising the development and maintenance of co-occurring mental health difficulties amongst autistic adolescents and adults.

1. Autistic Identity and Masking

In recent years, the neurodiversity paradigm has gained prominence, which emphasises autism as a condition defined by differences rather than deficits.[22] However, autistic people continue to experience high rates of stigma which can negatively impact their mental health, with identity focused strategies frequently used to manage this.[20] Stigma is defined as the perception and labelling of a group or individuals based on their 'undesired differentness' as inferior when compared to the social norm.[23,24] As Goffman (1968)[23] noted in his book *"Stigma"*, experiencing social stigma may increase motivation to "hide" one's authentic self. Autistic identity can be understood from numerous theoretical lenses including minority stress and stigma, social identity, and autism acceptance (defined as the extent to which one personally accepts themselves as an autistic person),[25] all of which have found cross sectional relationships between autistic identity related processes and improved psychological wellbeing and/or mental health.[25–28] In this paper we use a broad definition of autistic identity as a personal and a social identity, i.e., one that can be conceptualised as being a personal characteristic contributing to self-definition, as well as a group identity with associated cognitive and affective processes through which one can derive a sense of self-esteem and wellbeing.

Many autistic people describe that developing one's sense of autistic identity and using this to understand one's past experiences can have a positive impact on wellbeing.[29] However, others may choose to distance themselves from their diagnosis.[30] Some qualitative evidence suggests that autistic young people are more likely to distance themselves from an autistic identity compared to autistic adults,[31] however, a review of quantitative studies found inconclusive evidence regarding the relationship between age and autistic identity.[25] Choosing to distance oneself from autism is understandable in the context of the high rates of adverse social experiences experienced by autistic adolescents.[32] The constant interplay between an autistic individual's personal understanding of their autistic experiences, and internalising their experiences from the outsider's neurotypical lens, autistic individuals may experience a more fragmented development of their own identity as they navigate societal expectations.[33,34] For autistic adolescents, the moderating role played by environmental perceptions of their social difference and their felt pressure to "fit in" may be pivotal to how they choose to affiliate or distance themselves from having a positive autistic identity.

There is no longitudinal evidence to suggest that different identity management strategies lead to better outcomes than others, and there are likely to be cohort effects linked to generational differences in attitudes towards personal and social identities. For example, those diagnosed with autism in childhood in the past decade may benefit from increased awareness of autism and media campaigns aiming to increase acceptance of autistic individuals.[35] Autistic identity may well be an important starting point for improving psychological wellbeing and preventing the development of mental health problems in autistic adolescents. For example, autism satisfaction (defined as how positively one feels about their autistic identity)[25] is associated with lower social anxiety which in turn might support autistic people to form connections with peers.[31] This is in clear contrast to experiences of internalised stigma which can contribute towards loneliness that in turn mediates the relationship between social contact and mental health needs in autistic young people.[36] Evidence is needed to assess whether autism post-diagnostic support where adolescents can learn about autism and develop strategies to make sense of autism as part of their identity, can boost psychological wellbeing and likelihood of mental health problems later developing.

Drawing upon lived experiences of autistic individuals, especially through qualitative research completed with autistic women and girls, research has focused on cognitive and behavioural strategies used by autistic individual to suppress autistic traits. This phenomenon is labelled in numerous ways including 'masking',[37] 'camouflaging',[38] and 'compensation'.[39] In the current study, we choose to use the umbrella term 'masking' as defined by Pearson and Rose (2021), to refer to "the conscious or unconscious suppression or projection of aspects of self and identity, and the use of non-native cognitive or social strategies." It is important to acknowledge that masking behaviours may overlap with impression management, defined as behaviours aimed at influencing how others' perceive us, used to enhance one's

prospects at achieving interpersonal goals such as social acceptance.[41] Impression management strategies are also employed by non-autistic people.[41-42] The neurotypical social context and autistic cognitions might make impression management processing slower, more effortful, and resource demanding for autistic individuals, causing higher feelings of inauthenticity, depersonalisation, and emotional exhaustion/burnout.[41]

Within the family system, autistic children and young people may be encouraged to mask their social differences in order to avoid stigma and discrimination.[24,43] In a study that examined caregiving narratives of parents of autistic children, Grey and colleagues (2021) identified cycles of relationship ruptures within the family which were exacerbated through adopting a medicalised view of autism diagnosis that locates the problem within the autistic child that is separate to the family system. Invalidation within closer personal relationships can further motivate autistic individuals to minimise their social difference through masking, and result in implementing impression management strategies to avoid further stigmatisation. For autistic adults, autism acceptance plays a key role in predicting mental health difficulties, such that both personal and external autism acceptance from friends, family and society can buffer against the development of depression.[27] Autism acceptance within family transactions may have a positive influence on scaffolding the development of autistic individuals' positive self-esteem that can buffer against stress and depression in adulthood, and also model positive transactions for those outside of the family system on how to interact with autistic individuals in a way that allows them to be their authentic self.[45] These transactional processes, both within, and outside of the family system have implication of formulation and treatment of mental health difficulties, by drawing attention to the double empathy problem and highlighting the need for non-autistic individuals to maintain humility and curiosity when trying to understand autistic young people's lived experiences.

2. Clinical Considerations for Assessment and Formulation

Mental health professionals supporting autistic individuals should consider how an individual's experience of autism may intersect with their mental health needs. There is an emerging evidence base regarding how the *features* of autism and associated cognitive differences (such as reduced cognitive flexibility) may relate to particular mental health problems,[46] though such correlational approaches do not offer insight into how autistic individuals may perceive such behaviours to be a necessary response to address the unmet needs for predictability, establishing safe connections and maintaining monotropic focus in their environment. We argue that *autistic identity* and *masking* should also be considered. That is, alongside consideration of autism features, mental health professionals should consider how the individual makes sense of being autistic, and their feelings about this as a diagnosis or an identity, alongside behaviours linked to this, such as attempts to mask their autistic traits.

The psychological formulation of an individual's presenting problem may be disorder-specific or transdiagnostic,[47] depending on the number of mental health problems an individual presents with, their goals for treatment, and the therapist's modality and training. Autistic identity could be relevant to the formulation in multiple ways. For example, in a transdiagnostic formulation which includes strengths and protective factors, an individual's autistic identity may be a protective factor, if the young person feels a sense of acceptance, pride, or satisfaction in being autistic, has a sense of solidarity with other autistic people, feels connected to the autistic community, or takes a role in being an advocate for autistic people. Conversely, if a young person has a more negative relationship to their autism diagnosis, for example, experiencing shame or internalised stigma about being autistic, then this may be included in the predisposing factors as they are more likely to attribute negative experiences towards internal rather than external factors, thus increasing their vulnerability for developing mental health difficulties.

Within a disorder-specific formulation for social anxiety, fear of negative evaluation from others may be influenced by a young person's autistic identity.[31] If the young person has internalised experiences of stigma and views autism in terms of deficiencies rather than differences, or experiences shame about the social differences associated with autism, then they may be more likely to hold a fixed mindset that there is little they can do change other people's negative perceptions of their social performance, and be more inclined to continue hiding their authentic self as the only way to gain social acceptance. In contrast, an individual with a more positive view of autism may see non-autistic people as an outgroup who are contributing to the double empathy problem, that the responsibility and capacity for improving social communication lies within both parties, and feel more confident in asserting their opinions and willing to negotiate with others in a social situation, rather than only viewing the self as a social object failing at social interaction.

Similarly, for an individual struggling with depression, and who has a negative view of autism, the latter can exacerbate the core beliefs and negative automatic thoughts about the self. For example, an autistic adolescent who has been bullied and ostracised for being different may have core beliefs about being inadequate and may attribute the felt sense of inadequacy towards their autistic identity, resulting in further negative perceptions of their autistic self and reduced willingness to accept their autistic identity. In contrast, an autistic adolescent that views themselves through the lens of neurodiversity, which is possibly an outcome of having a strong support system, may be able to see that they are doing their best to cope in a world which is dominated by non-autistic people.

In autistic adolescents who have developed a mental health problem, the clinical assessment provides opportunity to discuss and develop a shared understanding of how the individual feels about being autistic, how much they understand about their diagnosis, and how their experiences as an autistic person have impacted their mental health (see Box A). If the individual has a limited understanding of autism, and autism is central to the formulation, this could

be a barrier to developing a comprehensive psychological formulation of the individual's mental health needs. However, this should not be used as a reason to discharge autistic adolescents from mental health services, but rather, seen as a reasonable adjustment necessary for some autistic individuals to access therapeutic support. Clinicians should explore with autistic adolescents how they make sense of their behaviours in social situations, especially relating to masking and stigma, in addition to their own autistic identity. Clinicians can help the autistic adolescent acknowledge that both below statements can be true at the same time:

1) Some masking behaviours might perpetuate co-occurring mental health difficulties,[48] for example, masking behaviours akin to impression management safety behaviours such as "rehearsing sentences in one's mind" and "trying to get words right" might maintain social anxiety over time.[49,50]
2) Some masking behaviours may be a response to interpersonal trauma including experiences of stigma, and may play a role to reduce interpersonal victimisation.[40]

Collaborating with the autistic adolescent to understand the multi-faceted nature of their masking behaviour and how it relates to their autistic identity and co-occurring mental health difficulties may be key to identifying behavioural targets when formulating treatment plan, and we include some questions for clinicians to consider during assessment (See Box A). Furthermore, clinical professionals working with autistic adults may also wish to consider adapting the questions in Box A and maintain a stance of curiosity to better understand how autism-specific factors may influence autistic adults' perception of their mental health difficulties. This is in the context of many autistic adults who have accessed mental health services having highlighted how clinicians often lack experience, competence and confidence when supporting their mental health needs and may hold unhelpful misperceptions about their experiences that hinder treatment planning.[51] Working with autistic adults to incorporate their autistic experiences into formulation can offer a more comprehensive and holistic understanding of the development and maintenance of co-occurring mental health difficulties, crucial for establishing a trusting therapeutic relationship and improving quality of care.[18] It must be acknowledged that in some instances, developing this keen sense of self-awareness will not be possible or may not feel appropriate given the environmental demands, even with the support of an experienced clinician. In these cases, therapeutic interventions should take a behavioural focus to reduce psychological distress, for example through behavioural activation work, alongside an environmental focus through working with key stakeholders to understand modifiable environmental factors which contribute to distress.

Finally, clinicians working with autistic individuals need to be sensitive towards how stigma and discrimination may disproportionately affect different subgroups within the autistic community because of intersectionality between different aspects of one's identity. For example, autistic people who identify as LGBT+ report finding themselves in a more

subordinate position within the social power hierarchy and feel 'othered' and less acceptable when presenting their authentic self. [52] Late-diagnosed individuals (often girls and women) may also engage in more masking behaviours and experience conflicts between their autistic identity and a traditional feminine identity,[53] and are more likely to have experienced sexual abuse, partially reflecting specific vulnerabilities from being a female with undiagnosed autism, all of which can add to the challenge of developing a positive autistic identity[53] in the context of trauma, and may require additional exploration beyond questions offered in Box A.

3. Conclusion

Recent advances in autism research that examine autistic young people's experiences have highlighted how a positive autistic identity may be beneficial for wellbeing, whilst increased masking or camouflaging to hide one's autism may have long term negative consequences for one's mental health. For clinical professionals that aim to assess and understand the cognitive and behavioural factors that contribute to and maintain co-occurring mental health difficulties amongst autistic adolescents, it is therefore important to enquire how the young person's relationship with their autism diagnosis may have a direct or indirect impact on the way they present themselves in social settings.

Using a disorder specific formulation model without considering broader influences of autism diagnosis may result in misinterpretation of the driving forces behind one's cognitions and behaviours that contribute towards the maintenance of a co-occurring mental health difficulty. Furthermore, autistic individuals and stakeholders report a desire for approaches aimed to improve mental health to not change characteristics of their autistic identity, and to also offer a safe space for autistic individuals to freely explore their identities.[54] We propose that integrating the exploration of autistic identity to develop a shared understanding of how autistic experiences relate to co-occurring mental health difficulties is an important step towards developing person-centred intervention that honours each autistic individual's unique experience.

We hope that through adopting a series of questions that systematically help the adolescent to explore their autistic identity and its impact on their behaviour, clinicians can have helpful conversations to identify treatment targets in a collaborative manner and improve understanding of mental health difficulties in the context of being autistic. We also hope clinical professionals working with autistic adults can consider ways of flexibly using and adapting the questions to account for autistic adults' experiences across development, placing their co-occurring mental health difficulties within the wider context of their autistic and life experiences, and work in a collaborative way that empowers autistic adults to feel not only listened to, but encouraged to self-advocate and adopt self-care to foster independence and improve quality of life [18].

Box A.

Possible assessment considerations linked to autistic identity and masking to contribute to the formulation (Which could link to protective, predisposing, perpetuating and precipitating factors, and/or disorder specific factors within a formulation)

Please note all questions serve as topic guide suggestions only, and we encourage clinicians to adapt the language and framing when using these topic guide questions to suit the autistic individual they are working with.

- *Timing of autism assessment, what triggered the referral?*
- *Nature of any post-diagnostic support accessed - how has the young person/family made sense of the diagnosis since?*
- *What words does the young person and their family use to describe autism? (positively or negatively)*
- *Parent acceptance and understanding of autism*
- *Does the young person consider autism to be a part of their identity? If so, is it an important part of their identity? How does their autistic identity relate to other identities? (e.g., gender, sexuality, ethnicity etc)*
- *Does the young person see any links between autism and mental health problems?*
- *How has the young person made sense of any adverse social experiences (including invalidation, stigma, and interpersonal victimisation)?*
- *Has the young person made changes to their behaviours because of adverse social experiences?*
- *Does the young person feel a sense of belonging in the autistic community? Non-autistic communities?*
- *Does the young person feel a sense of pride, acceptance, or shame in being autistic?*
- *Does the young person feel a sense of affiliation with or connection to other autistic people?*
- *How would the young person describe themselves so a new person could get to know them?*
- *Consulting young person and family about autism adaptations that may be needed in therapy – how aware are they of the features of autism? Are they able to act as a self-advocate?*
- *Are there aspects in the young person's environment that get in the way of them being able to live more authentically? How can the clinician support the young person to feel more accepted for their genuine self?*
- *Consider use of structured measures e.g. social identity measure[28,31], Camouflaging Autistic Traits-Questionnaire[38], Adolescent Social Behaviours Questionnaire[50]*

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Conflict of Interest Statement

The authors declare no conflicts of interest.

Ethics Statement

No human subjects were enrolled for the purpose of this commentary.

Authorship Contribution

JL, KC and MH conceptualised and co-authored the article. All authors reviewed and approved this article submission.

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