Title: *"It's a long process, and it's a long journey"*: Autistic adult's experiences of support and recovery after experiencing intimate violence and abuse

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Abstract (240 words)

Background: Many services designed to support victim/survivors of intimate partner violence (IPV) do not have a specific focus on, or understanding of neurodivergence, which may impact autistic access to meaningful support. The aim of this project was to examine the support and recovery needs of autistic adults who have experienced IPV.

Method: We recruited 21 autistic adults (mean age = 42) to take part in a semi-structured interview about the experience of IPV. We asked questions about their support seeking, and recommendations for future intervention. We analysed the data using reflexive thematic analysis. One author coded all data, engaging in reflexive discussion with the whole team. They then organised these into themes in collaboration with a second team member. These were circulated to the whole team for discussion and refinement.

Results: We identified three themes in the data, which focused on support and recovery: 1) Recovery is a journey (recovery is non-linear and involves multiple disclosures over time). 2) Building better systems (addressing systemic gaps in knowledge and practice, combatting under-resourcing), and 3) How do we stop this? (recognising potential individual risk factors and increasing relationship education).

Conclusions: Our findings suggest that approaches to supporting autistic victim/survivors in recovery needs a nuanced, multi-pronged approach. Intervention should focus on relationship education ensuring access to appropriate therapies and support for individuals and ameliorating systemic issues such as a lack of professional understanding, and lack of practical support for survivors

Community Brief (473 words)

Why is this an important issue? We know that autistic people are more likely to experience intimate partner violence. However, we don't know very much about how to what recovery looks like for them, or how to provide effective support.

What was the purpose of this study? The purpose of this study was to find out what recovery from IPV looks like for autistic people, and what we can do to improve services that they might encounter when seeking support for IPV.

What did the researchers do? We interviewed 21 autistic adults about their experiences, using semi-structured interviews. We gave people the option to do a spoken interview (n = 16) or to write down their answers (n = 5). We made sure that they felt safe to take part, and that we knew what to do if they became upset. We analysed the data using reflexive thematic analysis, which involved looking for patterns in what people had said, and then organising these patterns to identify common themes across participants.

What were the results of the study? We identified three themes in the data. Theme 1, 'Recovery is a journey' highlighted that recovery doesn't have an endpoint but tends to start with making disclosures to people about experiences of abuse. Going through the recovery process led people to feel empowered, but the experience of abuse never went away. Theme 2, 'Building better systems' showed that services and supports designed to help people who have experienced abuse often aren't suitable for autistic people. The people who work in these services need more training, and services need more funding to do this. Theme 3, 'How do we stop this' suggested that alongside improving support, we can try to prevent IPV happening by recognising that autistic people might struggle to recognise abuse and provide better education about what healthy relationships look like.

What do these findings add to what was already known? This is the first study to explore the support and recovery process for autistic people who have experienced IPV. Our findings add much needed guidance about what we can do to develop our understanding of what autistic victim/survivors want during support seeking, and what we can do to improve service provision.

What are potential weaknesses in the study? All of the people who took part in this study were white, and most were women. It is likely that autistic people from other groups might experience different barriers to support and recovery.

How will these findings help autistic adults now or in the future? We hope that our findings will help to services to improve how they work with autistic people who have experienced IPV. We have also used the findings from this (and another) study, to develop a ‘healthy relationships resource’ to help autistic people recognise what healthy relationships look like.

Intimate partner violence is defined by the World Health Organisation as "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours." This includes violence from both current and ex partners.[1] There is an emerging body of evidence to suggest that autistic people are disproportionately likely to experience sexual violence[2] and intimate partner violence (IPV), with a prevalence estimate of up to 70%.[3] Historically, autistic experiences of victimisation have been framed through a social deficit lens,[4] attributing heightened risk to impaired autistic social skills. However more recent research has aligned explanations of heightened prevalence within a critical disability studies framework which acknowledges the role of a complex ecosystem in explaining autistic victimisation.[5–7] Understanding victimisation through an ecological lens transcends the focus on individual vulnerability[7] and provides a more holistic basis from which to develop both better preventative measures, and support services.

Finding ways to support autistic victim/survivors[1] is crucial. Recent research has shown that victimisation contributes towards poor autistic mental health,[9] and many autistic victim/survivors feel that existing services and supports are inadequate and can exacerbate these mental health difficulties.[5] Hughes and colleagues[10] found that disabled people who experience mental health difficulties from IPV may be at particular risk for a cycle of violence, whereby the long term effects of one abusive relationship increase the odds of polyvictimisation. This is consistent with both

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[1] We use victim/survivor throughout to acknowledge the complex relationship that people who have experienced intimate violence with the terminology used to describe them. Whilst some people class themselves, and some as victims, others prefer to use the contracted victim/survivor to acknowledge the non-dichotomous way that people who have experienced intimate violence use to make sense of their own experiences.[8]

quantitative exploration of prevalence and risk,[3] and first-hand accounts of autistic victim/survivors.[5,6] Thus it is essential to understand how to increase effectiveness of support during the recovery process for autistic people, who are at a higher risk of IPV and may be more likely to experience prolonged trauma and polyvictimisation as a result.

However there is currently a gap in the literature about what support seeking and recovery after IPV looks like. Broader research into other forms of interpersonal violence among autistic people have suggested that services are ill prepared to support them, and that many people are put off help seeking due to a lack of accessibility and understanding.[5] However, we know little about how services could or should be tailored to suit the needs of neurodivergent people who are leaving or have left an abusive relationship. Williams and Jobe[11] worked with women with learning disabilities and/ or autism to explore barriers to justice when disclosing and reporting sexual violence. They found that many victim/survivors experienced disbelief and testimonial injustice during the justice-seeking process, which is consistent with our own findings.[12]

There are clear considerations for increasing accesibility within services when considering autistic people. For example, autistic people experience sensory differences that can impact how they experience environments and social spaces.[13] The double empathy problem[14] might mean a disconnect or breakdown in communication between autistic people, and non-autistic staff in service, and autistic people may present in ways that are unexpected to non-autistic staff. This might include autistic distress not being recognised and being labelled as ‘challenging behaviour’.[15]

As such, the aim of this study was to understand autistic adult's experiences of support and recovery after experiencing intimate violence and abuse, to provide a solid knowledge base for future recovery intervention-based work.

Method

Participants

We recruited 21 autistic adults (mean age = 42 years, range = 25-78) from the United Kingdom to take part in this study. We excluded people from outside of the UK as the study was part of a funded project to explore ways to improve intervention for victim/survivors of intimate violence in the UK context. We put out a call for participants across social media (e.g. 'X') and via third sector organisations (e.g. Somerset and Avon Rape and Sexual Abuse Support, Mankind), linking interested parties to a website which hosted information about the project and a link to express interest in taking part (https://intimateviolenceandautism.my.canva.site). One hundred and thirty-seven people responded to this call, providing some basic demographic information and contact details. We did not receive spam or bot responses to this call, which may be due to listing the financial compensation for participants in the information sheet and on the website, as opposed to in the study advert itself. Research assistants (RAs) were instructed to prioritise contacting a diverse range of people with regards to gender, and race. Despite this, the final sample of people who responded to invitation were all white and primarily female (n = 18), though two non-binary people and one man also took part (one additional man also responded, but was excluded from the analysis as he had witnessed parental IPV but had not experienced it within his own intimate relationships). Fifteen participants had a clinical diagnosis, and 6 were self-identified or awaiting diagnosis. All but one of those with a formal diagnosis were diagnosed in adulthood (for full demographic data see table 1). Eleven participants were heterosexual, 5 were queer or pansexual, two were asexual, and three were unsure. All but one had a co-occurring physical disability (e.g. fibromyalgia) or form of neurodivergence (most commonly ADHD, n = 9) and several reported unreliable speech. The majority described their current socio-economic status as comfortable but had experienced economic precarity earlier in life. We compensated all participants for their time at £25 per hour in accordance with UK National Institute for Health Research guidance on participant and patient involvement. The study received ethical approval from the University of Sunderland research ethics committee.

[**Insert Table 1**]

Methodological Approach

Research Question

The findings described in this paper were gathered as part of a larger project funded by the Violence, Abuse and Mental Health Network that had two overarching research questions:

1. How do autistic adults understand and make sense of their experiences of intimate violence and abuse?
2. What are the recovery and support needs of autistic adults who have experienced intimate violence and abuse?

This paper addresses question 2. The findings of question 1 are described in Pearson et al. (a).[12]

Interviews

We offered both spoken (n= 16) or written (n = 5) interview format to our participants, using the same interview schedule for each. One person who chose to write their account did this live with a research assistant (RA) over Microsoft Teams. We designed the interview schedule as semi-structured to allow for flow between the participant and interviewer, thus where the participant chose a written interview, we established that we might follow up with them if we needed them to provide further explanation. RAs WJ and AM conducted all interviews. Both RAs have experience with interviewing and counselling skills such as active listening. The spoken interviews lasted between 54 and 117 mins (average length of 79 minutes).

Positionality

This project was a collaboration between a group of academic and community co-researchers. The team included both autistic people, and people with lived experience of intimate violence and abuse. From inception, we shaped the project as a team, whereby power was shared among members, and we took decisions as a group. Community co-researchers (KR and SD) were also compensated for their time across the project in accordance with UK National Institute for Health Research guidance on participant and patient involvement.

Analytic approach and reflexive practice

We analysed the data using a reflexive thematic analysis[16,17] with an inductive approach whereby coding was completed in an open and organic manner. We followed the six-steps outlined by Braun and Clarke.[17] AP started with data familiarisation and annotation, and then coded the data independently using NVivo 12 based on both semantic and latent content. Throughout the coding process, she kept a reflexive diary where she noted emotional responses, potential biases, and how her experience as an autistic adult with lived experience of IPV may have influenced her interpretations, drawing upon standpoint epistemology.[18] She also discussed these interpretations and the coding process with the wider team. After coding the data, AP refined the codes and then met with MB to organise the codes into initial themes. We then sent these themes, example codes, and associated quotes to the broader team to refine into the final set. Once we finalised the themes, we gave participants the opportunity to comment on the findings to ensure that our interpretations represented their intentions. Given that autistic people frequently experience epistemic injustice within the research process,[19] we wanted to ensure that they were able to maintain narrative agency. Two participants responded to this follow up and confirmed that they were happy with the thematic structure and found the findings “validating”.

Procedure

Prior to interview, we contacted all participants to establish a safety plan,[20] mapping out how we would know if they were in distress, how they would like us to respond in such a situation, and whether they had any specific needs (e.g. having a friend with them) for the interview. We gave details of the questions we would ask, and who would be interviewing them for the spoken interview, as well as details for various support organisations and resources (e.g. Mensadviceline.org.uk, stonewall.org.uk). For those who completed written accounts, we sent the questions to them in a document which they completed and sent back. For those who gave spoken accounts, one (or both) RAs met with them on Microsoft teams and used the record and transcribe function to record the interview after gaining consent to both the interview and recording. After completing the interview, the interviewer checked the transcription for accuracy and edited accordingly. They then sent this to the participant, who had the option to expand on or amend anything they had said. We also used this process to follow up on how participants were feeling after the interview, and to give them the opportunity to ask any further questions.

Findings

We identified three themes (see Figure 1), that focussed on the journey of recovery, systemic issues in support seeking, and prevention. Pseudonyms are used to identify participants throughout.[21–23]

[Insert Figure 1]

1. Recovery is a journey

Discussions of recovery highlighted the misconception that recovery is a linear process, and results in reaching the destination of ‘recovered’ status. Lydia used the analogy of a previously broken bone to explore how therapy and support provide the ability to move on but not to forget:

> *“it gave me the tools I needed. What I need to leave in the past but not forget it. People think you have to forget it and you mustn't, it's part of who I am. I need to heal from it. It's just like I can't forget I broke my leg (some) years ago, it impacted me, but it happened right, and I can't forget it happened.”*

Recovery was very interlinked with the process of sensemaking[10] which involved a period of what Charlie described as “*grieving*”. Here participants recognised that things could have been different if they had had access to self understanding and the right language to describe their experiences. The impact of time, safety to disclose and access to adequte support meant that recovery was a journey, as opposed to a destination. This notion also serves to validate differing responses to trauma. There is no *right* way to respond to a traumatic experience, as highlighted in theme 1.2 below.

1.1. Reaching out - reaching in

One factor that was instrumental in the process of recovery was disclosure, whether that came from actively seeking help, or responding to the expressed concern of someone else. Catherine and Susan both outlined how important it was to "*tell someone*", though Catherine added that this could also be "*hard*" stating that "*It's a long process, and it's a long journey*. Y*ou might have to keep reaching out for support over and over again*". Catherine's comment highlights how, though disclosure might be seen as the start of a recovery journey, this process is often non-linear, and may require multiple disclosures (and the emotional energy needed to do them) over time.

Rowan suggested that being on the receiving end of a disclosure was in need of a sensitive response "*not to kind of scare somebody off*". Lydia suggested that the role of the recipient was:

> "*not to fix everything for you, blundering in telling the abuser what they are. The support has to be actual support, and needs to be a hammock, not a hammer.*"

Hannah echoed these sentiments, speaking of her ongoing efforts to support a close friend who was in an abusive relationship: "*she's not ready to leave him, so I support her. I just remind her 'you're worth more than this, this is not right…She needs to start with not looking at needing to leave, just to start to working on herself a little bit, planting the seeds and then it grows*."

This sensitivity in response to disclosure was crucial particularly given how confusing recognising abuse can be, and how many of our participants had experienced invalidation or disbelief during disclosure events.[12] However, participants stated the importance of disclosure and "*sharing stories*" in order to bring abuse out of the shadows. Lydia and Helen highlighted how media representation (e.g. radio show 'The Archers' storyline on coercive control) of IPV can encourage people to speak out and share their own experiences, and in turn help others to recognise their own situations. Likewise Grace described sharing stories as a way to raise awareness and change the future for others.

1.2. (un)happy endings

Recovery looked very different among the people we spoke to, and included fluctuations in mental health, and differences in how people approached their relationships (both intimate relationships, and friendships).

With regards to mental health, recovery was not a period of getting better, but of recognising the impact of the abuse on mental health and learning how to try and manage it more effectively, as described by Allison: *"For a long time I had a lot of suicidal thoughts and really bad bouts of depression, and sometimes when I can see the signs of maybe going into a bad bout of depression, I can easily just remember all those times and see it as a warning sign".* Conversely, Olivia avoided fully processing what had happened, stating that it would be harder to live with the idea of being "*a complete victim to it."* Charlie reflected that mental health management could sometimes impact on her relationship with her current partner but that they were able to deal with this in a “*healthy*” manner, which reinforced to her the importance of boundaries and trust.

For some participants, intimate relationships became incredibly difficult. Sophie recounted that in the period following what happened to her, she continued to have poor relationships which had led to ongoing difficulties and Lucy recalled how she felt “*burnt out*” from relationships, needing a period of recovery. Allison, Izzie, James and Michelle spoke about how the abuse had impacted their ability to trust other people, feeling “sensitive” to potential signs of controlling behaviour. Rachel however avoided relationships completely, worrying that she couldnt recognise the signs of abuse: *“I don’t know what that* (a non abusive relationship) *would look like and I can’t really imagine that it’s possible. I also do not feel as though I could recognise the signs of abuse if it were to happen again.”*
It was clear from participant statements that recovery wasnt about a ‘happy ending’, but simply being able to move forward, whatever that looked like to them personally.

1.3. Empowerment

Empowerment was an important part of the recovery process, marking a shift from self-blame to “*self-compassion*". For some this was directly related to recognition of their autistic self and needs, and being “*validated*” in that aspect of their identity, as Helen outlined: “*there is an extent to which getting my autism diagnosis helped because I could look at other peoples’ experiences and relate that back to my childhood, to everything*”. However others also spoke about the emotional validation that also came from hearing that what happened was not “*their fault*”, or as Izzie explained, simply “*being listened to, because that wasnt often a thing*”.

For some, professionals played a key role in fostering a sense of empowerment. Rachel recalled how a domestic violence support worker had provided both emotional validation and practical guidance that made her feel empowered to make decisions about her situation and how to stay safe. Likewise counselling was also empowering - Jessica recounted how hard it was to accept that she was allowed to spend her own money on counselling, and how instrumental the sessions were in her recognising her own power and agency. Having access to meaningful therapy like this provided a way for participants to emotionally process what had happened. Imogen spoke of her therapist introducing her to art as a way to express how she felt: “*For me it was Tori Amos Silent All These Years ...for some it’s a piece of art or a poem or a piece of literature or dance that can express what they feel after being given some time and thought*”.

Empowerment also came in the form of freedom. Hannah described this as “*becoming an adult and learning about myself in steps*”. Many of the participants had experienced such restrictive lives that everyday experiences were a source of power, as Olivia explained:

> *“I remember the first time I went out to the pub with a friend and came home and the house was quiet and I had a shower and I put the music on. And it was like the first time in my life that I hadn't had to kind of come in, tiptoe*

> *around, worry about everything, you know, all that sort of stuff, you know, that choices are really empowering. But they're also really overwhelming."*

Olivia's explanation that this sense of empowerment could also be overwhelming is crucial for understanding the needs of victim/survivors. Some of the people we spoke to needed a strong scaffold to help them as they developed agency, whether this came in the form of a role model (as outlined by Olivia), or practical support (as outlined by Rachel). As we will explore in theme 2, systemic issues can make the process of recovery and empowerment very difficult indeed.

2. *Building better systems*

Participants were passionate about a need for an improvement in the systems involved in the support and recovery of victim/survivors, and the urgency in ensuring that these systems are equipped to work with autistic people. These systemic issues manifested as a result of both theoretical (e.g. limited applied knowledge of autistic needs within services) and practical (e.g. under-resourcing, bureaucracy) factors, and impacted on both the accessing support, and the success of the support offered.

2.1 Knowledge and Accessibility

Participants found that many professionals and services lacked adequate knowledge of autism, which impacted on their ability to meaningfully access support. Catherine and Charlotte pointed out that forms of therapy often recommended for survivors (such as cognitive behavioural therapy, or group therapy) could be "*unhelpful*" or inaccessible for some autistic people. James explained that being understood by a counsellor was *“half the battle*” and required having to educate them about autism as opposed to simply engaging with therapy. Indeed Rowan stated how having a therapist who specialised in autism “*made it a bit easier*”. Lucy highlighted how good training and knowledge about "*different people's presentations, trauma, how that looks ”* could prevent further distress among traumatised autistic people. Additionally Jessica stated that a trauma informed, humanistic perspective could even compensate for a lack of autism specific knowlegde as “*it always comes back to understanding my experience*”. Their comments aligned with Rachel’s account of attempting to leave an abusive relationship whilst in inpatient services for mental health treatment. Her difficulties in transitioning out of the service whilst balancing her safety was viewed as “*disordered behaviour*” and a sign that she wasnt “*engaged in treatment/recovery anymore*” instead of her needs being “*recognised, accepted and accommodated by providing practical and emotional support”.* She described not feeling safe to process what had happened to her until leaving the service. Lucy recalled a similar experience with mental health services: “*Nobody ever asked. What's behind? What's going on here? I was just literally invisible to so many people...I had eating issues. It was just like there is obviously this was a distressed person for whatever reason, nobody asked anything*.”

These comments show the importance of up to date, [autistic] survivor informed knowledge and training. However, Allison highlighted how despite autism training being compulsory for many professionals due to the Autism Act,[19] it is not enough:

> “*You might sit and nod along all day and think, yeah, I'm going to do that, but without doing a case study or having supervised work to put that training into practice, I think it's so easy to think you're doing it, but actually you're not. It's almost like an intellectual understanding without the practical side*.”

Her comments suggested that many professionals have a ‘*theoretical*” understanding of autism, but lack experience of actually applying this to autistic people. Izzie suggested that training could be improved by including neurodivergent people in the design and delivery to ensure that it is underpinned by lived experience, and Charlotte suggested that an autistic run intimate violence service is needed. Several participants described encountering issues during support seeking where “*it wasnt even considered that these things could be challenging*” (Rachel). This included tasks like completing forms (Hannah), opening a separate bank account (Rowan), or “*setting up new GP, accessing local services, navigating the new area, finding friends*” (Rachel). These comments highlighted a need that goes beyond what autistic distress looks like and how autistic people might process trauma, to also providing practical support that meets the needs of autistic victim/survivors.

2.2. Right place, right time.

For those who had accessed structural supports, there was a feeling of being “i*n the right place at the right time*”. Participants who had sought help via the criminal justice system found themselves subject to delays between report and follow up. James recalled that it took 3 months for the police to follow up on his report, and that when they did visit him he felt like they were treating him like a perpetrator rather than a victim. Those who did experience immediate police intervention felt that it "*became about him [the perpetrator] and how it impacted him*" (Faye). Charlie explained how eye opening such an experience could be:

> "*I always had this belief, and that's white middle class privilege, that the police will be there when you truly need them. And then I phoned them because a guy was genuinely trying to murder me, and they took away his keys for the night and then gave him them back in the morning*." (Charlie)

Faye described the police having a "*devastating impact*" on how she handled what happened to her, and likewise Grace attributed her PTSD to '*the court system and the police*" rather than the abuse itself. Most participants felt that the police were more focussed on the evidence needed "*for court"* rather than acting as a vehicle for justice. However Olivia did recall the police patrolling her house to check her wellbeing and helping her to install alarms, which helped her to feel safe.

The police were not the only service to receive criticism. Both Charlie and Susan had negative experiences of refuge access. Charlie described having "*absolutely zero income and eating absolutely ******* nothing*" because workers there were unsure of how to help her apply for benefits. Susan recounted that she could not cope with "*communal life and no privacy"* and that her daughter's clothes were stolen whilst there, making it feel unsafe and ultimately leading her to (temporarily) return home to her violent partner.

Additionally Charlie described how refuge access led to a loss of police domestic abuse support due to "*funding issues*". The subject of funding was pervasive throughout participant accounts. Charlotte recounted how she was told that support was for people "*in much worse circumstances*", and Helen described how her own worries about being told this had prevented her from attempting to access services herself. Lydia recounted being "*grateful for that (local authority) house, it kept the children in the same school and in the same village... those benefits didn't give me luxuries, but they gave me enough to live on."* Likewise, Charlie reflected on how effective their eventual therapeutic support had been, but that "*it would have made a lot more difference if there had been more than one of him*". These comments are particularly stark in light of funding cuts to public services that have occurred in recent years. Many of the participants volunteered or worked with other victim/survivors, and whilst this aligns with suggestion that services are "survivor-led" it is important that this does not become "survivor-reliant", by which there is a pressure on traumatised people to be the main source of support for other traumatised people due to a lack of funding and resourcing.

3. How do we stop this?

Whilst theme 2 focussed on improving access to support and recovery and addressing systemic issues, theme 3 was centred on preventative measures that can be taken to address high prevalence of intimate violence experiences among autistic adults at a more individual level (though still requiring systemic change to be effective, e.g. recognising autistic needs, embedding knowledge through relationship education).

3.1. Recognising interpersonal vulnerability

Participants explained the complexity of acknowledging characteristics associated with being autistic people might relate to heightened risk of victimisation, whilst ensuring that professionals do not "*shift the blame onto the autistic person*" (Allison). In Pearson et al. (a)[12] we outline systemic forms of injustice (such as stigma and the normalisation of violence) that contribute towards increased prevalence of violence and abuse among autistic people, in addition to difficulty in recognising or processing abuse. However participants also highlighted the importance of recognising how autistic characteristics, and other aspects of being neurodivergent might relate to heightened prevalence, as well as recognition and recovery.

Some of the participants spoke about difficulty recognising when someone is being "*genuine*". Susan said that her difficulty "*recognising signals...and acting on signals*" contributed towards her avoiding relationships altogether. Charlie, Charlotte, Lucy and Faye recounted a "*lack of wariness*" and getting into "*unsafe situations*" through not recognising the danger they might be in (e.g. walking home alone at night through an unfamiliar area). Faye specificially highlighted a time she was assaulted after leaving a group of friends for "*time out*" when socialising, demonstrating that it is not simply autistic characteristics that increase risk, but a lack of safe accomodations for autistic people.

Some participants reflected on how growing up socially isolated meant that they felt less "*protected*" by friends who could have looked out for them, or adults who have may have “*kept them close*” if their neurodivergence had been understood. Lydia suggested that social vulnerability emerged through other people recognising difference and “*using that against you*”. Relatedly, Elizabeth spoke about the paradoxical relationship between the difficulty trusting people enough to make lasting friends, and “*trusting too much*”.

Participants also highlighted how sensory seeking and impulsivity had impacted on them being drawn into dangerous situations. Lucy spoke about mistaking intense social interaction for “*euphoric excitement*”, and Grace reflected on the importance of being diagnosed with, and medicated, for ADHD because it had reduced the likelihood of her seeking out “*high risk situations*”. Here we see the importance of acknowledging how other aspects of neurodivergence may also contribute towards heightened risk of violence and abuse.

Finally in addition to heightened risk of abuse, the participants also reflected on how being autistic had impacted on both their access to support and justice. Five people described becoming situationally mute and struggling to communicate verbally, especially during high stress situations. Lucy recalled how the police listened to her ex-partner instead of her “*because I couldn't verbalise anything*”. Likewise, Sophie avoided pursuing court proceedings and counselling through fear of being “*unable to speak well enough*”. Izzie highlighted the importance of being listened to even when struggling to use speech to communicate, an issue which feeds directly into the systemic barriers outlined in theme 2.

All participants suggested that more focus was needed on addressing these issues as early as possible for autistic people, including ensuring access to self-knowledge and diagnosis, and developing education (see theme 3.2) to function preventatively.

3.2. Prevention through learning about relationships

Participants highlighted relationship education as a crucial area of intervention for preventing the experience of violence and improving outcomes in autistic relationships. Catherine outlined the lack of focus on relationships in relationship and sex education in schools:

> *"They do loads on road safety and drugs and alcohol, but relationships are something everyone has at some point. Whether that be a friendship or romantic relationship or family relationship. I think understanding what a healthy relationship is in general is vital. They get sex education but there's a relationship there typically before you get to that point*"

Participants felt that some aspects of relationship and sex education had improved in recent years, e.g. Rachel highlighted how the lack of knowledge around informed consent contributed towards her own experiences, but Charlie mentioned an improvement in seeing resources available for young people informing them on consent. There *was* a consensus that not enough was being done, particularly with regards to accessible RSE for neurodivergent young people. Michelle spoke about the importance of schools covering "*basics about boundaries*" but Sophie suggested also needing to go beyond "*the biology diagrams of how to make babies*" and talk openly about "*the way people play games, the unspoken rules of what to do or not do. How to protect myself, who to trust or not trust, how to get help*."

Crucially, participants highlighted how relationship education was not solely the responsibility of schools. Lydia reflected on how social media has negatively impacted the safety of young people, and that "*as the goalposts keep moving, we have got to keep getting better*" at meeting new challenges in how it influences relationships. Charlie spoke about growing up in a family where there was no "*caring from parents*" regarding education about relationships and a need for input at school *and* home. Additionally Grace spoke about how having "*lovely family*" is not enough to ensure that young people are safe, reflecting on her own experience of having a supportive family but still feeling like she needed to be secretive about relationship experiences. She emphasised the importance of actively creating an environment of openness with children about relationships, so that they know when something is not "*normal*", or who they can go to about concerns. These comments emphasise that relationship education is a societal responsibility, and something that cannot be transmitted through one source (e.g. parents *or* schools) alone.

Discussion

With this study we aimed to explore the support and recovery experiences of autistic adults who have been subjected to intimate violence and abuse. Our findings showed that recovery is a journey as opposed to a destination, and is marked by multiple instances of disclosure and support seeking. Our participants highlighted systemic and structural barriers that impacted on professional knowledge of autistic people, and access to services and supports. Overall participants suggested that a a nuanced understanding of neurodivergent vulnerability is needed and that this vulnerability must be addressed through education.

For victim/survivors the act of disclosure is not a one time event, but an ongoing process of weighing up who to trust that demands emotional energy.[24] The threat of testimonial injustice[6,11] can be traumatic in itself, however participants also highlighted the potential harm of a heavy handed supportive response. Overall they suggested that sensitivity was needed during the disclosure process and that whilst support could be instrumental,[24] decisions ultimately lay with the victim/survivor.

The notion of recovery itself was misleading with the term implying an end to the impact of IPV. Participants instead outlined the protracted nature of the recovery process and how individual this could be. Some participants spoke of struggling to trust others and having ongoing mental health difficulties as a result of the IPV.[5,6] Those who had gone on to form new relationships had done so tentatitvely, often working very hard to develop trust and establish clear boundaries. It was clear from their stories that recovery was not a destination.[25] The non-linear process of recovery has clear implications for support services, as there may be an expectation for victim/survivors to appear to cope in a particular way in order to indicate that they are recovering. However it was clear from our discussions that recovery simply meant moving forward in a way that felt bearable for the individual, rather than reaching a universal ideal.

One aspect of the recovery process that was instrumental in beginning to move forward after IPV was empowerment. Many of our participants had experienced a lifetime of stigma, dehumanisation, and being treated as unreliable narrators in their own lives.[11,12] The experience of validation and effective professional support helped participants to develop self-compassion and recognise their own agency. However this new sense of agency could be overwhelming after feeling so restricted, with participants highlighting the need for supports and services that could provide a scaffold with both practical issues (e.g. opening a bank account), and emotional support.

Participants highlighted systemic issues within the support seeking process that affected victim/suvivors in general, in addition to those which impacted on autistic victim/survivors specifically. One broader issue included under-resourcing of services. Funding cuts have led to a race to the bottom whereby survivors own confusion about whether what happened to them was “bad enough” to warrant support[12] was exacerbated by those thoughts being echoed by services with incredibly limited resources. The lack of funding to third sector organisations and refuges can lead to further trauma for victim/survivors, who might be unable to access basic resources such as food and clean clothing. Participants reported returning to an abusive home because the alternative was not much better.

Engagement with the criminal justice system impacted at both levels. Participants highlighted a focus on evidence gathering and the likelihood prosecution, rather than justice or safety. The way victim/survivors are treated by the criminal justice system is well documented to contribute towards further trauma.[26] However being a neurodivergent victim/survivor can lead to unique barriers to justice.[11] Our participants highlighted the lack of understanding within the criminal justice system, including police not knowing how to respond to their struggles with spoken communication, which contributed towards their testimony also being viewed as unreliable.[11]

A lack of understanding of neurodivergence was seen across services that participants attempted to access. Some participants outlined the benefits of therapists who were knowledgable about neurodivergence[27] or who had a more humanistic approach, whereas participants who had experienced non-tailored therapy recalled the additional labour of educating their counsellors. Concerningly, the lack of knowledge in more acute mental health services had a more devastating impact. Participants were labelled as challenging for displaying distress, and there was a lack of accomodations reported when participants expressed needing additional support in order to cope. These reports are consistent with wider accounts of the traumatic nature of accessing mental health services and suggest that systemic change is needed in order to facilitate more effective support.[15]

Overall participants highlighted a need for better quality training for professionals and services, which was designed and led by/with neurodivergent people. However, it is important that we balance the need for a lived experience underpinning with the labour that comes with it. Many of the people we spoke to were actively engaged in supporting other victim survivors, either through working alongside the police or with IPV services. Though IPV advocacy and support has primarily occurred through the work of victim/survivors,[28] we suggest that this is not taken as a stand-in for proper resourcing and funding to services. It is also crucial that training goes beyond the delivery of information about autism, as participants felt that this did very little to actually change practice. We recommend that training about autistic people is supplemented with supervision, and that practitioners engage in reflexive practice when implementing new knowledge into their work. Previous research has shown that explicit training does little to reduce implicit bias[29] suggesting that alternative approaches are needed to ensure that an intellectual understanding translates to behaviour change. We also recommend that training programmes are robustly evaluated, using long term follow-up where possible to assess efficacy.

Finally participants outlined two key considerations for reducing IPV among autistic people. The first was to explicitly address the relationship between neurodivergence and IPV, through a nuanced lens. Participants highlighted the complex interaction between struggling to recognise social signals and dangerous situations, and the broader social context which invalidates autistic intuitive action.[12] The difficulty some of our participants had with recognising relationship red flags cannot be divorced from the othering and invalidation that our participants experienced across the lifespan. Thus it is essential that we address autistic risk through a social-ecological approach that goes beyond the lens of individual vulnerability (and the associated victim blaming that can occur with it).

Interestingly our participants also highlighted the need to recognise how other aspects of neurodivergence may be related to heightened risk of IPV. Nine of the participants reported ADHD alongside autism. Some of these participants reflected on how they felt that the intense emotional stimulation and impulsivity associated with (unmedicated) ADHD had contributed towards the risk of interpersonal danger. These findings are consistent with Gibbs and colleagues[30] who found that ADHD characteristics were a stronger predictor of polyvictimisation than autistic traits in a sample of autistic *and* non-autistic adults.

The second key consideration is a desperate need for better relationship education for neurodivergent people. Our participants highlighted that relationship and sex education in schools tends to focus on biological outcomes (e.g. pregnancy), though there has been a shift towards discussion of consent in some curriculum materials. These findings are consistent with Sedgewick and Douglas,[31] whose participants also highlighted a need for more of a focus on healthy relationships from an early age. Participants also highlighted that education outside of the school system is also crucial, with a need for accessible resources to be available at different points across the lifespan. Importantly, the development of tailored relationship education should absolutely not focus on social skills training for autistic people. This approach would sit in direct opposition to our concurrent findings that invalidating autistic communication directly contributes towards the normalisation of violence among autistic people.[12]

Limitations

Our sample was limited in terms of representativeness and does not capture some of intersectional issues that may impact on access to recovery, support and justice among a broader range of autistic people (e.g. Black autistic people). We give a full discussion of this issue in Pearson et al.[12] Additionally, our work was limited to a UK context. Though findings are likely to be widely applicable to other countries and contexts, focussed work is needed to ensure cultural sensitivity is embedded alongside an understanding of the needs of neurodivergent people.

Actions for change

Overall our participants highlighted several key areas for change within services that encounter and support victim survivors, centered on improving access and knowledge (see figure 2). They made several important recommendations that would improve future provision, and minimise iatogenic trauma during the help-seeking process.

[Insert Figure 2]

In addition to co-designed/delivered training, participants emphasised that:

1. Organisations should move away from single point access (e.g. having to speak on the telephone) and towards integrating the use of other access modalities (e.g. text message) that enable those with unreliable speech to access support.
2. Services should develop clear, unambiguous resources that can be accessed anonymously. Provide specific examples of the types of abuse people might experience whilst making clear that abuse is not limited to these examples.
3. Practitioners should learn how to communicate with people who may struggle with speech. Being aware of and offering alternative communicative tools or offering third party support such as an independent advocate or appropriate adult[32] could facilitate communication for those who struggle when in distress.
4. Services should keep paperwork simple and offer support in completing complex more paperwork (e.g. welfare applications).

Conclusions

This study is the first to explicitly explore the support and recovery needs of autistic people who have experienced intimate partner violence. Our findings highlight a clear need for neurodiversity-informed training for professionals working in victim/survivor facing services, and improved and inclusive relationship and sex education targeted at neurodivergent young people. Given the over-representation of autistic people among victim/survivors of IPV, it is imperative that services are properly resourced to meet the needs of this population.

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Authorship Confirmation Statement

AP, MB, FS, SD and KR designed this study. WJ and AM contributed towards interview design and project organisation.

AP, WJ and AM collected the data.

AP and MB analysed the data, and KR, SD and FS provided discussion and contributed to final theme organisation.

AP and MB wrote the first draft of the manuscript. FS, SD, KR, WJ and AM provided feedback and edited the manuscript.

Author Disclosure Statement

The authors declare the following potential conflicts of interest with respect to the research, authorship, and publication of this article: AP, KR, MB, SD and FS have accepted speaker fees to discuss their work on autism, neurodiversity, relationships and inclusivity at conferences and training events. KR is has received fees for the delivery of training and consultancy on autism through his business ‘The Autistic Advocate’. AP and KR have received royalties from Pavilion publishing for a book on autistic masking and stigma. SD and FS have received royalties from Routledge Publishing for a book on autistic relationships, and FS has received royalties from

Jessica Kingsley Publishing for a book on autistic masking. None of the other authors have a COI.

Data availability statement

Anonymised and safeguarded project data is available via the UK data service https://dx.doi.org/10.5255/UKDA-SN-857139. All requests must be submitted directly to AP for approval. You can also access the open project documentation (e.g. interview questions) via this link.

You can also access our open source resource on healthy relationships for autistic people via the following link: https://www.durham.ac.uk/research/institutes-and-centres/neurodiversity-development/impact-and-engagement/healthy-relationships-for-autistic-people/

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Table and Figure legends

Table 1: De-identified participant demographics

Figure 1: Themes and sub-themes identified from the thematic analysis

Figure 2: Key takeaway points and recommendations based on participant suggestions.

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