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Neurodiversity-Affirming Emotion-Focused Group Therapy: An Exploratory Outcome Study

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ABSTRACT

Aim: Autistic adults experience high levels of mental health conditions, such as depression and anxiety. Autism has been associated with difficulties in emotional processing, which may reflect co-occurring alexithymia. Although other psychological approaches have been developed, emotion-Focussed Group Therapy might also be a relevant intervention for helping autistic adults develop their emotional processing.

Method: Nine autistic adults were offered a nine-week group neurodiversity-affirming emotion-focussed therapy (neuro-EFGT). An observer measure was used to track change across therapy in emotional processing for affective empathy for self (emotion regulation) and other (empathy), and in cognitive empathy for self (self-reflection) and other (mental representation).

Results: Significant pre-/postoutcome differences were found, for both modality (therapy vs Interpersonal Process Recall; $d = 2.20$) and time ($d = 5.68$), with seven of the nine participants showing significant reliable change in emotional processing by the end of therapy.

Implications: This is the first outcome study of neuro-EFGT that offers an initial account of autistic adults' experiences of the intervention. Neuro-EFGT may be a useful alternative therapy for autistic adults who report emotional processing difficulties.

1 | Introduction

Clinically, autism spectrum disorder (ASD), hereafter autism, is defined as a neurodevelopmental condition characterised by qualitative differences in communication and socialisation, along with restricted, repetitive behaviours and interests, and sensory differences (American Psychiatric Association 2013). In this article, we opt for identity first language, such as autistic adult, in accordance with the autistic community preference (Kenny et al. 2015). Autism has been associated with difficulties in emotional processing, in particular problems with recognising emotions in others (Bird and Cook 2013). However, research suggests emotional processing difficulties reflect co-occurring alexithymia (Cook et al. 2013). A meta-analysis found a higher prevalence of alexithymia in autistic groups compared to neurotypical groups (49.93% compared to 4.89%; Kinnaird et al. 2019). These findings add to a growing body of evidence that co-occurring autism and alexithymia represents a specific subgroup in the autistic population that may have specific clinical needs.

Autistic adults experience high levels of co-occurring conditions (Lai et al. 2019), trauma-related experiences (Robinson 2018), post-traumatic stress disorder (PTSD; Stewart et al. 2022) and suicidality (Conner et al. 2020). Up to 60% of autistic adults have at least one co-occurring psychiatric condition, with a wide range in prevalence rates from 20% to 80% reported for anxiety or depressive difficulties (Wigham et al. 2017). Over a third of autistic individuals, across all ages, have experienced suicidal ideation (Newell et al. 2023). A systematic review examining suicidal thoughts and behaviour (STB) between 2018 and 2024 found rates of 34.2% for suicide

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Implications

Practice Implications

- Neuro-EFGT is a neurodiversity-affirming group therapy that rejects the negative diagnostic narrative that leads interventions to target perceived deficit skills based upon neurotypical development.
- We propose autistic adults experience trauma because of misempathy within neurotypical–neurodivergent intersubjective encounters by being stigmatised and othered but this may not be formulated within their awareness as a trauma narrative.
- Our findings show Neuro-EFGT identifies markers with tasks that enhance autistic adults' insight into their emotional processing for self and other when dealing with emotional injuries and trauma.

Policy Implications

- We propose that Neuro-EFGT offers autistic adults an alternative therapy to the social skills-focused group Cognitive Behavioural Therapy recommended by NICE guidelines (2012).

ideation and 24.3% for suicide attempts in diagnosed autistic people (Brown et al. 2024). Further, they report an eightfold increased risk of death by suicide compared to non-autistic people.

Mental health guidelines for autistic adults suggest the use of a group-based social learning programme to support social interaction (NICE 2012). This guidance underpins the predominance of Social Skills Training (SST) for autistic people following diagnosis (Reichow et al. 2013). The evidence suggests that SST is generally effective, that is, it produces changes in the targeted outcomes (Hume et al. 2021). The basic premise of SST is to teach social rules, such as conversation skills, and social behaviours, with the intent of improving social competence. Autistic adults are offered SST as an intervention to support the development of social communication and interaction, often through role-play, modelling, or group activities. More recently, SST is being challenged with an emerging view that these approaches can be harmful for autistic people (Bottema-Beutel et al. 2018).

Traditional SST interventions have been linked to increased mental health issues as they can encourage autistic people to mask by suppressing behaviours to conform to neurotypical social norms (Walsh et al. 2025). Autistic people experience their social environments as highly stressful, hostile, or unsafe and consequently use masking and camouflaging to hide autistic behaviours (Field et al. 2024). Autistic adults report social camouflaging to present as non-autistic, and to hide autistic characteristics, so they can 'pass' in social situations (Cook et al. 2021). However, camouflaging has been described by autistic adults as emotionally exhausting, identity-eroding and a contributor to burnout (Cage and Troxell-Whitman 2019).

Rather than solely avoiding negative treatment, autistic adults mask and use camouflaging strategies to fit in, form relationships and to make friends and to achieve social connection (Cook et al. 2021). Self-reported camouflaging is associated with higher anxiety, higher depression, greater psychological distress and increased suicidality risk (Hull et al. 2021). A recent meta-analysis shows elevated anxiety and depression associated with camouflaging (Khudiakova et al. 2025). Camouflaging is argued to be a plausible mechanism through which stigma, trauma, or social demand harms mental health (Perry et al. 2022). Consequently, autistic adults seek psychological interventions for a range of issues, such as high levels of anxiety (Parr et al. 2020), depression and other mental health challenges (Underwood et al. 2023), for personal growth and to establish safe, accepting relationships (Mazurek et al. 2023). However, therapists and mental health professionals report that working with autistic adults often requires highly individualised adaptations (Moore et al. 2024).

Autistic adults indicate that some interventions have led to harm and trauma (McGill and Robinson 2021). They also report a need and desire for psychotherapy, yet report higher levels of unmet mental health needs (Nicolaidis et al. 2013) and are less satisfied with mental health services (Vogan et al. 2017). They regularly report barriers to accessing appropriate mental health support (Brede et al. 2022). Therapists' lack of autism knowledge and use of non-tailored approaches to psychological intervention are identified barriers experienced by autistic adults (Adams and Young 2021). A recent study exploring therapist experiences of working relationally with autistic adults found that effective therapy depends on validating autistic identity, adapting communication and challenging stereotypes (Brook 2022).

Adaptations to standard mental health interventions (MHIs) are frequently used in practice and are viewed as important by autistic people (Brice et al. 2021). Various group treatments have emerged in recent years as highly effective for helping general client populations enhance their psychological wellbeing (Rosendahl et al. 2021). Yet, group interventions adapted to autistic adults are scarce, with the majority based on cognitive behavioural therapy (CBT), although some autistic adults have reported early behaviourist interventions have led to harm and trauma (McGill and Robinson 2021). Nonetheless, a range of benefits have also been reported for these adapted group approaches, including: for CBT, improvements in self-reported social anxiety (Spain et al. 2017); for Mindfulness-Based Training for Autism Spectrum (MBT-AS), reduction in depression, anxiety, rumination and increased positive affect (Spek et al. 2013); for Mentalization Based Therapy for Autism Spectrum Disorder (MBT-ASD), improvement in the patients' mentalising abilities (Krämer et al. 2021); and for Acceptance and Commitment Therapy for autism (NeuroACT), improvements in perceived stress and quality of life (Pahnke et al. 2023). Nevertheless, autistic adults have also reported MHIs have neglected their traumatic experiences, which points to a need for a more exploratory and a less training-oriented approach. Furthermore, based on the wider psychotherapy outcome literature (e.g., as reviewed in Barkham et al. 2021), it can be argued that depression and trauma lend themselves to a broader range of traditional kinds of psychotherapy.

Therapist empathy and alliance are robust predictors of therapy success (Elliott et al. 2018). Therapists' understanding of

autism is essential for therapeutic alliance with autistic clients (Mazurek et al. 2023). An examination of psychotherapists' knowledge found misconceptions and outdated beliefs about autism (Lipinski et al. 2022). The double-empathy theory of autism suggests that autistic and non-autistic people experience mutual difficulty in understanding and empathising with one another (Milton 2012). Autistic people have been found to communicate more efficiently with other autistic people than with neurotypical people, and to experience higher interactional rapport with other autistic people (Crompton et al. 2020). Experiences of intersubjective misattunement between neurotypical and neurodivergent people predispose autistic people to interpersonal trauma (Robinson 2018), through being stigmatised and othered. Studies that include clinical diagnosis found 2% of autistic adults have a clinical PTSD diagnosis at a given point compared to 5.7% of the general population (Mansour et al. 2025). However, this is likely an underestimation as symptom-based studies suggest higher rates of autistic people are experiencing PTSD-like symptoms that are not formally diagnosed (Quinton et al. 2024). As such, autistic adults may seek psychological intervention for their emotional distress and unresolved trauma.

Emotion Focused Therapy (EFT) is a humanistic-experiential psychotherapy rooted in person-centered therapy, Gestalt therapy and contemporary emotion theory, and emphasises the centrality of emotion in adaptive functioning and psychological change (Elliott et al. 2025). Within the EFT framework, emotions are seen as adaptive or maladaptive: primary adaptive emotions guide effective action, while primary maladaptive emotions, such as shame or fear tied to early experiences, produce and maintain distress (Elliott et al. 2004). In addition, secondary and instrumental emotions obscure adaptive emotional experience (Greenberg 2015). EFT conceptualises emotional transformation as the core mechanism of psychological change. EFT is also marker guided, and these observable markers indicate where the client is in their emotional process, pointing the therapist toward specific therapeutic tasks to address difficulties. EFT therapists use empathic attunement and experiential methods, such as focusing and enactment tasks such as two-chair work, to help clients access and reorganise emotional experiences (Elliott et al. 2004). This facilitates the transformation of maladaptive emotion schemes and supports more adaptive responses (Elliott et al. 2025). Change occurs through corrective emotional experiences within a safe, empathically attuned therapeutic relationship (Elliott et al. 2013).

EFT is empirically validated for different psychological difficulties, such as depression (Greenberg and Watson 2006), generalised anxiety disorder (Timulak and McElvaney 2015), social anxiety (Elliott 2013) and complex trauma (Paivio and Pascual-Leone 2010). Adaptations exist for families (Dolhanty and Greenberg 2009a, 2009b), couples (Greenberg and Goldman 2008), groups for those with eating disorders (Wnuk et al. 2015) and for autistic and neurodivergent people (Neuro-EFGT, see Robinson and Elliott 2017).

As is the case for EFT more broadly, the protocol for EFT for clients on the autism spectrum is grounded in humanistic-experiential principles and features the key EFT therapeutic tasks (cf. Elliott and Greenberg 2021), such as systematic evocative unfolding (to re-experience a previous puzzling reaction), focusing (slowing down and attending to unclear bodily feelings), two chair work (helping the client enact a conflict between two parts of self), empty chair work (helping the client express their unresolved feelings toward an important person) and self-compassion work (helping the client comfort self). However, it differs in that it incorporates specific adaptations of standard EFT tasks intended to make those more accessible to this client population. For example, it incorporates an adaptation of Interpersonal Process Recall (IPR; Kagan 1975) as a process guiding method using video playback of small, edited segments of a session to aid in deepening processing experiences of self and others. The focus across Neuro-EFGT is on conceptual-affective domains, with the aim of enhancing emotion regulation and empathy for self and others. Specifically, understanding emotions is important through body awareness and empathy for self and others, both in the here and now interchange and through process guiding using IPR to deepen self and other experiencing.

Neuro-EFGT uses a small group therapy format because many autistic people report experiencing difficulties in interpersonal situations with their neurotypical peers, and as such, a group format offers a therapeutic space for shared understanding. Within this space, members share their current and previous challenges with other neurodivergent group members, addressing both cognitive and affective levels. These include exploring emotional and sensory processing, such as issues related to emotion overwhelm, interoception and alexithymia, as well as deepening self-understanding and compassion, and exploring pain and distress caused by distressing experiences with neurotypical peers.

Neuro-EFGT addresses mistreatment associated with a lifetime of being marginalised. Neuro-EFGT case formulation uses neurodivergent–neurodivergent intersubjectivity to facilitate compassion responses in group members. Therapists help clients explore unresolved painful experiences to access maladaptive emotions and transform these into more adaptive emotions. This facilitates the client's self-organisation by deepening their understanding of emotional experiences and needs, enabling new meaning-making processes that form coherent patterns of feeling, thinking and relating that constitute the self (Greenberg 2015).

This article describes the design and outcome of a non-randomised, single-arm, 9-week group Neuro-EFGT intervention, piloted on three occasions. We aimed to investigate the extent to which autistic adults changed on a process-based outcome measure over the course of a neurodiversity-affirming Emotion-Focused Group Therapy (Neuro-EFGT) in areas of emotional processing for self and others (i.e., affective empathy for self [emotion regulation] and other [empathy] and cognitive empathy for self [self-reflection] and other [mental representation]). We hypothesised that (1) participants would show higher levels of within-session cognitive–affective components of emotional processing in IPR sessions compared to regular group therapy sessions; and (2) participants would show increases in within-session cognitive–affective components of emotional processing (during both regular and IPR sessions) from early to late in therapy.

2 | Method

2.1 | Participants

2.1.1 | Clients

The participants were recruited from two organisations: Scottish Autism, a national autism organisation that provides education and adult services throughout Scotland for all ages and across the spectrum; and Hope for Autism, a regional autism organisation that provides outreach support to young autistic adults and their carers. The participants consisted of nine adults—two women and seven men—each with an autism diagnosis and a range of co-occurring conditions (for a detailed listing of demographic and clinical information, see Table 1). All participants had undergone a standardised diagnostic process. Autism spectrum disorder was diagnosed by evaluation of historic and current symptoms by an experienced psychologist with training in autism. A semi-structured interview was conducted with all participants to assess ASD criteria per DSM-5 (APA 2013). For each diagnostic criterion, a standard primary question was asked, followed by questions to clarify whether the participant met criteria for the given item. The research protocol was approved by the University of Strathclyde Ethics Committee, and following an information session, participants gave their informed written consent for participation in the study and research purposes. For anonymised case illustration, approval to use quotes was sought and granted.

2.1.2 | Therapists

Two therapists provided the therapy. Therapy in early cases was delivered by the first author, who is the main developer of the Neuro-EFGT protocol and a psychologist with more than 20 years of experience specialising in psychotherapy (person-centred-experiential, including EFT) and work with neurodivergent clients. The work was supervised by the second author, one of the developers of EFT. In later groups, a trainee therapist (a senior autism practitioner with 8-day training in Emotion-Focused Counselling Skills in Autism Spectrum) co-delivered the therapy under the lead of the first author. In one group, three clients were seen by one therapist, and in two separate groups, three clients in each group were seen by the two therapists together.

2.1.3 | Raters

Raters included the first author and two independent raters, who were Masters in Autism graduates and experienced autism practitioners, and who were trained over a 12-week period to rate video footage using the Client-Emotional Processing Scale for Autism Spectrum (Robinson and Elliott 2016).

2.2 | Measure

The measure used to track client progress was the Client Emotional Processing Scale for Autism Spectrum (CEPS-AS; Robinson and Elliott 2016), an observer process-outcome measure for both affective empathy (emotion regulation; empathy) and cognitive empathy (self-reflection; mental representation). The CEPS-AS was used to rate client performance by the first author and two independent raters. The independent raters attended four online (Zoom) training sessions on the CEPS-AS, using practice video material from other sessions not rated in the final analysis.

2.3 | Procedure

2.3.1 | Therapy Intervention

Clients participated in small therapy groups of three. The first author co-delivered the training and led the delivery of the therapy, mentoring the trainee in the method during the process. Three groups, consisting of an adult group ($n = 3$; mean age = 39.67 years) and two young adult groups ($n = 6$; mean age = 20.83 years), each received a 9-week group Emotion Focused Therapy protocol for Autism Spectrum (Neuro-EFGT; Robinson and Elliott 2017). The therapy progressed through pairs of sessions, consisting of a regular small group therapy session followed by an Interpersonal Process Recall (IPR) session that incorporated edited video clips from the previous therapy session. This cycle was repeated across therapy, concluding with a final session (see Figure 1).

2.4 | Post Therapy Follow Up Interview

Five exploratory semi-structured interviews ranged between 36 and 77 min, with an introduction and debriefing. Movement breaks were offered as needed. Interviews were transcribed verbatim.

2.4.1 | IPR Selection

The video recording of each regular group therapy session (T1, T3, T5, T7) was analysed to identify cognitive–affective empathy markers (see Table 2 for brief illustrations). The therapist located and edited three or four 1- to 2-min segments to be used in the subsequent IPR session, focusing on selecting discourse involving emotion, empathy, self-reflection (self-formation) and mental representation (formation of other).

2.4.2 | Coding Procedure

The sampling procedure employed a thin-slice data method (Ambady and Rosenthal 1992) using 2-min video segments that contained short observations of expressive behaviour across the four dimensions. Each rater independently rated 114 × 2-min segments, consisting of 34 segments from the first regular group therapy session (used as a pre-test, T1), 25 from the first video IPR session (session 2, T2), 29 from the final therapy session (session 7, T3) and 26 from the final video IPR session (session 8, T4). Instead of calculating global ratings on the four CEPS-AS dimensions, raters used partial interval sampling (Bakeman and Gottman 1997) by coding across behavioural indicators of each of the five ordered levels within each of the four CEPS-AS dimensions. Raters first had to decide whether a given 2-min video segment contained

TABLE 1 | Demographic information for autistic adults.

Name	Gen	Age	Clinical diagnosis	Co-occurring conditions	Life situation	Presenting problem	Therapy focus
Matt	M	39	Asperger Syndrome	Depression	Unemployed/ living alone	Social isolation; over regulated emotions	Interpersonal rejection; unresolved trauma; adult diagnosis
Martin	M	37	Asperger Syndrome	Anxiety; OCD; Depression	Unemployed/ living with mother	Social isolation; intrusive OCD thoughts; over regulated emotions	Peer victimisation; interpersonal trauma; adult diagnosis
Carla[a]	F	43	Asperger Syndrome	Anxiety; Depression	Unemployed/ married/mother	Interpersonal conflict; impulsive; under regulated emotions	Interpersonal trauma; masking; adult diagnosis
Andy[a]	M	22	High Functioning Autism	Dyspraxia; Social Anxiety	Unemployed/ living with family	Social isolation; over regulated emotions	Social anxiety; interpersonal trauma
Jonny[a]	M	27	Asperger Syndrome	Bipolar Disorder	Self-employed/ living with family/engaged	Anxiety, depression	Peer victimisation; interpersonal trauma; stigma
Danny[a,b]	M	28	Asperger Syndrome	Anxiety; depression	Unemployed/living alone/UG study	Anger management; under regulated emotions	Education stigma; masking; interpersonal trauma
Liam	M	19	Asperger Syndrome	Anxiety; online addiction	Unemployed	Depleted emotion due to online addiction; over regulated emotions	Autism learning & theorising
Sami	F	17	Autism Spectrum Disorder	Social Anxiety Disorder	Employed	Panic attacks; under regulated emotions	School internalised stigma; masking; trauma; adolescent diagnosis
Jimmy[a]	M	22	Asperger Syndrome	Dyspraxia; Depression	Job seekers scheme	Depression due to employment; over regulated emotions	Communication stigma; employment rejection; interpersonal trauma

[a]Post therapy follow-up interview.
[b]Illustrative Case Study.

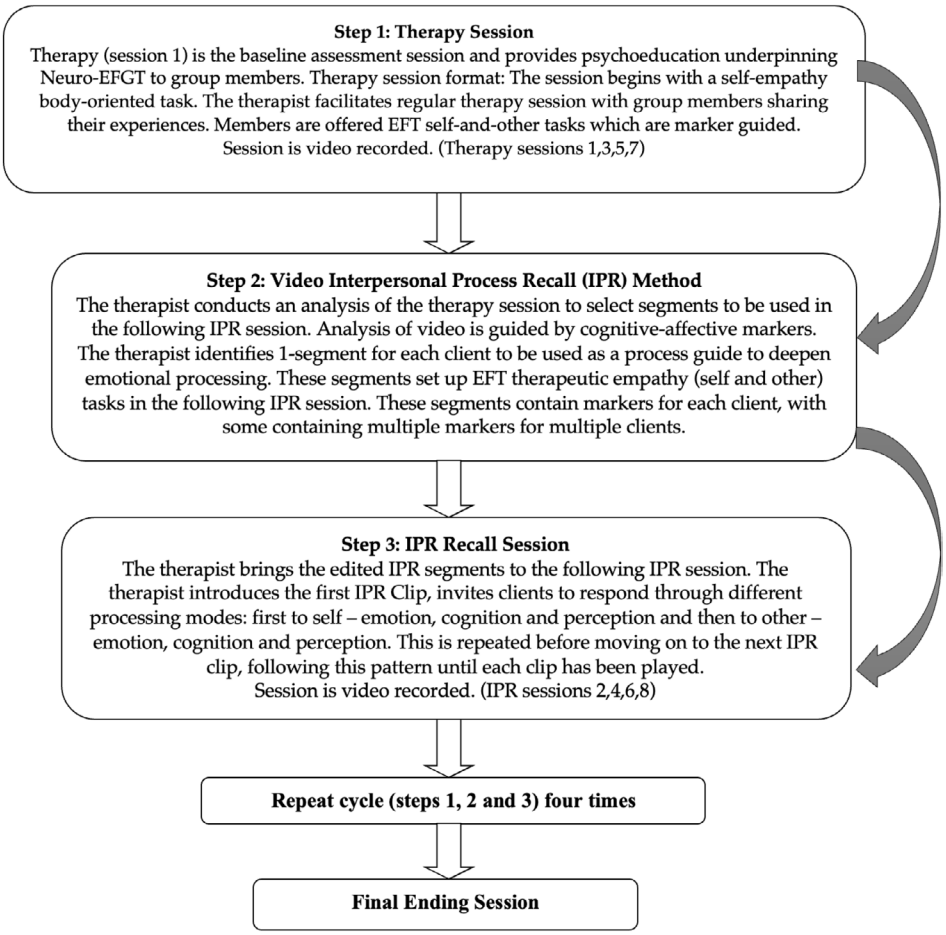

FIGURE 1 | Sequence of Neuro-EFGT: Therapy, IPR selection and IPR replay.

TABLE 2 | Illustrations of IPR selection guide.

	Self	Other
Affective empathy	Emotional self-attunement (Processing own emotions) ◦ Dialogue of client sharing painful experiences ◦ Discourse relating to puzzling emotional processing ◦ Synchrony/dysynchrony of affective expression and narrative storytelling ◦ Dialogue of being in-or-out of touch with embodied emotions ◦ Emotion regulation challenges (over/under regulated presentation)	Interpersonal attunement (Empathic relating) ◦ Moments of shared affective intersubjectivity (empathic resonance) ◦ Missed opportunities to emotionally respond to another's pain ◦ Dialogue of misempathy experiences in previous interpersonal relationships ◦ Moments of misempathy between group members in session ◦ Compassion responses offered to others ◦ Compassion offered by others received
Cognitive empathy	Self-understanding (theory of own mind) (Self-reflection and conception) ◦ Dialogue of theory generation of self-constructs ◦ Discourse of client engaged in negative self-treatment talk ◦ Discourse relating to impact of autism ◦ Discourse of internalised self-stigma	Other awareness (theory of your mind) (Mental representation) ◦ Discourse demonstrating clients engaged in metacognitive thinking ◦ Discourse demonstrating clients engaged in solution focused problem solving ◦ Dialogue of false assumed similarity ◦ Exchanges involving clients misunderstanding one another ◦ Exchanges of interpersonal ruptures between group members

TABLE 3 | Inter-rater reliabilities and inter-dimension correlations for the CEPS-AS.

	Dimensional ratings		Inter-dimension correlations		
Measure	**Individual ratings (*r*)**	**Combined ratings (alpha)**	**Empathy**	**Self-reflection**	**Mental representation**
Emotion regulation	0.94	0.98	0.90	0.90	0.91
Empathy	0.89	0.96		0.91	0.95
Self-reflection	0.90	0.96			0.94
Mental representation	0.90	0.96			
Overall	0.92	0.97			

behavioural indicators of one or more of the four dimensions. Once a decision on segment rateability was agreed, raters chose which behavioural indicators were present on a five-point scale for each of the dimensions. Segment ratings ranged from 1 to 3 behavioural indicators. These indicators were then averaged to produce a mean indicator value for each segment. These mean segment indicator values were used for the reliability analyses. Interrater reliability was calculated for both individual raters' (Pearson *r*) reliability and cross-judge averaged data (Cronbach's alpha).

2.4.3 | Summarising Procedure

For overall session-by-session comparison of client performances, segments were summarised by averaging first across raters ($n = 3$), then across segments within sessions ($n = 1–5$), and finally across clients ($n = 9$).

2.4.4 | Statistical Analysis of Effects

The study was analysed using a two by two within-subjects design with two factors of modality (Therapy session/IPR session) and time (early/late). Analyses were conducted using SPSS version 28. The main effect for emotional processing overall and the four inter-related dimensions of emotion regulation, empathy, self-reflection and mental representations were analysed for main effects for modality and time. For *modality effects*, therapy sessions were compared to IPR sessions: first therapy (T1) and last therapy (T3) were compared to first IPR (T2) and last IPR (T4). For *time effects*, first therapy (T1) and first IPR sessions (T2) (= 'early') were compared to final therapy (T3) and final IPR sessions (T4) (= 'late') (see Table 3 for design).

2.4.5 | Clinically Significant Change Analysis

First, for clinical change analysis, a rational (i.e., based on rating scale anchor points) threshold for caseness was used, denoting the boundary between someone who is clinically distressed and someone who is viewed as not clinically distressed. The CEPS-AS is not a measure of distress per se, but instead assesses skills of emotional processing in four cognitive–affective subscales. For each subscale, the clinical cut off on the CEPS-AS is 3.5, halfway between 3 (mildly insufficient skill in cognitive and affective empathy for self and other) and 4 (sufficient skill). For clinically significant change, overall scores of ≥ 3.5 are rounded up to 4 and considered in the sufficient skill range, whilst scores < 3.5 are rounded down to 3 and considered in the clinically insufficient skill range. Following Jacobson and Truax (1991), minimum reliable change values for $p < 0.05$ were based on test–retest correlations and pretreatment standard deviations; this was 0.46 for overall mean CEPS-AS ratings and varied from 0.45 (for Mental Representation) to 0.69 (for Self-Reflection; see Table 4).

TABLE 4 | Research design.

Modality	Time		Week
1	1	Early Therapy session	Week 1/ Session 1 (T1)
	2	Early IPR session	Week 2/ Session 2 (T2)
2	1	Late Therapy session	Week 7/ Session 7 (T3)
	2	Late IPR session	Week 8/ Session 8 (T4)

2.5 | Post Therapy Follow up Interviews

Reflexive thematic analysis was used to analyse interview transcripts. This method acknowledges the interpretative approach of data analysis and enables the researcher to identify patterns across datasets through a standardised analysis procedure (Braun and Clarke 2022). Following this step-by-step process, data were individually coded, line-by-line, in an inductive manner. Initial themes were constructed through code refinement and further refined as each transcript was reviewed. Main themes, subthemes and illustrations are presented in Table 5.

3 | Results

3.1 | Interrater Reliability

The interrater reliabilities of CEPS-AS judgements are presented in Table 2, and were high overall, with an alpha reliability of 0.92 for judgements averaged across raters. Interrater reliabilities

(Cronbach's alphas) for level of emotional processing on the CEPS-AS were analysed both for each of the four processing dimensions and for combined ratings. The individual processing dimension reliabilities varied from 0.89 (Empathy) to 0.94 (Emotion Regulation); reliability for ratings averaged across the four dimensions was 0.92 (see Table 6). This indicates that, for this rating task, single raters might be sufficient for rating Emotion Regulation, Empathy, Self-reflection, Mental Representation and combined ratings. This indicates higher interrater reliability than a previous research rating of 4-min segments for each of the dimensions: 0.69 (emotion), 0.88 (empathy), 0.85 (self-reflection) and 0.91 (mental-representation; Robinson and Elliott 2016).

3.2 | Inter-Dimension Associations

Inter-dimension correlations were analysed for all three raters (Pearson correlations) across the four processing dimensions. All four dimensions were highly significantly correlated with each other: this varied from $r = 0.90$ ($p < 0.001$, empathy and self-reflection) to $r = 0.95$ ($p < 0.001$, empathy and mental representation; see Table 2). The overall inter-dimension reliability statistic (Cronbach's alpha) was 0.97. These point to a high degree of overlap, indicating that the four items of the CEPS-AS are not in fact independent dimensions but rather are closely interwoven components of emotional processing.

3.3 | CEPS-AS Processing Change Across Therapy

3.3.1 | Overall Emotional Processing

Overall results are presented in Table 7 and Figure 2, and the four subscale results are presented in Figure 3. A two-way repeated measures ANOVA indicated that the main effect of modality was significant, $F(1, 8) = 39.66$, $p < 0.001$. The effect size for modality (regular session vs. IPR session), as measured by Cohen's d, was $d = 2.20$, indicating a large effect size. The main effect of time was also significant, $F(1, 8) = 257.9$, $p < 0.001$, with a very large pre-post effect size ($d = 5.68$). There was no interaction effect for modality and time, $F(1, 8) = 0.69$, $p < 0.432$. For significant reliable change, seven out of the nine participants showed significant reliable change on emotional processing overall, although only four of them crossed the 3.5 boundary for clinically significant change by T3.

3.4 | Illustrative Case Study

Having presented the results from the outcome data, we now present a case study that illustrates how Neuro-EFGT looks in a neurodivergent adult person within a small group alongside other neurodivergent members. The case has been de-identified by changing the client's name and age; no further

TABLE 5 | Time and modality effect for CEPS-AS ratings.

CEPS-AS dimensions	T1		T2		T3		T4		*F*	*F*	*F*
	M	SD	M	SD	M	SD	M	SD	Modality	Time	Modality × time
Emotion regulation	1.42	0.28	1.86	0.52	3.24[a]	0.48	4.04[a,b]	0.67	23.95** (df 1,8)	171.93** (df 1,8)	1.51 (df 1,8)
Empathy	1.83	0.20	2.40[a]	0.30	3.28[a]	0.40	4.0[a,b]	0.66	29.03** (df 1,8)	116.87** (df 1,8)	0.39 (df 1,8)
Self-reflection	1.66	0.28	2.51[a]	0.45	3.40[a]	0.42	4.29[a,b]	0.58	38.02** (df 1,8)	156.50** (df 1,8)	0.02 (df 1,8)
Mental representation	1.82	0.20	2.43[a]	0.38	3.65[a,b]	0.41	4.20[a,b]	0.67	24.26** (df 1,8)	135.81** (df 1,8)	0.05 (df 1,8)
Overall	1.68	0.19	2.30[a]	0.35	3.38[a]	0.41	4.16[a,b]	0.52	39.66** (df 1,8)	257.9** (df 1,8)	0.69 (df 1,8)

[a]Pre–post reliable change (T3 vs. T1 and T4 vs. T2).
[b]Significant pre–post change (past 3.5 cut-off).
**$p < 0.01$.

TABLE 6 | Case illustration of CEPS-AS ratings showing change across therapy.

Index	RECI (min) for $p < 0.05$	Cut-off	T1	T2	T3	T4	T4-T1
Emotion regulation	0.61	3.5	1.40	2.29	4.0[a]	4.33[a,b]	2.93[a]
Empathy	0.46	3.5	1.93	2.79	3.75[a]	4.29[a,b]	2.36[a]
Self-reflection	0.69	3.5	1.83	2.17	4.16[a]	5.0[a,b]	3.17[a]
Mental representation	0.45	3.5	1.77	2.58	4.11[a,b]	4.50[a,b]	2.73[a]
Emotional processing	0.46	3.5	1.73	2.46	4.01[a,b]	4.53[a,b]	2.8[a]

Note: Minimum amount of pre-post change to meet a $p < 0.05$.
[a]Reliable change.
[b]Significant reliable change.

TABLE 7 | Autistic adult experiences of Neuro-EFGT.

Main theme	Subtheme	Illustration
Developing my sense of me with you	Sharing painful experiences together Seeing me as others do I got them and they got me	I didn't really open up or talk to anyone before. Hearing others helped me open up Seeing myself every week and hearing others saying things about me is when things started to change I don't like to be with other autistic people because of really painful childhood experiences. I'm more palatable to other autistic people now.
Living life beyond the group	Seeking emotional 'mastery' Being kind to me Making sense of what I've learned and moving on	It has left me looking at my emotional responses to other people more intently, questioning why I'm responding that way, and reflecting on whether my emotional responses to others is helpful for me. I was hard on myself, but I began to recognise my loving side as well as being protective. Now, I recognise these traits in me. I worked out that my loudness and dominance are signs of my anxiety. I accept this now, it makes sense to me.
An overall affirming experience	The wonder of EFT group EFT Therapists are warming guides Just want more of it A little tweak here and there	It's good, it's really, really good. I found EFT a singular comfort in a week. You's were really good at engaging us when we weren't really wanting to, and I found that really helpful. If we could carry on, and keep going, I'd be there! The ability to look at yourself, over a longer period of time might be useful, but beyond that I think that it's great.

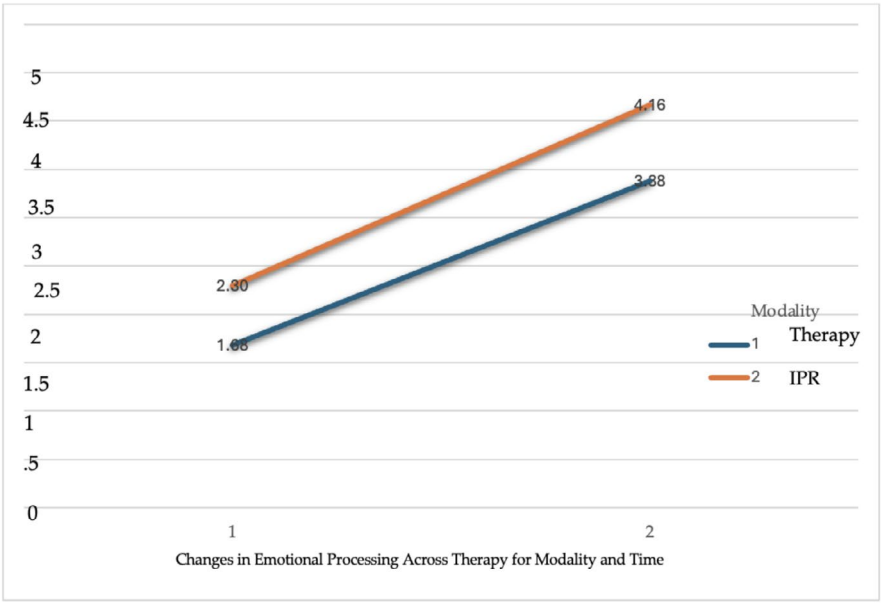

FIGURE 2 | Changes in emotional processing overall for modality and time.

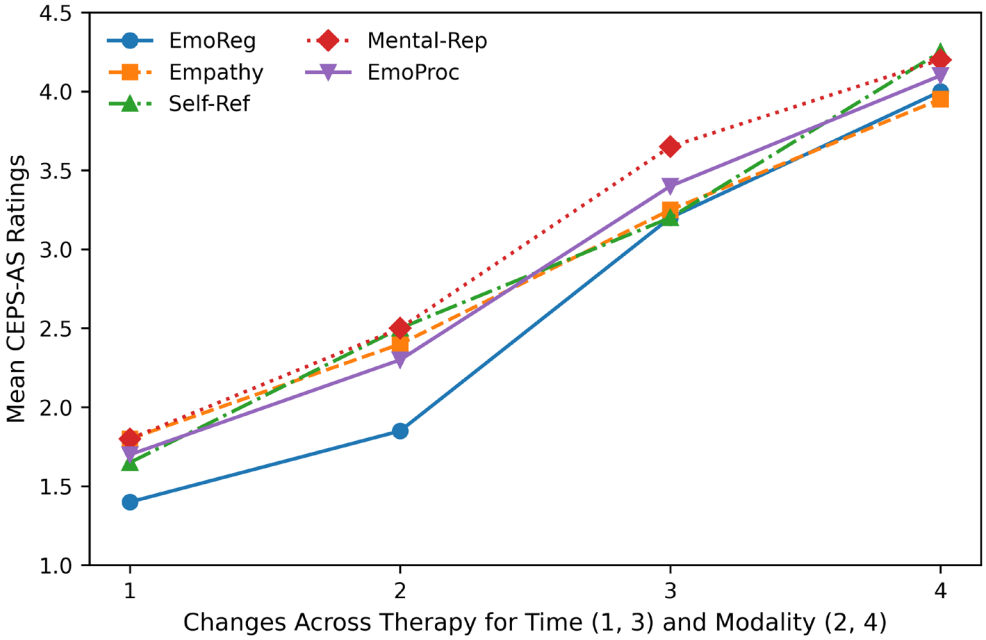

FIGURE 3 | CEPS-AS ratings for time and modality.

personal information was used. The following presents the case of Danny, a 28-year-old neurodivergent male, unemployed and living independently, who was diagnosed with Asperger syndrome at 8 years old and attention deficit hyperactivity disorder (ADHD) in adulthood. He self-referred to therapy for high levels of social anxiety, as well as for depressive symptoms, including despondency, hopelessness and isolation. Emotional regulation was also difficult, with Danny presenting with several impulsive, violent attacks resulting in injury to himself and others, which led to police involvement.

Danny's EFT group process lasted nine sessions and included a range of different kinds of emotion work (cf. Robinson and Elliott 2015). Danny entered therapy with a low level of emotional processing overall according to the CEPS-AS (see Table 4). Based on clinical impressions, a solid therapeutic alliance appeared to have been achieved in the beginning phase of therapy, while group cohesion appeared to have developed toward the end of the early phase of therapy (around session three).

Experiential tasks, such as allowing and expressing emotions, as well as deepening interoception through movement and breathwork (e.g., the step-out technique, see Robinson and Kalawski 2023), appeared to facilitate better emotion regulation on the CEPS-AS across therapy: '... when my hands were going up and down, it seemed to help. You sweat a lot when you're warm, but if you can regulate your breathing, you can control your rate of sweat'.

In one session, Danny wanted to explore a recent episode he found confusing, where he had been unable to control his anger with his peers. This puzzling reaction was a marker for evocative unfolding. Using the EFT evocative unfolding task, Danny began to explore his experience and associated sensations and feelings, which helped unfold the trigger point that led to the episode that resulted in emotion dysregulation and violence:

Danny: They told me that I couldn't know, they dismissed me. How could I know because I was too young.

Therapist: Take me back to the night and talk me through it, slowly. Try to help me see what it was like for you.

Danny then slowly recalled what happened, going back to his feelings and sensations, moment by moment. In the next session, deepening his emotional processing by using IPR to unfold his emotional response, Danny reported while viewing the video,

Danny: I'm tense there, I can see how tense I am when I was saying that.

Therapist: You were tense there? I wouldn't know that without you saying.

This led to new insights and self-reflection:

Danny: Oh! You can't tell ... Maybe that's the problem. People can't see me. I'm hard to read ... I wish they could see me. See my signs, see me getting anxious. Help me before I explode.

This change in Danny's understanding was apparent on the self-reflection and the mental representation subscales, with Danny developing his self-reflection and his thinking about how others think about him.

In a later session, the EFT version of Focusing helped Danny connect to feelings of early lonely abandonment by slowing down, turning his attention inward and attending to unclear bodily feelings:

Danny: While I was doing that, a feeling was coming; like water on my face, fluid, a wet sensation, all around my face. Like inside pushing to get out.

This emerging insight progressively helped him access, express and symbolise his avoided difficult emotions:

***Danny*:** I was the one who could have been successful, it was my thing. Kayaking was my thing. I'm angry at the lost opportunity. Why did she do that to me? I'm mad at her, and just beginning to realise how mad I am at her for doing that to me ... and sad for myself.

It was also necessary to help Danny reprocess specific traumatic early childhood experiences and memories associated with shame and fear. Trauma did not present as an issue during intake, but recovering and reconnecting aspects of his memories helped Danny in making new meaning associations. Trauma retelling work was intertwined with the meaning creation work, which involved identifying and re-examining violated cherished beliefs:

***Danny*:** I'm not stupid, I'm not stupid! Maybe they're right, maybe I am stupid ... I was terrified that they were right that I was stupid, and I was wrong. I was absolutely terrified I spent 25 years hating everyone.

Enactment tasks using two-chair, empty-chair and self-compassion chair work were offered for working with anxiety, self-criticism, self-interruption and anguish (e.g., Elliott et al. 2025). While each active client engaged in one or all enactment tasks to varying degrees and at different stages across therapy, the observing clients were able to offer both cognitive and affective empathic conjectures about others, as well as mental representations and compassion. During chair work for a self-interruption split, Danny (as the experiencer) said:

***Danny*:** I want help. I need help. If I'm going to get through this, I have to let them help me.

***Therapist*:** Right ... I need help ... right, mm-hm. Can you move over here? (Client changes chairs). What does this side—What does he say to this?: 'I need help, I'll never make it without help?, this desperate part of you crying out for help?'

***Danny (as interrupter)*:** You can't ask for help! Don't you dare ask for help! You'll have to do it alone, don't let them see.

***Therapist*:** Mm-hm. Don't let them see that you need help ...

***Danny*:** I'm just trying to warn you of the consequences. Don't let them see that you need help.

***Therapist*:** Right, don't let them see ... because ...?

***Danny*:** They'll see it. They'll see that they were right all along ... They'll all see how stupid you are. That you're not clever and that you're stupid.

***Therapist*:** Right, so in some way, I want to protect you.

***Danny*:** I'm warning you, to keep you safe. Safe, from the hurt.

Self-compassion work is often used in combination with empty-chair dialogues with significant others ('unfinished business') and two-chair dialogues with the inner critic. Below is an example of the client receiving compassion from another group member, facilitated by the therapist:

***Therapist*:** I hear how terrifying that is for you, to be stripped of your intellect ... it feels scary. [Speaking to the rest of the group:] Would anyone like to say anything to Danny?

***Liam*:** I was bullied and attacked at school for being what they said was 'stupid', because I was different. It sounds like this, you're frightened of what others think about you, it's affected who you are. I get that.

As the active client, Danny was able to enhance his own emotion-regulation and self-reflection, whilst the observing clients were able to offer both cognitive and affective empathic conjectures.

3.5 | Qualitative Analysis of Autistic Adult Experiences of Neuro-EFGT

Following the illustrative case study, we report autistic adults' experiences of Neuro-EFGT based on a qualitative analysis of post-therapy follow-up interviews. Table 5 presents the main themes, subthemes and illustrative quotations.

The first theme, 'developing my sense of me with you', comprises three subthemes: 'sharing painful experiences', describing the group's healing function; 'seeing me as others do', highlighting the impact of visual imagery and peer feedback; and 'I got them, and they got me', reflecting growing connection and empathy. The second theme, 'living life beyond the group', also includes three subthemes: 'seeking emotional mastery', referring to ongoing emotional understanding; 'being kind to me', describing shifts toward greater self-compassion; and 'making sense of what I've learned and moving on', capturing post-therapy meaning-making. The final theme, 'an overall affirming experience', contains four subthemes: 'the wonder of the EFT group', expressing positive overall impressions; 'EFT therapists are warm guides', describing the empathic therapeutic stance; 'just want more of it', reflecting a desire for longer therapy; and 'a little tweak here and there', offering suggestions for improvement.

4 | Discussion

This is the first outcome study of a brief, small group protocol for neurodiversity-affirming Emotion-Focused Therapy for clients on the autistic spectrum (Neuro-EFGT; Robinson and Elliott 2017). Using within-session CEPS-AS ratings as a process-based outcome measure, the study aimed to examine change over the course of therapy in areas of emotional processing for self and others in autistic adults. This is the first study to report outcome findings of Neuro-EFGT. The results showed a high degree of change in four inter-related dimensions of self and other empathy and across emotional processing in general. The main effects for modality (regular therapy sessions vs. IPR sessions) and time (early vs. late therapy) were significant and large, but the interaction effect between them was not. There were orthogonal independent effects for modality and time, with regular sessions and IPR sessions being parallel to each other; their effects were additive. There was no interaction effect between modality and time, but both progressed in the same direction, with time having a larger effect than modality. Clients processed slightly more than a half a point higher in IPR sessions than they did in regular group interaction with each other. Further, we found that clients in

this study processed approximately a point and a half higher at the end of therapy than they did at the beginning of therapy, according to the CEPS-AS.

For autistic adults, Neuro-EFGT first appeared to have helped clients improve their emotional processing via IPR; the therapy-IPR cycle was then repeated four times across therapy. By the end of therapy, clients had, on average, moved their emotional processing up from 1.7 at T1, indicating a low level of processing, to 3.4 at T3, a moderate level of processing on the CEPS-AS. Clients' overall emotional processing improved in regular therapy sessions, but they showed enhanced processing in IPR sessions across therapy. Our findings demonstrate that clients can make use of the IPR as a helpful resource in therapy as they move up from 2.3 in the first IPR session to 4.2 in the final IPR session, indicating large effects across therapy. As the regular therapy and IPR session scores moved up in parallel to one another and did not cross for all processing dimensions, it seems that each modality had a positive incremental effect; in fact, it could be hypothesised that one scaffolds the other.

Our case illustration offers further insight here. Some clients may experience alexithymia, with rates as high as 66.2% in autistic adults presenting at specialist ASC clinics (Albantakis et al. 2020). Neuro-EFGT uses video-IPR in each alternate session. These visual moments (markers) enable clients to view themselves sharing their experience and responding to other group members from the previous session. Autistic people's episodic memory difficulties are thought to be related to retrieval mechanisms and are most prevalent when unsupportive questioning interventions are used (Desaunay et al. 2020). When playing video-IPR markers during therapy, we noted that these appeared to support the client's capacity to recall what may have been lost through episodic memory difficulties. Further, these video reminders acted as a support to elicit emotional responses in the IPR session. The emergent qualitative category, 'seeing me as others do' shows how important autistic adults found seeing themselves and the role this played in their change process. This was linked to softening one's critical attitude to self, and promoting kindness and self-acceptance, as shown in another emergent subtheme, 'being kind to me,' promoting a more positive autistic identity, which in the literature is associated with improved mental health and well-being (Davies et al. 2024). Further, video-IPR markers helped clients to access their emotions, which they could then unfold and process in the session. Unfolding, labelling and describing emotions address alexithymia difficulties as well as facilitating meaning creation, supporting the development of self-formation (i.e., how the self develops and reorganises through emotional processing; Greenberg 2011). The subtheme 'seeking emotional mastery' shows how autistic adults developed their emotional understanding, meaning making and mastery over their emotion regulation. To understand IPR further, in our programme of research we are exploring markers in collaboration with autistic adults.

This sample of autistic adults had sought therapy for social isolation, emotion dysregulation, interpersonal conflict, anger management, anxiety and depression. However, during therapy, we found eight of the nine clients revealed traumatic interpersonal experiences resulting from misempathy within neurotypical–neurodivergent encounters where they had felt stigmatised and othered (Robinson 2018). Although trauma is not always recognised as a presenting issue with an autistic spectrum presentation, trauma not yet in awareness or formulated was unfolded through exploration, uncovering painful triggers and shared trauma experiences. Our findings support previous trauma research, with all participants except one reporting trauma associated with interpreting social situations, increased rates of stigma, social exclusion, victimisation and bullying (Han et al. 2022; Trundle et al. 2023). Further, we found that guided exploration of shared painful experiences could strengthen emotion regulation, as well as facilitate self-formation and emotion transformation. This, too, led to interpersonal connection, a sense of shared belonging and accurate empathic conjectures. The subtheme 'sharing painful experiences together' shows how these autistic adults opened up when sharing together and learned from each other's painful experiences. We recommend that therapists be aware that autistic clients are likely to have experienced interpersonal trauma, but this may not be formulated within their awareness as a trauma narrative. Helping clients to access, unfold and transform emotions connected to trauma is a key therapeutic task in this therapy.

The therapeutic alliance is one of the key variables to a positive therapy outcome (Flückiger et al. 2018). We propose that this can be effectively achieved within Neuro-EFGT. The subtheme 'EFT therapists are warming guides' shows how autistic adults found the empathic stance of the therapist important. This aligns with previous research that therapist acceptance and understanding were seen by autistic adults as critical for therapy success (Mazurek et al. 2023). We found that Neuro-EFGT offers an ongoing space to scaffold mutual understanding and support among neurodivergent individuals. The subtheme 'I got them, and they got me' shows how empathy between group members develops and can reframe painful experiences. This aligns with peer support being a valuable mechanism for autistic people to cultivate a positive autistic identity (Davies et al. 2024). We are arguing that this shared meeting of minds enhances empathic resonance between neurodivergent clients, as shown in the case illustration, as well as the emergent themes. Clients' shared experiences help normalise and reduce feelings of difference and being alone in one's pain. They also support compassionate responses from self and others in the group (Robinson and Elliott 2017), as well as providing opportunities for soothing painful emotions from trauma-related experiences (Robinson 2018).

This study has several limitations. We explored how, in autistic adults, self-empathy and empathy for others changed within small-group EFT. This is a preliminary outcome study, and, as such, it is too soon to make strong claims for its effectiveness. The sample size was restricted, based upon the experiences of nine autistic adults and limited to the work of only two therapists, thus limiting the generalisability of the findings. It could also be argued that the positive effects are biased, as one of the raters was also the therapist and one of the developers of the Neuro-EFGT protocol. This may be viewed as a limitation, but it is an essential step when trialling an adapted mental health intervention. The next steps in this programme of research are first training other therapists to deliver the approach, then conducting a larger open clinical trial or series of controlled single-case studies using a range of baseline and post-intervention assessments. Such a more controlled design would enhance

confidence in the pre-post findings we have presented here. Randomised control or comparative group designs are further steps beyond this.

There are limitation concerns regarding the representativeness of the sample to the broader autistic population. First, the study was conducted in a specific cultural context (i.e., Scotland) and may or may not generalise to other cultural contexts. Finally, the findings cannot be generalised beyond autistic adults who have characteristics similar to the participants in this small sample. The sample did consist of additional neurodivergences (e.g., ADHD), which is increasingly recognised as a common feature for autistic adults. Screening and controlling for additional neurodivergences would also be important next steps.

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Ethics Statement

The study was granted ethical approval from the University Ethics Committee at the University of Strathclyde. All participants were provided with full disclosure of the study.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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