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‘The girls are out there’: professional perspectives on potential changes in the diagnostic process for, and recognition of, autistic females in the UK

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There is widely growing recognition of autism in girls, and both researchers and community members have called for improvements in the diagnostic process. What is not yet known is whether these recommendations are being taken up by professionals. In this study, nine semi-structured interviews were conducted with a variety of professionals involved in the autism diagnostic process. The collected data were analyzed using thematic analysis. Three main themes were identified: gendered differences; lack of services; and informal change. Our study found that diagnostic professionals are aware of gender differences in presentation, and they make a range of informal adaptations to their processes for girls. While this is positive for those girls who interact with knowledgeable professionals, our data highlight the need for more systematic changes to ensure equality of access to diagnosis and post-diagnostic support.

Key words: autism, females, diagnosis, clinical practice

Autism is a life-long neurodevelopmental condition, diagnosed when an individual presents with difficulties with social imagination, social communication, sensory sensitivities, and with restricted or repetitive behaviors and interests (RRBIs). Historically there has been a perception that autism is predominantly a male condition, but this has been heavily scrutinized in the last decade, as it has limited the recognition of autism in girls and women (Sproston et al., 2017; Lai & Baron-Cohen, 2015).

Until recently, it was commonly accepted that females were rarely autistic, or that autism in girls was associated with severe intellectual difficulties (Happé & Frith, 2020). This began with the earliest autism research by Kanner and Asperger in the 1940s, whose samples were either solely male or only included a few females with learning difficulties (Young et al., 2018). Much autism research to this day continues to have a significant male bias in the participant group, which reinforces and reifies an androcentric view of autism. Although the existence of a female autism phenotype was suggested as early as the 1990s, it is only in the last decade or so that research has started to focus on gender differences in autism presentation (Kopp & Gillberg, 2011; Gould, 2017).

While it is true that autism is diagnosed more often in males than in females (Loomes et al., 2017), this does not automatically mean that females are less likely to be autistic. Rather, they are less likely to present ‘classically’; that is, with the specific difficulties listed in the diagnostic criteria. For example, autistic females tend to show more advanced socio-cognitive skills than autistic male peers, such as better knowledge of facial expressions and friendship rules (Lehnhardt et al., 2016; Tubío-Fungueiriño et al., 2020). Autistic females are also found to have more emotive vocabulary in their speech and be more inclined to interact with peers and have close friendships (Lai et al., 2015; Green et al., 2019). This is supported by Sedgewick et al. (2016, 2019), who found that on the Friendship Qualities Scale (FQS), autistic females rated their friendships similarly to non-autistic females, and showed similar social behaviors such as participating in gossip. Thus, the advanced social skills of autistic females are a challenge for many diagnosticians. Clinical psychologists, when interviewed about their conceptualisation of autism, said that they felt the presence of notable challenges in social communication and interaction was sufficient to receive an autism diagnosis, while other aspects such as sensory sensitivity or RRBIs alone were not (Muggleton et al., 2019). This could mean that autistic girls are missed because they do not fit with clinical assumptions of what autism ‘looks like’.

Indeed, many autistic females learn techniques that appear to mask typical autism traits, a process also known as camouflaging. These can include developing social scripts for interactions or tricks to give the appearance of making eye contact (Hull et al., 2020). This not only compromises their chances of being recognized and recommended for clinical pathways, but research has suggested that the additional stress and cognitive effort involved in masking increases the risk of developing depression and anxiety (Lai et al., 2017). Although camouflaging can and does occur in autistic males, studies have highlighted that it is heightened in autistic females (Wood-Downie et al., 2020). For example, when Lai et al. (2017) operationalized camouflaging by examining differences in an individual's 'external' presentations of social behavior and their 'internal' status, they found that autistic females engaged in more camouflaging than autistic males.

It is important to recognize the role of gender expectations when exploring the differences between autistic males and females, since all children learn to conform to gender-based rules from a very young age. According to Geelhand et al. (2019), how behavior is perceived is influenced by gender expectations, where traits such as shyness are expected more in females than in males, so cases of 'extreme shyness' in autistic females are more likely to be overlooked by professionals, and not result in referral or intervention.

These gender roles are also enforced in peer groups. For example, research has shown that boys who are solitary-anxious (that is, they withdraw socially due to shyness) are significantly more likely to be rejected by peers than solitary-anxious females, since being shy is the opposite of stereotypical ideas about men and boys as assertive and confident. This social exclusion of solitary-anxious boys can then result in them being more easily spotted by caregivers as struggling, leading to intervention and support that girls are less likely to get in the same situation (Geelhand et al., 2019). Therefore, the role of gender expectations heavily influences how the behaviors of autistic males and females are perceived and reinforces a male bias in the presentation of autism, as autistic females are more likely to be overlooked in diagnostic processes if they do not present with additional problems (Young et al., 2018).

There is a growing recognition of the importance of getting an autism diagnosis in a timely manner. Receiving an autism diagnosis is a profound moment in an individual's life (Leedham et al., 2020), both because it provides people with a framework for understanding and accepting themselves,

and because it enables them to access support. Previous studies have highlighted that good post-diagnosis support has a major impact on lowering levels of depression and anxiety among autistic people (Lewis, 2017). This is vital considering that research on late-diagnosed autistic individuals reported that up to 70% of individuals experience suicidal thoughts and 35% had planned or attempted suicide, significantly higher than same-age peers in the general population (Cassidy et al., 2014). Although this is an issue for all autistic individuals, recently diagnosed autistic women are significantly more likely to report high rates of suicide risk compared to autistic men (Zener, 2019).

Consequently, research has started to focus on the experience of late-diagnosed autistic women, with participants reporting significant mental health difficulties including suicide attempts and self-harm. They linked these to having difficulty understanding themselves, and a lack of agency when wrongly diagnosed with other conditions, leading to ineffective interventions (Leedham et al., 2020). Work by Bargiela et al. (2016) supports this link between lack of diagnosis, poor mental health and issues related to identity; for instance, adult autistic women reported finding it difficult to separate their authentic self and their 'mask', leading to anxiety, depression and vulnerability to abuse. Considering the links between camouflaging and internalizing problems highlighted by recent research (Cage & Troxell-Whitman, 2019), the delay in diagnosis because of masking may be contributing to the greater rate of mental health issues among autistic women when compared to autistic men (Sedgewick et al., 2020).

According to several studies, many autistic women feel their lives would have been easier if their autism had been recognized earlier (Bargiela et al., 2016; Harmens et al., 2022). However, as discussed, the diagnostic criteria and even diagnostic tools can present barriers to diagnosis, as they do not recognize the female autism phenotype (Estrin et al., 2021). In recognition of these barriers, there is a pattern across recent autism research of recommending adaptations to diagnostic systems to improve the diagnosis of autistic females.

Duvekot et al. (2016) emphasized the need to incorporate scoring items which reflect typical female characteristics, as well as recommending gender-specific cut-offs for the diagnostic tools. This is echoed by Dinkler et al. (2021), who argued that a questionnaire focusing on the female phenotype should be adopted rather than 'generic' measures, something which has been explored with

promise in other work (Haney, 2016). Furthermore, Muggleton et al. (2019) argued for the need to expand assessments to better identify the more subtle presentations of autism in social interactions.

Although plenty of literature has outlined the changes that could improve rates of autism diagnosis in females, no study has yet investigated whether real-world changes have been introduced into the diagnostic system.

To address this gap in the literature, the research questions were:

1. From a professional perspective, how has the autism diagnostic process changed for autistic females in the UK?
2. Have professionals adapted their practices either formally or informally when approaching young girls or women with suspected autism?

Methods

Participants

Nine professionals took part in this study, aged between 32 and 60 years (mean = 48.44, SD = 6.96). They were mostly female (88%) and had an average of 10 years 9 months of experience working in the area (participant information in Table 1 below). Data saturation was reached, with no new themes identified after six interviews.

Table 1: Participant characteristics

Pseudonym	Age	Gender	Job title
Jane	32	Female	Child and Adolescent Mental Health Services (CAMHS) nurse
Sarah	50	Female	Specialist teacher for children with speech, language and communication needs
Jessica	45	Female	Head of Inclusion at a secondary school
Alice	50	Female	Neurodevelopmental nurse
Sue	50	Female	Curriculum leader of an Additional Learning Needs (ALN) department
Calon	52	Female	CAMHS nurse
Pete	60	Male	Consultant child and adolescent psychologist
Katie	48	Female	Neurodevelopmental nurse
Rosie	49	Female	CAMHS Cognitive Behavioral Therapy (CBT) therapist

Recruitment took place through a mix of personal networks and snowball sampling, with participants informing colleagues in other roles in the autism diagnostic process about the study. This resulted in a participant sample representing a wide range of roles and providing insights into different stages of the process. Ethical approval was granted by the University of Bristol School of Education's Ethics Committee, and all participants completed an informed consent form and had opportunities to ask questions prior to the interview taking place. Participants were not paid for their time, nor were they provided with any incentives for participating in this research.

Materials

Demographic information about participants was collected at the time of interview.

The schedule for the semi-structured interviews was originally produced by the first author and was checked by the second author and an autistic person who prefers to remain unidentified. It was developed based on existing literature and researcher interest, and there were no major changes made in response to the checking by the autistic person. Questions covered similarities and differences in the experiences of autistic boys and girls, current professional practice, changes to their practice made by the professional, and wider reflections on the diagnostic process for girls. All participants were asked the same questions, and were asked all planned questions, with some differences in the follow-up questions. Participants were offered the opportunity to review their transcripts, but none did so.

Qualitative methods, and specifically semi-structured interviews, were chosen for this study because they offer scope for in-depth data collection. They also have the flexibility to respond and adapt to the information shared by participants, which is an advantage over the rigidity of an open-ended online questionnaire or similar.

Procedure

Participants were offered the option of being interviewed online via video calls, via phone call, or by live text chat. All participants opted for video calls. Participants were provided with the interview schedule prior to the session, so that they had time to think about their responses. All the interviews were conducted by one researcher and lasted on average 41 minutes (range: 25–62 minutes). Interviews were audio-recorded and transcribed verbatim, and then deleted once checked for accuracy.

Data analysis

Data were subject to inductive thematic analysis – without any predetermined themes based on existing theories, and as far as possible separate to the researchers’ preconceptions. This involved following the steps laid out by Braun and Clarke (2006): first, familiarization with the data by becoming immersed in the transcripts; and second, generating initial codes, which are later refined into super- and sub-ordinate themes in the third stage. Codes were initially based on semantic reading of the transcripts, with themes generated through grouping together similar codes. This portion of the analysis was initially carried out by the first author, as a condition of her BSc thesis, with the second author contributing to the fourth and further stages. In the fourth phase, ‘reviewing themes’, the authors worked together to ensure themes accurately reflected the content of the transcripts, following the second author’s independent review of the transcripts. Inter-rater reliability was not quantitatively measured, but all themes were discussed and agreed upon. The fifth stage is defining and naming themes, in line with the review in phase four, and the final stage is producing the report.

Positionality statement

The research was led by the first author, as it constituted the independent study portion of her BSc thesis. The first author was younger than the participants, meaning that the traditional power imbalance between researchers and participants was lessened, and rapport was easier to build. The second author acted as supervisor to the original project, as she has extensive research experience on the topic of autism in girls, and therefore brought this knowledge to her interpretation of results, but was not directly involved in conducting interviews.

Results

Three main themes were identified: gendered differences; lack of services; and informal change. We now look at each of these in turn.

Gendered differences

Across participant interviews, it was clear that many professionals either held, or were aware of, views which saw autism presentation as inherently gendered. This was often phrased as girls deviating from the male ‘norm’: for example, ‘*girls can present quite differently from boys*’ (Katie, neurodevelopmental nurse); ‘*they don’t present as males would*’ (Rosie, CBT therapist).

Participants focused on differences in social behaviors, challenging behaviors and restricted interests as key areas of gendered differences, often seeing these as more aligned with expectations of non-autistic girls:

'they do things to fit in with the other girls even if they don't quite know why people are doing it'.

(Sarah, specialist teacher)

'females tend to be stronger with the social communication stuff ... [they] might have the upper hand on their male counterparts'.

(Katie, neurodevelopmental nurse)

'boys tend to show behavioural problems whereas girls don't'.

(Jane, CAMHS nurse)

'they get very intense obsessive interests in their friends'.

(Calon, CAMHS nurse)

'obsessional interest in makeup ... for a 13-year-old girl in the past I think we would have passed that off as normal'.

(Pete, consultant psychologist)

This sense was strongly linked to the idea that autistic girls camouflage significantly more than boys do: *'females are very good at camouflaging their symptoms ... they tend to hide it well'* (Sarah, specialist teacher); *'eye-contact and facial expression ... girls may be more inclined to mask'* (Katie, neurodevelopmental nurse).

This camouflaging therefore meant that autistic girls did not 'look' autistic in the ways they had been trained to expect and did not match the classic diagnostic criteria (such as avoiding eye contact, or an inability to take part in social situations). In our participants' eyes, this contributed to them not being diagnosed: *'they just haven't been diagnosed' cause ... they have that kind of ability to fit in and hide'* (Sarah, specialist teacher); *'they're underrepresented because they're better at masking'* (Calon, CAMHS nurse).

These differences in underlying autistic behaviors, combined with the camouflaging girls were thought to engage in, were seen as interfering with normal (male-oriented) diagnostic processes, from the point of identification at school:

'[we need] SENCos and teachers to recognise girls earlier ... in primary it's a very protective environment ... diagnosing girls in their mid-teens when they present with depression is a disaster'.

(Pete, consultant psychologist)

to the diagnostic assessment itself:

'descriptions are very much based on the male phenotype'.

(Pete, consultant psychiatrist) *'it becomes quite hard when you're interviewing girls to actually pick up the sort of subtler stuff'.*

(Rosie, CBT therapist)

This was raised by multiple participants, and they connected it directly to the next theme concerning services that are, and are not, available.

Lack of services

Another factor which many participants felt was important in the diagnostic journeys of autistic girls was the lack of services available for, and targeted at, this group. All mentioned this in some way, whether it was a lack of training about autism in females:

'They didn't think I would ever see someone with autism, so they missed that part of the nurse training'.

(Alice, neurodevelopmental nurse)

or diagnostic tools being based on male stereotypes and missing out on female presentations:

'quite often for a boy filling it in you're like "oh, this is so obvious" and then for a girl ... they don't speak with an American twang and repeat phrases from films constantly'.

(Jessica, Head of Inclusion)

'the ADOS one ... it isn't good at identifying females with autism ... they don't get picked up'.

(Sarah, specialist teacher)

to difficulties with getting traditional diagnostic pathways and teams to recognize that girls may be autistic:

'the team is quite restricted in their diagnostic procedures ... if the child is being referred for ADHD that's all I could assess, even if I see this real clear evidence of female autism'.

(Alice, neurodevelopmental nurse)

'I find with first opinion they are turned down because [detailed assessments] haven't been done, when you actually go to second opinion and you do that more in depth, that's when you get people with definite diagnoses'.

(Rosie, CBT therapist)

This was especially the case when autism and mental health conditions were co-occurring in the girls – something which is true for most autistic people, particularly women and girls. In these cases, the mental health diagnosis was often prioritized, or overshadowing – even hiding – the underlying autism: *'they often get labelled personality disorder as they get older if it hasn't been caught'* (Alice, neurodevelopmental nurse); *'[they] come [to us] with one thing – depression or anxiety – and we would end up picking up traits of autism'* (Calon, CAMHS nurse).

Some also talked about how the lack of services for autistic girls led them to question the value of giving a diagnosis at all, either because they felt

girls were often ‘coping’ without it – as Sarah (specialist teacher) put it, ‘*does diagnosis really matter if pupil manages to find their way?*’ – or because they thought that without tailored post-diagnostic support, many girls were being given a label and then abandoned, and that this could make things worse because each team then saw them as ‘someone else’s problem’:

‘people get turned away because “actually well they’re autistic” ... we used to do so much more with mental health, but we’re not allowed’.

(Rosie, CBT therapist)

‘without a diagnosis you would have no services, no support, no financial support, people don’t understand that without a diagnosis nobody will help you’.

(Alice, neurodevelopmental nurse)

This lack of formal training, pathways, and diagnostic and follow-up services was a recurring theme throughout the experiences and discussions of our participants. While many bemoaned the current state of formal affairs, they also talked about the informal changes to practice which they or their area had instituted.

Informal change

Instead of formal changes to policies related to recognition, diagnosis and support, our participants talked about the informal changes they had made to their own practice in education and clinical settings. This often came from knowledge they had also gained informally, rather than through official training: ‘*I always had a real interest in [autism]... going on summer camps and talking to people around the world*’ (Alice, neurodevelopmental nurse); ‘*we have lots of training on autism ... but nothing specific for girls*’ (Sarah, specialist teacher).

Those involved in schools discussed how they did not rely on an official diagnosis before enacting support: ‘*it’s not about waiting for a diagnosis ... [it’s] about putting those friendly strategies in place straight away*’ (Jessica, Head of Inclusion). Participants in clinical settings talked about how their increased knowledge resulted in them making changes to their diagnostic practices:

'we are doing [ADOS – a diagnostic observation] with two people ... we tend to do it together so that we're picking up on more'.

(Rosie, CBT therapist)

'I do believe we make more allowance now in accepting perhaps more girls just under the cutoff'.

(Calon, CAMHS nurse)

'following [questions on assessments] with asking for examples so they can't bluff'.

(Katie, neurodevelopmental nurse)

Some felt that recent developments in their area, such as the introduction of a multi-disciplinary '*neurodevelopmental forum*' (Jessica, Head of Inclusion), had improved the diagnostic chances of autistic girls. This forum removed the reliance on the knowledge and potential biases of a single professional, instead emphasizing team input, and this made it more likely that someone in the room would recognize an autistic girl, especially as this kind of informal knowledge became more common: '*five years ago you'd be shut down compared to the last few years*' (Alice, neurodevelopmental nurse).

Not all participants had access to, or were involved in, such neurodevelopmental forums though, and some who were not talked about wanting a specific pathway for girls, staffed by individuals who knew about their differences and needs: '*there should be a specialist service for females*' (Rosie, CBT therapist). This emphasizes the awareness of need for diagnosis and post-diagnostic support among our participants, who represent professions from across a range of settings and services. However, the current landscape is such that those who are interested and invested in the experiences of autistic girls feel that they are significantly underserved, and that informal changes to practice are happening rather than formal recognition of this fact.

Discussion

This is the first study to explore whether the increasing knowledge of autism in females provided by academic research is reaching professionals involved in the diagnostic process, and, if it is, whether it is resulting in changes to that

process. Through interviews with professionals, we found that knowledge is reaching practitioners, but that it is not translating into formal changes to practice, either in education or in clinical services. Instead, individual professionals are making a range of informal adaptations, based on their own knowledge and in response to the person in front of them. While the fact that these informal changes are happening is positive, the lack of consistency raises questions about a ‘postcode lottery’ of recognition and provision for autistic females. The lack of post-diagnostic support available for autistic females was a key theme raised by participants, who felt that without this provision, getting or giving a diagnosis was of debatable value.

It is interesting that even within this cohort of professionals who were explicitly aware of autism in females, they framed autistic girls and women in terms of how they were different to autistic males. This is consistent with criticisms of early autism research, which centres male experiences and views autistic females as a deviation from those norms (Hull & Mandy, 2017; Young et al., 2018). Some participants directly addressed this gender bias in their own diagnostic practice and linked it to broader gender stereotypes, in line with the work of Geelhand et al. (2019). Participants emphasized the visibility of externalizing behaviors, as discussed in other studies of traits associated with earlier diagnosis (May et al., 2016). Autistic girls, who often lack these prominent externalizing behaviors, therefore confound professional expectations and may not receive an accurate diagnosis. Differences in intense interests were also discussed as interfering with standard diagnostics, as girls who focused on friendships and other people could easily be mistaken for having ‘normal’ social development, as highlighted in other studies (Halladay et al., 2015).

One major barrier to diagnosis described by all participants was camouflaging among autistic females, in line with previous research showing that this ability to (temporarily) conceal autistic traits creates problems during clinical observations and diagnosis (Duvekot et al., 2016). Participants felt this masking was a key characteristic of female presentation, supporting the research of Lai et al. (2017) showing that autistic females present surface-level behaviors which do not reflect their internal status. While camouflaging is not limited to females and may also interfere with the timely diagnosis of some males, it is interesting to note that most participants associated the term predominantly with autistic girls and women. Combined with the male bias in diagnostic procedures, this may in effect create an environment which allows autistic girls to blend in and be missed, as has been seen in their social interactions (Dean et al., 2016).

Crucially for this study, participants had not generally seen formal changes to practice that would improve recognition and support of autistic females, despite knowledge of the growing literature criticizing the male bias of the diagnostic criteria and measures (Estrin et al., 2021; Dinkler et al., 2021). The only formal change for some participants was the introduction of a panel of specialists or neurodevelopmental forums, which allowed the diagnostic process to become more of a conversation between multiple professionals with different insights. Instead, most participants felt that it was personal experience and knowledge among professionals that allow more autistic females to be recognized.

Personal judgments by professionals weigh heavily in determining an individual's progression on the diagnostic pathway. Participants demonstrated concern that without knowledge of autistic females' ability to camouflage, professionals will fall for these techniques, especially when combined with a pre-conception that girls and women cannot be autistic (Duvekot et al., 2016). This is emphasized by research showing that clinicians' conceptions of autism are mostly based on social communication challenges when issuing a diagnosis (Mugleton et al., 2019), so autistic females' strength in imitating peers to appear more socially advanced is likely to hinder clinical judgment (Lehnhardt et al., 2016; Tubío-Fungueiriño et al., 2020). Our participants discussed the importance of improving professional knowledge so that clinicians can delve deeper when assessing autistic females. This supports research showing that improving awareness of gender differences in autism can reduce gendered diagnostic imbalance (Rutherford et al., 2018).

This need for better knowledge about autism in females also extended to recommending training of school staff; as Wood-Downie et al. (2020) have pointed out, school staff are usually the first to raise concerns. As discussed by our participants, autistic females are less likely than males to express their traits externally (Dean et al., 2016), and this has been shown to impact teachers' judgments on whether a child is autistic (Duvekot et al., 2016). Thus, to ensure autistic females are being recognized, participants felt teacher training on gender differences was vital. Participants also recommended adding a specific female phenotype questionnaire to diagnostic suites, in line with research recommendations (Dinkler et al., 2021; Duvekot et al., 2016). They felt that if some clinicians struggle to account for masking, it would be helpful to have tools that inherently allow for this.

The debate among participants as to the ‘value’ of an autism diagnosis for girls was unexpected. As so much research has emphasized the importance of the diagnosis for autistic women (Bargiela et al., 2016; Harmens et al., 2022), it was interesting that professionals are less clear on this. While some agreed with Leedham et al. (2020) that receiving an autism diagnosis is a significant moment in a person’s life, others felt that if autistic females appear to be coping, then a diagnosis is unnecessary.

Supporting the idea that diagnosis is worthwhile, participants emphasized that anxiety, depression and attempted suicide are extremely common among autistic females. Research has shown that masking, difficulty in understanding themselves and erroneous diagnoses contribute greatly to mental health challenges (Lai et al., 2017; Leedham et al., 2020). Participants felt that this mental health crisis could be reduced significantly if autistic females were diagnosed earlier, supporting research which reported that autistic women feel that life would have been easier with a diagnosis (Bargiela et al., 2016).

However, some participants felt that diagnosis was not worthwhile, as there is a lack of services and support post-diagnosis. Research has shown that receiving good support after a diagnosis significantly reduces depression and anxiety for autistic people, but diagnosis alone does not transform an individual’s life (Harmens et al., 2022). Further to this, participants discussed how an autism diagnosis can act as a barrier to other services, as all difficulties are attributed to autism. Thus, for these participants, the value of diagnosis is heavily dependent on the accompanying support and services.

Despite the importance of our findings, there are limitations to this research. Firstly, conducting research during a global pandemic with restrictions such as social distancing made the process more challenging. For example, video calls restricted the researcher’s ability to read the behavioral cues of the participants. Secondly, only one researcher carried out the initial coding, meaning the codes possibly include researcher bias. While the second author did read and review the codes, it was not appropriate to generate inter-rater reliability statistics. Third, although only a small number of participants were interviewed, this was because by interview six no new themes were found, so data saturation was reached (Fusch & Ness, 2015). Fourth, the use of personal networks and snowball sampling meant only professionals working in south-west England and Wales were recruited. The lack of formal changes

and the presence of informal changes may therefore be geographically specific. Even so, the under-diagnosis of autistic females is a worldwide phenomenon (Gould, 2017), so it is vital that research continues to explore this in a variety of contexts.

Implications for research and practice

This study, which explicitly sought to relate research discoveries to professional practice, is well placed to make future recommendations. In terms of practice, it highlights the importance of providing training to everyone involved in each stage of the diagnostic process to improve the recognition of and support for autistic girls. Teachers and school staff, who are often best placed to notice girls, should be given training on gender differences in autism to ensure that they do so. Clinical and diagnostic staff should also receive training on gender differences as a mandatory part of their autism education, so that when girls are going through the process, they are not reliant on happening to encounter a professional who has an independent interest in the topic, as highlighted by our participants.

For future research, it would be valuable to conduct interviews with late-diagnosed autistic males and the clinicians who diagnosed them, as this group have also gone unrecognized until later than usual. It may be that there are lessons to learn about alternative autism presentations on many fronts, and this may help to move beyond a binary or essentialist view of autism phenotypes. Studies examining diagnostic practices in a wider range of settings would also be useful, to gain a sense of the national or international picture, and to compare public and private diagnostic contexts to discover whether there are differences in the process and support offered to girls coming for assessment.

Conclusion

This study explored professional perspectives on whether and how the autism diagnostic process has changed for autistic females in the UK. It found that there have been no formal changes to the autism diagnostic process that reflect the recommendations of previous research. However, this does not mean that diagnostic practices have remained unaltered, or that participants do not acknowledge gender differences in the presentation of autism. Instead, participants discussed a range of informal adaptations they made when working with females suspected of being autistic, usually based on their personal knowledge of gender differences in autism. However, participants made it clear that this informal change has not transformed the diagnostic process for the majority, and until teachers,

mental health nurses and clinicians take time to recognize these subtleties in autistic females, more large-scale formal changes are necessary to improve the diagnosis of autistic females. Unexpectedly, there was a debate in the data about the value of diagnosis, dividing participants on the need for diagnosis to improve mental health countered by a lack of support post-diagnosis. Most importantly, this research has illuminated the worth of diagnosis in the face of a mental health crisis, opening the debate on whether diagnosis is only as useful as the support provided afterwards.

Ethical statement

We confirm that this research was carried out in accordance with the ethical standards expected of psychological research, having been reviewed and approved by the University of Bristol School of Education Ethics Committee. Data can be made available upon request by research teams. There is no funding to disclose, and there are no conflicts of interest.

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