**Title: “*I felt like I deserved it because I was Autistic*”: Understanding the Impact of Interpersonal Victimisation in the Lives of Autistic People**

**Running title: Interpersonal victimisation in Autistic Adults**

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**Keywords:** Autism, stigma, relationships, victimisation, masking

**Abstract word count:** 187

**Manuscript word count:** 5993

**Lay Summary word count:** 248

**Acknowledgements**

We would like to thank Alexandra Mitchell, Conte Apostoulou and Rachel Wilson for their help with transcribing the data on this project. We would also like to thank everyone who took part in this research for sharing your stories with us, and trusting us to represent your experiences accurately.

We would also like to thank Dr Monique Botha for their comments on a previous draft of this manuscript.

**Declaration of Conflicting Interests**

There are no conflicting interests to declare.

**Funding**

The author(s) received no financial support for the research, authorship, and/or publication of this article.

**Data Availability Statement**

The data for this project is not freely available due to the nature of the topic and the potential for identification of participants based on their data.

Supplementary materials, including interview questions, anonymised quotes and an additional report on findings are available on the Open Science Framework <https://osf.io/fs9nd/>

**“*I felt like I deserved it because I was Autistic*”: Understanding the Impact of Interpersonal Victimisation in the Lives of Autistic People**

**Abstract:**

Research suggests that there is a high prevalence of interpersonal violence and victimisation (IPV) within the autistic population, and that this accounts for poor mental health outcomes. This study aimed to examine the impact of IPV on autistic adults from their own perspective, and explore what helps or hinders their recovery. One hundred and two autistic adults completed either an online survey, or a spoken interview about their experiences of IPV. We analysed the data using a thematic analysis, and found four themes: 1. *The usual for autism* (expectations of victimisation, experiences of othering), 2. *Personhood revoked: The cost of living* (being part of a neurominority, trauma, masking, and burnout), 3. *Unpacking the baggage* (impact of hermeneutical injustice) and 4. ‘*If you want to make an apple pie from scratch, you have to invent the universe first’* (structural inequality/power dynamics, support, community). Findings highlight the importance of considering the relationship between stigma and victimisation, and the relationship between trauma, masking, and burnout in autistic people. Reducing barriers to support and recovery are contingent on reducing structural inequality and providing better training about autistic people to frontline professionals.

**Introduction**

Autistic people experience interpersonal violence and victimisation (IPV) at an alarming rate, with estimated prevalence between 50-89% (Papadopoulos, 2016; Griffiths et al. 2019), including exposure to polyvictimisation (repeat instances of IPV) (Fardella and Weiss, 2018). IPV is characterised by the experience of violence and abuse (including emotional and physical harm, sexual violence, and financial exploitation) within interpersonal relationships, e.g. friendships, intimate partnerships, and families (Fardella, Burnham-Riosa, and Weiss, 2018). The prevalence of IPV may explain higher rates of Post-Traumatic Stress Disorder (PTSD) within the autistic population (Reuben, Stanzione and Singleton, 2021), and has been related to poor mental health outcomes (Botha and Frost, 2020; Reuben et al. 2021). Thus, it is essential that we understand the impact of IPV among autistic people, and how to support autistic adults who have been victimised by familiar others.

Stigma may help to explain the high prevalence of IPV and its associated impact among autistic people. Stigma is the labelling of an individual or group as inferior or discreditable based on ‘undesired differentness’ (Goffman, 1963; Herek 2009). Autistic people are stigmatised at both the group level, due to negative perceptions of autism, and at the individual level for failing to meet normative expectations (Botha, Dibb and Frost, 2020; Perry, Mandy, Hull and Cage, 2021). First-hand accounts of IPV in autistic adults have highlighted a relationship with masking and concealment of autistic identity (Forster and Pearson, 2019), and heightened compliance (Pearson, Rees and Forster, 2022) – both of which are a response to stigmatisation and normative expectations (Milton, 2016; Han, Scior, Avramides and Crane, 2021).

The impact of stigma can be best understood through an integrative approach (Frost, 2011) as a multi-faceted phenomena embedded within the external social context. Frost’s (2011) process model of social stigma and its consequences (see figure 1) accounts for the relationship between how stigma is perpetrated and experienced, alongside responses and associated outcomes, acknowledging the role of structural inequalities. Frost’s model encapsulates the enhanced stress burden that stigmatised populations experience, termed ‘minority stress’ (Meyer, 2003). Botha and Frost (2020) examined the impact of minority stress on wellbeing outcomes in autistic people (Botha & Frost, 2020), who constitute a ‘neurominority’ (Bertilsdotter-Rosqvist, Stenning and Chown, 2019). They found that autistic adults were more likely to experience negative events (including victimisation), which predicted lower mental wellbeing and heightened psychological distress. This study highlighted how social marginalisation impacts mental health in autistic adults, accounting for the social context that they occupy.

**Figure 1**: Frost’s (2011) Process model of social stigma and its consequences (reproduced with authors permission).

Thus, exploring IPV through the lens of minority stress and social stigma contextualises the experiences of those victimised as it places the increased risk of negative events outside of the individual (into the situation), instead of emphasising personal vulnerability (Mathews, 2018; Shakespeare, 2012). This is termed ‘situational’ vulnerability and acknowledges that fluctuation in personal circumstances for any person may result in a marginalised social status through events such as unemployment or social isolation (Rogers and Lange, 2013). Previous research suggests that trying to understand IPV through the lens of autistic social difficulty is both limiting, and ableist as it blames the victim for failing to ‘spot’ manipulation while ignoring contextual factors (Fardella et al. 2018; Pearson et al. 2022).

The aim of the current study was to expand on previous research and examine the impact of IPV on autistic adults. Here we use a phenomenological approach to explore impact and outcomes, barriers to support, and facilitators of recovery, using Frosts process model of social stigma to underpin our interpretations.

**Method**

***Participants***

We recruited 102 autistic (mean age = 37.8, range = 19-73) adults through snowball sampling on social media and personal networks (i.e. KR administrates several support groups). Our advert stated that we were looking for autistic adults (18+, self-identified welcome) to take part in a study on experiences of victimisation within relationships.

Seventy-two participants were clinically diagnosed (average age at diagnosis = 31.2, range 3-70) and 30 were self-identified (average age at self-identification = 32.6, range = 16-60). Eighty participants had multiple diagnoses alongside autism, such as depression (31), anxiety (39), Attention Deficit Hyperactivity Disorder (ADHD, 27), and PTSD (18). Ten people also reported Fibromyalgia (4), or Ehlers-Danlos Syndrome (6). Ninety-eight participants reported their primary form of communication as speaking, and 4 as non-speaking (full demographics are listed in Table 1).

This study received ethical approval from the University of Sunderland research ethics committee (application reference 006740).

**Table 1**: Participant demographics

***Methodological Approach***

*Research Questions*

We had three main research questions:

1. What is the impact of IPV on autistic adults?
2. In what way does IPV impact on, and relate to, autistic identity?
3. What kind of support is needed in helping autistic people recovering from victimisation, and what are the barriers to effective support?

*Interviews*

We provided 2 modalities (written or spoken) for study participation, designing a structured interview schedule for written online data collection (see supplementary materials). We used the same schedule during the spoken interviews, however due to the nature of these interviews we allowed a more flexible structure to account for the natural flow between questions and the participants’ response.

In both formats no answer was compulsory, so that participants did not feel pressured into providing a detailed account of their experiences. While it is important to establish the prevalence of different forms of IPV, this was not the focus of the current study. As such, we felt that asking people to supply this detail was unnecessary.

*Analytic Approach*

We analysed the data using reflexive thematic analysis (Braun & Clarke 2006; 2020) with a blended inductive/deductive approach. We used reflexive thematic analysis to facilitate a flexible yet detailed interpretation of the dataset, and a blended approach to facilitate consideration of the data in relation to Frost’s model (2011), alongside new interpretations that arose during the coding process. We drew upon a critical realist framework (Bhaskar 2010; Botha, 2021; Kourti, 2021) in our interpretations of the data. We remained mindful that our positionality may influence our own interpretations, as an autistic team with lived experience with IPV.

The first author read through the dataset of each participant multiple times to familiarise themselves, making annotations against salient statements, then coded the transcripts using Nvivo 12, referring back to these annotations. We used Frost’s process model of social stigma (Frost, 2011) to produce deductive codes, whereas inductive codes were produced in an open and organic manner (Braun & Clarke, 2020) throughout the coding process. The majority of the coding was completed at the semantic level, however some of the coding drew upon more latent content (see figure 2). Throughout the coding process the first author engaged in reflexive consideration of their interpretations, discussing these and their own positionality with the remaining team members (who also engaged in reflection of how their own experiences and knowledge may impact interpretations). After all of the data had been coded, AP and KR discussed and grouped these codes into initial themes. We then refined these themes and named them. The final author provided discussion and feedback throughout this process.

***Procedure***

One hundred participants completed the interview in written format, and two participants gave spoken interviews. Participants completed the written version using a Qualtrics survey. We presented them with a detailed information sheet outlining the aims of the study, the questions we would ask, and why we were asking these questions. We provided detailed information due to the sensitive nature of the study. We provided participants with the contact details for the lead researcher, and support services (i.e. Samaritans). After reading, participants clicked to confirm consent, agreeing that they were a) 18 or older, b) knew they could withdraw at any time during the study, and c) wanted to proceed. Participants completed demographic questions (about both themselves, and aspects of their experiences) first, followed by the interview questions. For each question we prompted participants to provide as much detail as they wished, and to provide context where they thought necessary. Finally, we thanked participants for their time, and restated details for the researcher and support services.

The two spoken interviews took place over Zoom, and participants gave consent to record these interviews. We sent the information sheet in advance, and went over this at the start of the interview. After completing the interview the researcher thanked the participants for their time, and gave them the opportunity to ask any questions. The researcher followed up with these participants by email a day later to check how they were feeling and to ask if they had any further questions.

***Community Involvement Statement***

This project was conducted according to the practice based AASPIRE guidelines (Nicolaidis et al. 2019). The project team (all named authors) consisted of two autistic academics, and one autistic community partner.

**Results**

There was extensive variation in the amount of detail participants provided; some people gave very short responses (e.g. a line of text) whereas others provided multiple paragraphs. The two spoken interviews lasted 50 and 90 minutes respectively.

We asked participants for basic descriptive information about their experiences, such as whether the perpetrator knew that they were autistic (see table 2). The majority of participants first experienced IPV in childhood. The most common perpetrators were friends or family members. Around half of the participants reported that the perpetrator was not aware that they were autistic, and most people were not sure whether the perpetrator was also neurodivergent (we use the same definition as Chapman and Carel (2022) to include cognitive, neurodevelopmental, and psycho-social disabilities).

**Table 2**: Frequencies reported in response to descriptive questions about characteristics of victimisation experience

***Thematic Analysis***

We identified 4 main themes in the dataset (see figure 2). These themes comprised both inductive and deductive codes. We provided each participant with a pseudonym, which we use here to identify the quote.

**Figure 2**: Themes and sub-themes, with examples of semantic and latent codes and associated quotes.





1. ***The usual for autism***

Many of the people who took part in this study described their experiences of victimisation as a standard expectation for life as an autistic person, as Rena reported *“I think my experiences are pretty standard”.* Many people reported not realising that what they had experienced was abuse until long after it had happened due to how normalised it was, *“I thought it was normal that I was treat (sic) the way I was, and by the time I recognised it was not right, I had already overcome that chapter of my life”* (Charlie). These repeated instances of victimisation often started in childhood, as Lidia wrote, “*I experienced near constant victimization by parents, teachers, classmates, co-workers, bosses, strangers, etc from the time I was very young.”* They also continued across the lifespan, *“For the past 50 years…Some have robbed me; some have battered me. I learned that damn few people reciprocate kindness.”* (Wilford).

Within this perceived normalisation we identified two sub themes, which centered on a) the belief that this treatment had been deserved, and b) the experience of being labelled and treated as ‘other’ regardless of outsider knowledge of autism diagnosis.

* 1. *‘I thought I deserved it’: Expectations of additional stress burden*

The expectation and normalisation of a higher stress burden was associated with the feeling that this was deserved:

 *“I felt like I deserved it because I was autistic”* (Leigh)

*“I thought at the time that I deserved to be treated like that”* (Charlie)

For others, repeated negative experiences led to the view that there must be something wrong with them for people to treat them poorly, “*Made me feel there must be something wrong with me because it was so common. Learned to think of myself as a monster”* (Sophia).

Internalising the belief that they were somehow the cause of their own abuse, prevented participants from realising that what was happening to them was not normal, or deserved.

* 1. ‘What’s wrong with you, then?’

The participants’ perception of feeling like there was something ‘wrong’ with them was not unfounded. Many participants reflected on the way that other people had perceived and labelled them as other, regardless of whether there was an explicit awareness that they were autistic:

*“this happened a lot…before I was diagnosed with anything like, so like ‘howay then what's up with you’…that was quite upsetting”* (David).

*“I must have done something to cause it because I was seen as a weird kid”* (Aarjun)

These experiences also led participants to expect dehumanising treatment from others:

*“It’s also hard to believe people don’t see me as subhuman, as I’ve often been treated that way due to my disabilities”* (Catalina)

Some of the participants expressed feeling like the ‘odd one out’, *“How come if we’re all different, how come everybody else apart from me seems to get on with each other and socialize?”* (David).Similar feelings were reported across multiple people:

*“I just want to not be rejected and bullied for my autistic traits”.* (Rhia)

*“There are a couple of people who get it, but the majority don’t, nor do they try. Why would they? They are the dominant society and we are not part of it.* (Han)

Feeling othered was also related to the experience of disbelief from others about the scope of victimisation participants had experienced. Alex wrote: *“Either nobody believes you or they say "what did you expect would happen" so you learn not to even try’.*

Here participants were stigmatised for failing to meet normative expectations regardless of their label, and invalidated when they did try to seek help, facing either disbelief or blame.

1. ***Personhood revoked: The cost of living***

The experience of victimisation had led to the development of masking and associated survival strategies, as Lidia stated:

 *“(Masking) is a survival skill I have adapted and cannot turn off. It is a hard won battle scar that deflects potential future pain. It is hyper vigilance. I don’t choose to do it, sometimes I feel like I am watching my behaviour from outside myself like I’m on autopilot. But it is very exhausting nevertheless. And sometimes it even feels embarrassing and demoralizing”*.

This experience was described by some as beginning in childhood:

 *“Yes, I am the very definition of a ’people-pleaser’. The idea of someone being upset/annoyed/angry with me causes me great anxiety. I never knew as a child why people didn’t like me or why I didn’t fit in so I always tried my best to please them to try to make them like me.”* (Eva)

*“I’m trying to be more accepting of myself and of the fact that other people’s reactions etc are theirs- not mine to manage…It was a survival mechanism for the majority of my life and is hard to unlearn”.* (Sophia)

The impact of trauma was clear from the emotionally charged way people described their strategies to avoid harm:

 *“I feel like I must fulfil people’s expectations. If I don’t I will get into serious trouble. I live with a constant sense of dread…If they like me, they won’t try to harm me”.* (Scott)

But also from the way they described how it led to grieving for the person they could have been, as Laurie reflected, “*I had been robbed of so many opportunities to fully develop as a person*”. For some the only way to safely be themselves was to be alone, “*I can now, as a recluse, be myself…But before, it was all masking, all exhausting, all identity-denying”.* (Carter)

Many of the participants described the insidious relationship between masking and compliance, and the concept of ‘fawning’:

 *“The people pleasing has had such a lasting effect- the fawning response I think it’s called… politeness rules in my world, and I don’t always want to be polite. Politeness isn’t always called for”.* (Jasmine)

*“I fawn as a trauma response and I always try to never ‘rock the boat’”* (Ellen)

These experiences reflect the difficulty that many autistic people face trying to blend in and avoid harm. The strategies that facilitate survival (i.e. masking) are also risk factors for polyvictimisation (e.g. heightened compliance and fawning).

In addition to the more indirect cost of fawning, the exhausting nature of masking led to a energy cost. This resulted in burnout and extreme exhaustion for many participants, for example Noelle wrote:

*“I have been masking my entire life either for safety reasons or to enable myself to keep a job. Over time it has caused massive burnout…I haven’t fully recovered”.*

In contrast to perceptions of masking as a social strategy, the statements made here allude to the experience of masking as a survival strategy for many autistic people.

1. ***Unpacking the baggage***

Distinct from the exhaustion and burnout from masking, was the sheer emotional impact of victimisation itself. This was arduous and took time to process:

*“I’ve done a lot of work to unpack this baggage, I can’t be totally all negative, sometimes we don’t get rid of all of the trauma…I worked through that…I looked inside and said ‘what the fuck is going on here’?”* (Jasmine)

This impact was also evident in those who found it difficult to describe their own emotions (alexithymia): *“I’m alexithymic…I can describe that my body felt weighed down, defeated, tired.”* (Yaz)

Living with the emotional impact of repeated victimisations had also resulted in many people struggling to trust others, as Jean recounts: *“Either I’ve went all in trying to prove my love / am worthy, or I’ve lost trust and am just waiting for the proverbial sucker punch.”* This difficulty with trust was related to expectations of rejection, and often resulted in participants socially isolating themselves for fear of being harmed again, as Shawna wrote: *“I no longer do relationships or friendships”.*

*3.1. Finding the right words*

Having access to the right language to describe their experiences had a profound impact on many of the participants, providing a way to make sense of their experiences and create meaning out of what had happened to them.

*“I am the same with getting the terminology that came with autism, getting the terminology that came with the relationship abuse. It’s really important to be able to put names to the concepts and things”* (Jasmine)

*I didn’t really know how to talk about it. I didn’t have the right words and I just felt stupid”.* (Yvonne)

For many people, realising what had happened was a long and arduous process, and had led to feelings of confusion, shame, and anger:

*“It takes a long time to process what happened and an even longer time to process how to feel and react”* (Norma)

*“Angry, I guess. Wondering why I didn’t realize what was happening”* (Jamie)

For some people, realising they were autistic had helped them to make sense of their experiences and provided them a new lens through which to story their lives. For example, Rena wrote:

*“Knowing about the autism meant I could get appropriate help and begin to understand and therefore accept myself…I step away from people that have taken advantage of me, filtered out abusers and I learned what self-care and boundaries are”.*

Here the ability to make sense out of one’s own experiences was facilitated by self-understanding across multiple levels. It took extra time to process experiences, but this processing was facilitated by knowledge about one’s own identity, and having access to the right concepts to describe what had happened.

1. ***‘If you want to make an apple pie from scratch, you have to invent the universe first’***

Access to support and recovery was variable among our participants, and many did not see good support as plausible due to existing systemic barriers and structural inequalities, as Han wrote:

*“It requires a complete re-think of the way we view disability. Carl Sagan once said, that if you want to make an apple pie from scratch then you have to invent the universe first.”*

We identified three sub-themes here, focussed on power dynamics, good support and recovery, and the importance of community.

* 1. *An imbalance of power*

Power dynamics impacted on the experience of help-seeking. Some participants wrote about how power imbalances initially affected the relationships that they had ended up in, for example:

*“Because I could not support myself, I had to live with (and please) men who were willing to have a live-in girlfriend. This trapped me in relationships where I had none of the power. I had to keep them happy so that I could have a place to live and food to eat.”* (Jana)

The incidence of feeling ‘trapped’ through inadequate access to support was expressed by multiple participants and compounded by the expectation of abuse.

Multiple participants who had attempted to seek support after experiencing victimisation reported negative encounters with police officers, therapists, and other professionals:

*“The policed laughed at me, forced me to look into their eyes.”* (Enoch)

*“Victim Support were unbelievably useless. Psychologists, likewise….The Police, they - amazingly - believe my body language says I am lying.”* (Carter)

*“I was told I should admit myself to a mental health ward and they made my mental health so much worse and invalidated my pain and expression of pain even further… it only made things worse”.* (Leigh)

However these experiences were not universal, as one participant recounts, *“Working in the police, the men I worked with generally took it more seriously and helped gather evidence against the women bullying in case I decided to take it to a tribunal.”* (Aanya).

Here structural inequalities came into play for those seeking support. Those with existing support networks and links within organisations were able to access to support more readily. However for many participants there was a lack of both access to good support, and understanding from professionals.

* 1. *Acceptance and mutual respect; such a rare and precious thing*

For those who had gone on to receive support and start the process of recovery, good support had come from multiple sources. Some participants wrote about the importance of finding deeper relationships that went beyond surface sociality, and the experience of unconditional love and acceptance:

*“My current relationship with my life partner is based on acceptance and mutual respect; such a rare and precious thing. She respects my autistic identity…I accept her irritating but socially acceptable neurotypical ways and she accepts me for the human being I am.”* (Han)

*“We enjoy each other’s company and have very open communication and I know realistically outside of PTSD episodes that I can trust him with everything”.* (Lottie)

Some people acknowledged that poor experiences within relationships had helped them to recognise what a good relationship looks like, *“Since I have had negative experiences with relationships, both friendly and intimate, I now have an even better understanding than most of what a healthy relationship is”.* (Charlie)

In addition, some viewed it as an important lesson in learning about protecting their own boundaries:

*“It was the life of hard knocks- but those lessons were pounded in. I will never make the same mistakes I made with that past partner again. I recognise the red flags, you know, the warning signs”* (Jasmine)

Importantly, some participants expressed how important preventative strategies are for avoiding the need to ‘learn by experience’ about boundaries and healthy relationships. They emphasised early education about good relationships, and how to spot abusive behaviour:

*“It should start with teaching all children from very young ages about personal autonomy and what healthy friendships actually look like…We TELL kids that bullying is bad but society in general is all about making people feel othered until they fall in line with what’s considered ‘normal’…That’s how we learn how to mask even as undiagnosed autistics who don’t get ABA”* (Alex)

*“I wish there were services where you could go and check whether how you were being treated was normal.”* (Lottie)

For those who had sought therapy, they valued therapists who were open to using different ways to communicate, as Yvonne recounted:

 *“Provide different ways of communicating in therapy. I’m very visual and I paint. My current therapy allows me to bring in my current painting and then we can use that as a point to talk about all my shit”.*

Ideal forms of support included therapy with professionals who are ‘knowledgeable about autism’, something that many people reported as lacking, and professionals who offer multiple forms of engagement:

*“Professional people I know and trust can be talked to in a very short amount of time (hours to days), talking can also mean writing via chat or phoning or meeting in a park so I don’t have to go there by bus because that’s difficult.”* (Norma)

* 1. *Strength in numbers*

For many participants a connection to other autistic people provided a sense of support that they had not experienced elsewhere:

*“I did have an autistic social worker who helped me understand how I was being impacted and what steps I could take to slowly begin to recover a sense of control over aspects of my own life. That was an eye-opener”.* (Carter)

Others viewed autistic community support as one potential way to help those who have experienced victimisation to recover in an environment free of stigma:

*“It would be community-based, like support groups with other autistic people where we can relate to each other, validate each other, and figure out ways to face the world together, because I don’t believe victimization ends for us. It’s kind of an ongoing thing in a neurotypical world. The idea that trauma is just one event you can recover from and one day feel safe again is not really relevant when the world is not built for you, and in many cases, is actively built to harm you”.* (Luna)

*“Autistic only spaces are desperately needed more than anything else right now… realising the problem was never us just for existing it was always other people making us feel like we don’t belong, but we do.”* (Leigh)

However, others also emphasised the intersection of different communities, and finding overlapping spaces for support in each, “*Taking neurodivergence and queerness into consideration. One of the most difficult aspects about finding support is finding an intersection between acceptance of autism in adults and acceptance of queerness”* (Jamie).

In addition, some specifically emphasised political community connectedness (e.g. engaging in autistic advocacy), and the positive role that mutual advocacy work could play in support and recovery from victimisation:

*“Recovering comes from talking to other autistic people and fighting back as a community”.* (Kemp)

This highlights the importance that finding your community can play in recovery.

**Discussion**

The aim of the current study was to examine the impact of IPV on autistic adults within the context of the social process model of stigma (Frost 2011), exploring barriers and facilitators to support and recovery. Our findings highlighted the normalisation of the dehumanisation and violence that many autistic people experience, and how they attempt to cope with its impact. Here we discuss our findings in relation to existing literature.

Many of our participants had normalised the expectation of victimisation, believing that they must have done something to deserve it. The experience of stigma often leads to an expectation of rejection from others (Frost, 2011) and the internalisation of stigma, whereby negative external attitudes are integrated into our self-concept (Woods, 2017). Findings highlighted how these external attitudes had impacted participants through the process of othering, which occurred regardless of whether participants had a diagnostic label, or were simply seen as ‘weird’. Here our findings relate to the broader literature on IPV in disabled adults. In cases where extreme violence has been perpetrated against disabled people by known others, it has been preceded by othering regardless of perpetrator knowledge of disability (Quarmby, 2011). However this has made it difficult to prosecute perpetrators under disability hate crime legislation as they exhibit plausible denial of knowledge of the victims disability. This is also confounded by evidence that perpetrators are often themselves disabled (Quarmby, 2011), which again is echoed in our descriptive data which showed that a third of the participants had been victimised by other neurodivergent people. There are two important considerations here. The first is the need to develop knowledge on intra-community victimisation, and how to break cycles of stigma and violence within the autistic community. The second is how we reduce stigma and IPV across neurotype. Our findings suggest that interventions which focus on education about autism itself are unlikely to fully reduce stigma towards autistic people, as stigma goes beyond the label (Farahar, 2021). This may also explain why programmes to reduce negative bias towards autistic people are not as effective on reducing implicit bias (Jones et al. 2021).

The expectation of poor treatment from others had also led some of our participants to struggle with ‘spotting’ abusive behaviour, and it had taken many of them a long time to emotionally process events. This is consistent with the literature on IPV more broadly and not limited to autistic people (Pearson et al. 2022). However, some participants expressed additional challenges with understanding their own emotions (i.e. alexithymia), which had made it more difficult to identify, process, and deal with the emotional impact of their victimisation. These findings emphasise the importance of recognising factors that might impact on the processing of interpersonal trauma in autistic people, and developing good ways to support them.

For many, the meaning making process had also been impacted by hermeneutical injustice. Hermeneutical injustice refers to having access to shared knowledge that enables one to situate their social experiences (Fricker, 2007). Hermeneutical injustice is often experienced by people who face structural inequality and marginalisation, and is associated with epistemic violence wherein knowledge about a particular social group is obscured by the dominant societal viewpoint about them. Autistic people face epistemic violence frequently, both through outsider conceptualisations of autism pervading the public consciousness and furthering dehumanisation (Botha, 2021; Rose 2018), and these conceptualisations preventing an individual from gaining self-understanding. For many participants, being able to process their experiences was reliant on having the both the right words to describe what had happened, *and* the knowledge that they were autistic. This emphasises the importance of not only education around healthy relationships, but also improving access to diagnosis/identification and accurate information about what it is like to be autistic.

Perceptions of dispositional diversity (Milton, 2014) pervaded the responses, with both negative and positive implications. Whilst some participants wrote about having good cross-neurotype relationships, there was an overwhelming focus on feeling like an outsider, being misunderstood and othered. These experiences had led participants to engage in masking and concealment to avoid further victimisation, highlighting how masking can arise as a trauma response (Lawson, 2020; Pearson and Rose, 2021). This was particularly evident in the descriptions participants gave of fawning, people pleasing, and compliance, which is consistent with Pearson et al. (2022). Our findings here suggest that the relationship between compliance and victimisation can be a vicious cycle, whereby compliance develops as an attempt avoid further harm, but instead facilitates situational vulnerability to revictimization. Thus, it is essential that we acknowledge that interventions which focus on compliance training in autistic people are harmful (Bottema-Beutel and Pavlopoulou, 2021; Davison, 2018) and contribute towards risk of victimisation.

Participants highlighted a complex relationship between trauma, masking and burnout whereby trauma contributed to masking, masking contributed to burnout, and burnout contributed to being unable to mask further. Our findings support previous research highlighting the role masking might play in burnout occurring (Raymaker et al. 2020; Mantzalas et al. 2021). They also suggest that burnout can result from the interaction between different aspects of an increased stress burden associated with stigma (e.g. masking, stressful life events, etc). This relationship will be essential to examine in future research that aims to understand and ameliorate the impact of burnout.

The presence of structural inequalities (e.g. lack of healthcare access) created a barrier at multiple levels of the recovery process. Some participants struggled to leave abusive situations, and others who attempted to seek support found it was either not available, or compounded the harm they had already sustained. This is consistent with previous experiential accounts, where attempts to support distressed autistic people have led to further harm and trauma (Quinn, 2018). It is also consistent with the experiences of other minority groups (for whom neurotype might also intersect), who have reported how prejudice and biases (e.g. racism) pervade services and perpetuate additional trauma (Kulkarni, 2019; Sokoloff and Dupont, 2005. Our findings highlight the importance of ensuring good quality training (ideally developed and delivered with/by autistic/neurodivergent people) and continued professional development for those who might encounter autistic (and otherwise neurodivergent) victims within their line of work.

Finally, participants outlined the importance of community in providing support for those who have been victimised, and in providing education and a space to make-meaning and resist. Frost (2011) highlights how positive marginality can be a positive outcome from stigma, by which people re-frame perceptions of their community. This was emphasised by participants who outlined how important political community activism could be for building a more positive sense of identity. These findings support Botha (2020) who found that political community connectedness among autistic adults predicted lower internalised stigma and better mental health outcomes. More work is needed to examine how positive marginality might provide a healing space for autistic people, however the emphasis here on community support suggests that this is an area which might benefit from increased funding (i.e. grassroots organisations).

***Limitations***

The current sample was mostly racially and ethnically homogenous, and the majority came from Europe (specifically the UK, where the researchers are located) or the United States of America. Some participants referred to intersectional aspects of their experiences (i.e. being queer and autistic), thus it is likely this homogeneity limits how representative our findings are. Despite the goals of qualitative research not being generalisability, using findings to improve services makes diverse representation important.

Relatedly, though we had a small number of non-speaking participants it is important that research into IPV continues to explore and amplify the experiences of non-speaking autistic people, and those whose support needs might lead others to label them as ‘more vulnerable’. Community accounts (e.g. Montgomery, 2020) suggest that IPV is particularly rife for autistic people who have higher support needs and/or have experienced institutionalisation.

**Conclusion**

This study aimed to explore the impact of IPV on autistic adults, elucidating barriers and facilitators to support within the context of social marginality. Our findings highlight how stigma normalises victimisation, leading to internalised stigma and masking for autistic people. Support is scarce, and the limited support available is fraught with structural barriers, including a lack of understanding from professionals. Future work should focus on the improvement of training and professional development for those working in support services (i.e. police, therapists), and the removal of barriers that prevent access to these services.

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