Inpatient Psychiatric Interventions for Acute Suicidality: Enhancing Support for Autistic People - Two Case Studies

Intervenciones hospitalarias para la suicidalidad aguda: mejorando el apoyo para personas autistas. Dos estudios de caso

Intervenções hospitalares para suicídio agudo: melhorando o suporte para pessoas autistas. Dois estudos de caso

Sivakami Mary Ashley
Autonomous University of Barcelona, Spain
sivakamiashley@gmail.com
https://orcid.org/0009-0009-2190-5726

Abstract

Autism is a neurodevelopmental condition characterized by differences in social communication and behavior. A recent meta-analyses indicates that up to 34% of autistic people without intellectual disability experience suicidal ideation, and 24% have attempted suicide, rates far exceeding those in the general population (Newell et al., 2023). This qualitative case study explores suicidality—encompassing suicidal ideation and intent—in two autistic women without verbal or intellectual impairments and evaluates the effectiveness of current inpatient interventions in Spain. Demoralization and emotional dysregulation emerged as key contributors to suicidality. The study identifies both helpful and harmful aspects of inpatient care, highlighting limitations in standard suicide prevention protocols for autistic individuals. These findings underscore the need to adapt psychiatric hospitalization protocols to better support autistic people and offer specific recommendations to improve crisis care. While based on two cases, this research contributes to the growing understanding of autism and suicide risk, informing more effective and sensitive interventions.

Keywords: Asperger, Autism Spectrum Disorder, Suicide, Hospitalization, Demoralization

Resumen

El autismo es una condición del neurodesarrollo caracterizada por diferencias en la comunicación social y el comportamiento. Un metaanálisis reciente indica que hasta el 34% de las personas autistas sin discapacidad intelectual experimentan ideación suicida, y el 24% han intentado suicidarse, tasas muy superiores a las de la población general (Newell et al., 2023). Este estudio de caso cualitativo explora la suicidabilidad—que abarca la ideación e intencionalidad suicida—en dos mujeres autistas sin alteraciones verbales ni intelectuales, y evalúa la efectividad de las intervenciones hospitalarias actuales en España. La desmoralización y la desregulación emocional surgieron como factores clave que contribuyen a la suicidabilidad. El estudio identifica aspectos tanto beneficiosos como perjudiciales de la atención hospitalaria, poniendo de relieve las limitaciones de los protocolos estándar de prevención del suicidio para personas autistas. Estos hallazgos subrayan la necesidad de adaptar los protocolos de hospitalización psiquiátrica para apoyar mejor a las personas autistas, y ofrecen recomendaciones específicas para mejorar la atención en crisis. Aunque se basa en dos casos, esta investigación contribuye a la comprensión creciente del autismo y el riesgo de suicidio, informando intervenciones más eficaces y sensibles.

Palabras clave: Asperger, Trastorno del Espectro Autista, Suicidio, Hospitalización, Desmoralización.

Resumo

Autismo é uma condição do neurodesenvolvimento caracterizada por diferenças na comunicação social e no comportamento. Uma meta-análise recente indica que até 34% das pessoas autistas sem deficiência intelectual apresentam ideação suicida e 24% tentaram suicídio, taxas muito mais altas do que as da população em geral (Newell et al., 2023). Este estudo de caso qualitativo explora a suicidalidade — abrangendo ideação e intenção suicidas — em duas mulheres autistas sem deficiências verbais ou intelectuais, e avalia a eficácia das intervenções hospitalares atuais na Espanha. Desmoralização e desregulação emocional surgiram como fatores-chave que contribuem para a tendência suicida. O estudo identifica aspectos benéficos e prejudiciais do atendimento hospitalar, destacando as limitações dos protocolos padrão de prevenção ao suicídio para pessoas com autismo. Essas descobertas ressaltam a necessidade de adaptar os protocolos de hospitalização psiquiátrica para melhor

dar suporte a indivíduos com autismo e oferecem recomendações específicas para melhorar o atendimento de crise. Embora baseada em dois casos, esta pesquisa contribui para a crescente compreensão do autismo e do risco de suicídio, informando intervenções mais eficazes e sensíveis.

Palavras-chave: Síndrome de Asperger, Transtorno do Espectro Autista, Suicídio, Hospitalização, Desmoralização.

Inpatient Psychiatric Interventions for Acute Suicidality: Enhancing Support for Autistic People - Two Case Studies

Suicide is a global concern with over 740,000 annual deaths worldwide (Weaver et al., 2024). Spain witnessed a peak in suicides in 2022, reporting over 4,200 cases (INFOCOP, 2023). Of particular concern, suicide rates among children and adolescents are rising (Turecki & Brent, 2016) and suicide now stands as the primary cause of non-natural fatalities in Spain (Instituto Nacional de Estadística, 2024). The autistic community faces a disproportionately heightened risk of suicidality, which are thoughts of suicide or a clear intention to act (Jachyra et al., 2022; Newell et al., 2023). A recent meta-analyse indicates that up to 34% of autistic people without intellectual disability experience suicidal ideation, and 24% have attempted suicide, rates far exceeding those in the general population (Newell et al., 2023). Death rates due to suicide are three to nine times higher amoung autistic people than controls (Hirvikoski et al., 2016; Kõlves et al., 2021) and autistic people are recognized as a high-risk group for suicide by the National Institute for Health and Care Excellence (NICE, 2022). It is necessary to examine the intersection between autism and suicidality in order to inform effective interventions.

Globally, 1-2% of the population is believed to be autistic (Zeidan et al., 2022). Autism, a complex neurodevelopmental condition, varies widely in symptoms, skills, and impairment levels (O'Halloran et al., 2022). Key challenges associated with autism include difficulties in social interaction, communication issues, repetitive behaviors, and specific interests (American Psychiatric Association, 2013). Research has shown that many autistic people prefer identity-first language, such as "autistic individual/person" as opposed to "person with autism" (Bottema-Beutel et al., 2021). Accordingly, this paper adopts identity-first language while acknowledging that these preferences may not be universal.

Advocates of the neurodiversity paradigm and autistic acceptance movement, emphasize the multifaceted nature of autism, viewing it as a blend of disability, difference, and identity, and underscore that neurological variations are a part of human biodiversity (Botha & Cage, 2022). A fundamental concept of the neurodiversity movement, as opposed to the paradigm of the *DSM-5 (Diagnostic and Statistical Manual of Mental Disorders)*, is that differences in neurological development and functioning among individuals should not be automatically considered pathological (Kapp et al., 2019).

The elevated risk of suicidality among autistic people is attributed to a complex interplay of factors, including autism-related characteristics, social difficulties, feelings of not belonging, and co-occurring conditions such as depression, anxiety (Cleary et al., 2023), and post-traumatic stress disorder (Horowitz et al., 2018). Autistic people exhibit a wide range of communication abilities and may encounter difficulties expressing themselves and interpreting social cues (Hughes et al., 2020). Many autistic individuals face challenges in identifying, expressing, or articulating their own feelings and emotions (Costa, Look & Steffgen, 2020; Mazefsky, 2015). Additionally, cognitive rigidity and rumination—characteristics commonly associated with autism—have been linked to increased suicide risk (Hedley et al., 2021). Other autism-related traits, such as sensory sensitivities and camouflaging (i.e., masking of autistic traits), are also influential risk factors for suicidality (Cleary et al., 2023; Cassidy et al., 2018). Notably, autistic females, a group often under-researched and under-diagnosed, frequently engage in camouflaging in social settings (Lai et al., 2017; Hull et al., 2017). Since camouflaging is associated with a heightened risk of self-harm, encouraging autistic individuals to modify their behavior to fit social norms may be detrimental (Cassidy, Gould, et al., 2020).

Sensory sensitivities in autistic people can lead to sensory overload when exposed to certain stimuli, such as specific sounds, textures, or types of lighting (MacLennan, O'Brien, & Tavassoli, 2022). Sensory overload frequently results in feelings of anxiety, stress, and physical discomfort (Hughes et al., 2020). This overwhelming experience can cause a strong urge to escape the environment and may lead to meltdowns or shutdowns (Hughes et al., 2020).

Meltdowns are intense, involuntary responses to overwhelming sensory or emotional input, resulting in a temporary loss of behavioral control (Leicestershire Partnership NHS Trust, n.d.). Unlike tantrums, meltdowns are not intentional and are not aimed at gaining attention or support. They may involve verbal expressions such as shouting, crying, or

growling, as well as physical behaviors like flapping, kicking, or other repetitive movements. During meltdowns, autistic individuals may experience extreme distress and exhibit involuntary behaviors, including self-injury, crying, shouting, or rocking (Cassidy, Robertson et al., 2020). In contrast, shutdowns are also triggered by overwhelm but are characterized by withdrawal, emotional numbness, dissociation, or unresponsiveness. During a shutdown, an individual may become non-verbal or experience situational mutism, often isolating themselves and disengaging from their surroundings (Leicestershire Partnership NHS Trust, n.d.; Cassidy, Robertson et al., 2020).

Despite the prevalence of meltdowns and shutdowns in autistic individuals, these responses to overwhelm are often misunderstood by hospital staff. This mismatch can result in escalating distress, as the autistic individual is unable to convey their needs or de-escalate the situation, and staff lack the understanding to intervene appropriately (Dillenburger et al., 2016; Haydon, Doherty, & Davidson, 2021). As one autistic adult reflected, "If the staff had a better understanding of autism, then so many emergency situations could have been avoided" (National Autistic Society, 2018).

Psychiatric hospitalization is a conventional response to acute suicide risk, focusing on safety, stabilization, and psychopharmacology (Hayes et al., 2019). However, post-discharge suicide rates remain notably high, particularly among adolescents (Chung et al., 2017; Butjosa et al., 2024). Research has highlighted that emergency and crisis services often fail to address the distinctive needs of autistic people (Wachob & Pesci, 2017; Hutchinson & Forster, 2019; Dobson, 2024). Emergency staff frequently lack formal training and experience in supporting autistic individuals, which can result in the use of more intrusive interventions—such as restraint and sedation—when standard approaches are ineffective (Salvatore et al., 2022). Pediatric psychiatric emergency clinicians have emphasized the urgent need for tailored screening tools and evidence-based interventions for suicidal thoughts and behaviors in autistic youth (Cervantes et al., 2023).

Despite the elevated risk of suicide among autistic people, research on effective identification and mitigation strategies for this group remains limited (Jager-Hyman et al., 2020; Hedley et al., 2022). Understanding the specific risk factors and manifestations of suicidality in autistic individuals is essential for improving assessment and prevention strategies (Newell et al., 2023; Rodgers et al., 2023). There is a growing consensus within autism research on the value of participatory approaches, which involve collaboration between researchers, autistic people, and their families (Fletcher-Watson et al., 2018;

Benevides et al., 2020; Hedley et al., 2022). This study adopts a qualitative case study approach, focusing on two autistic women hospitalized for suicidality, to elucidate the manifestation of suicidality, evaluate inpatient interventions, and propose improvements to current suicide prevention protocols in Spain.

Methods

Study Design and Approach

This study aimed to enhance understanding of how psychiatric hospitalization for suicidality in Spain could better address the unique needs of autistic individuals without intellectual or verbal impairment, thereby contributing to tailored suicide prevention strategies. A qualitative, exploratory case study methodology was chosen due to the scarcity of prior literature and the need to capture nuanced experiences. Data were collected through multiple sources, including semi-structured interviews, review of interview transcripts, and examination of personal journals. Anonymity and confidentiality were preserved through data de-identification.

Participants and Sampling

Four key informants (KIs) were purposively selected-that is, they were intentionally recruited based on specific criteria related to their experiences with autistic suicidality and psychiatric inpatient care, rather than chosen at random. The sample included individuals with lived experience and a professional working within the psychiatric system, aiming to capture diverse perspectives.

- Key Informant 1 (KI#1): A deceased 17-year-old autistic adolescent (Laura) without intellectual or verbal impairments, fluent in four languages, passionate about dance, and the eldest of five children. Laura died by suicide in May 2023 after spending over 16 months in psychiatric hospitals. Her inclusion was posthumous, through her written journals provided by her mother.
- Key Informant 2 (KI#2): Laura's mother, who provided insights into her daughter's experiences with suicidality and hospitalization.
- Key Informant 3 (KI#3): A bilingual 53-year-old autistic woman, artist, and writer without intellectual or verbal impairments, who was hospitalized twice for suicidality in her twenties.

● Key Informant 4 (KI#4): A 53-year-old female psychology master's student with internship experience in a psychiatric hospital in Catalonia, Spain.

Study Procedures

In accordance with the ethical requirements of the Autonomous University of Barcelona, all living key informants received an information sheet and provided written informed consent prior to participation. Multiple semi-structured interviews were conducted via Zoom, exploring the following topics:

● Manifestations of suicidality

● Helpful interventions

● Harmful or unhelpful interventions

● Recommendations for additional supports or approaches for autistic individuals experiencing high suicidality

Each interview lasted between 55 and 75 minutes, was conducted primarily in English, and was transcribed using Zoom. Data collection continued until thematic saturation was reached. Seven of Laura's journals were reviewed, with relevant portions photographed according to the four thematic questions, along with selected phone messages provided by KI#2. KI#3 also contributed extracts from her hospital journals.

Data Review, Organization, and Analysis

Interview transcripts and selected journal entries were converted into Word documents for each key informant. Narrative analysis, a qualitative method that focuses on interpreting the stories people tell to make sense of their experiences, was employed to examine these documents, and a manual coding framework was applied across the dataset to identify key patterns, themes, and relationships. Code co-occurrence—instances where multiple codes appeared within the same or overlapping segments—was tracked to highlight connections between concepts. Analysis was conducted using ATLAS.ti (ATLAS.ti Scientific Software Development GmbH, 2023).

To enhance credibility and contextual relevance, member checking was implemented: key informants were provided with drafts of their quotes and the "Results" and "Discussion" sections, and invited to verify accuracy and offer corrections or comments. This participatory approach reinforced the trustworthiness of the findings.

Results

A total of 32 thematic codes were identified through manual narrative thematic analysis. Table 1 Summarizes the number of codes and quotations identified for each Key Informant (KI).

Table 1. Number of Codes and Quotations Analyzed Across Key Informants (KIs)

| KEY INFORMANT	NUMBER OF CODES	NUMBER OF QUOTATIONS
KI# 1	32	284
KI# 2	32	154
KI# 3	28	140
KI# 4	4	13
	TOTAL CODES: 32	TOTAL QUOTATIONS: 591

Note. Data derived from participant interviews and journal entries collected by the author (2023–2024). Data available upon request.

The codes that most frequently co-occurred with quotations referencing suicidal thoughts were: "Wanting relief," "distress," "demoralization," "anxiety and fear," "poor self-confidence," and "thwarted belonging." These co-occurrences are illustrated in Figure 1.

Figure 1. Ten codes with the most quotations co-occurring with the code "suicidal thoughts."

Code Co-Occurrence View: "Suicidal Thoughts"

10 codes with most co-occurence ("Suicidal Thoughts" had a total of 37 quotes)
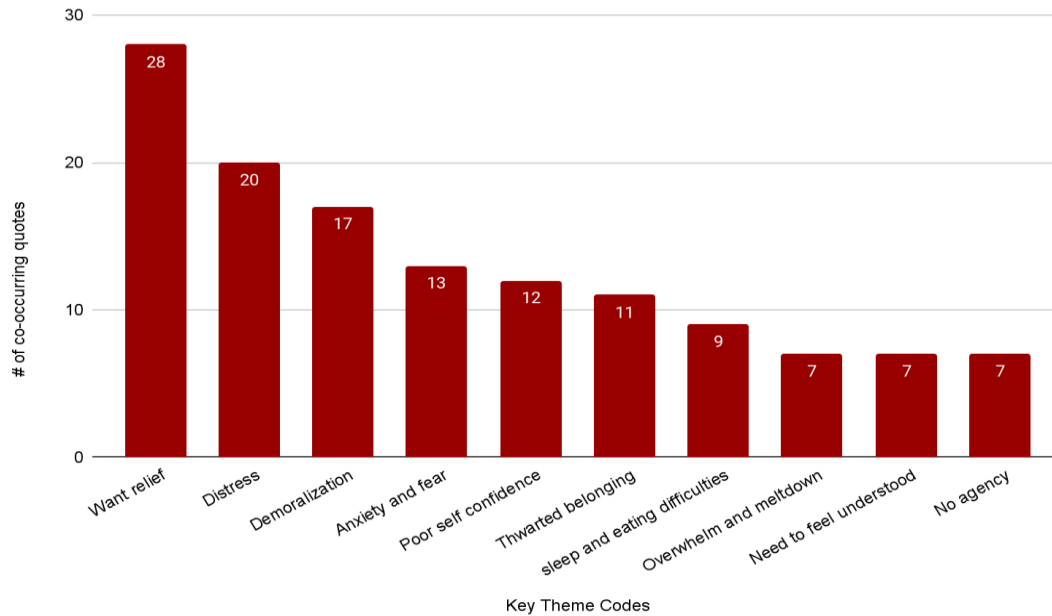
Note. Data derived from participant interviews and journal entries collected by the author (2023–2024). Data available upon request.

Manifestations of Suicidality

Key Informant 1 (Laura)

According to Laura's diaries, her suicidal thoughts began at age 12 but were first disclosed to her mother at age 15. Her writings document a progression of chronic and escalating suicidality, closely accompanied by distress, demoralization, anxiety, poor self-confidence, thwarted belonging, and perceived burdensomeness. These experiences align with risk factors commonly identified in autistic youth, such as social isolation and feelings of not belonging. Her original language, including the use of curse words, has been preserved in the quotations to maintain authenticity and accurately reflect her voice:

> I just want to exit this world, in other words I want to die. Nothing works out. School is sh#t, boring, scary, no after school activities. I have no productivity. I feel I am losing all my talents, my hopes, everything, my happiness, my creativity,

imagination, motivation, as if nothing really had any meaning…I feel nostalgic with no hope for anything, not even to live… How am I supposed to be happy when all I can think about is black, gray and basically terrifyingly bad!! I just can't stand it! The voice that says that I should not eat is a lot louder recently, and the voice that says "I want to die" as well. Everything is too intense.

These quotations illustrate how, for Laura, the search for relief from distress intensified over the years. Her diaries reflect classic features of demoralization and hopelessness, as well as the unique ways these manifest in autistic individuals.

However, Laura's diary entries also suggest an absence of pervasive anhedonia. Despite her ongoing suicidality, she documented many moments of preserved mood reactivity and a capacity to experience joy and motivation in the present moment:

Alice threw Ita's ball on the roof so I went to get it and I had to go on the ledge to get it down and Ita lifted me on her shoulders. What fun!!... Ita wrote a love letter to Mia (sooo cute) then we encouraged Cris to do the same for Nicky. With mom during the visit we listened to music while playing Virus and Cubo…

She also expressed hope and future-oriented thinking, even while struggling with negative urges:

I want to get out of here...what I could do is try for 1 year to live, and afterward I can evaluate whether it's worthwhile or not to live. This way, everyone will be calm and know that I will not hurt myself…There are things that I want to do, so I will make a list. The only thing is that when I am not feeling well I will have "negative" urges because now I am saying this but what if I change my mind…?

These entries demonstrate that, despite chronic suicidality, Laura was able to experience positive affect and enjoyment, challenging the assumption that suicidality in autistic youth is always linked to pervasive anhedonia.

Key Informant 3

KI#3 described a lifelong struggle with sensory and emotional dysregulation and the challenges of managing societal expectations. She explained:

When I get that angry, there's always a part of me that wants to cease to exist…I've always had, especially like in my teen years, a death wish part,...but it was very much by moments because part of my neurodivergence is that I exist five minutes at a

time… Whatever is happening in the moment feels like it's going to last forever…and it's really hard for me to see outside of that, even now at 53…

KI#3 clarified that her self-injury was primarily a strategy for emotion regulation, not an expression of suicidality: "(Self harm) wasn't in that case that I wanted to end my life, it wasn't a suicidal thing, it was a thing for regulating my emotions… especially if I was angry." She indicated that her suicide attempt was unplanned and impulsive, occurring during a particularly distressing period in her life, which led to a 10-day hospitalization. KI#3 described the experience of suicidality and emotional overwhelm:

Wanting to kill myself as punishment for putting myself in the position of an already inner death… I feel anxiety washes over me, I get that tingling sensation like I'm going to pass out. I feel like I'd cry forever. I just want to be rocked like a child… There is no return to the womb. Life is so unfair and we persist. Where is the peace in what is?... I feel that if I'm not completely in control that I will disappoint myself and others. And then people say it's ok to be depressed or sad or whatever, but at the same time my parents are telling me to do this or that for the house, or cheer up, or (my professor) is saying write that paper… no one has much patience. I feel like I'm carrying a heavy load and don't know where to set it down.

These quotations reveal how a loss of agency and overwhelming emotional states contributed to her suicidality, and how self-injury functioned as a coping mechanism rather than a suicidal act. Five years after her first hospitalization, KI#3 was involuntarily hospitalized again when a friend called emergency services. Despite explaining to emergency staff that this was not a suicide attempt, she was admitted against her will—an experience she described as humiliating and traumatic.

Helpful Interventions

Supportive inpatient interventions identified by key informants included: adopting a compassionate approach to self-harm, providing support during moments of distress, offering art therapy and animal-assisted therapy, implementing sensory modulation techniques, facilitating engaging and real-life activities, maintaining a minimum restraint protocol, and ensuring the presence of empathetic nursing staff. The codes that most frequently co-occurred with "interventions that supported wellbeing" are illustrated in Figure 2.

Figure 2. Five codes with the most quotations co-occurring with the code "interventions that supported wellbeing."
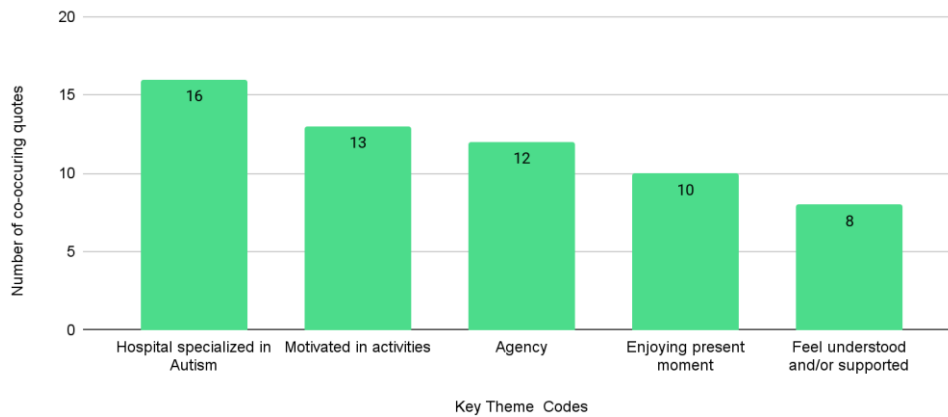
Note. Data derived from participant interviews and journal entries collected by the author

(2023–2024). Data available upon request.

Hospital Specialized in Serving Autistic Youth

Many positive interventions were described by KI#1 and KI#2 in reference to Mutua Terrassa Hospital, a facility specializing in the treatment of autistic youth for three-month periods. KI#1 reflected positively on her experiences:

> We visited Hospital Mutua Terrassa, and I loved the place. It's really cool…I tried out the weighted blanket while she did the massage with the massage device...Today I slept well after a very long time…. We tried boxing to let out anger…then I went to print calendars.

This hospital provided a variety of methods likely designed to help autistic inpatients regulate their nervous system and reduce distress caused by sensory and emotional overload. Reported interventions included the use of weighted blankets, massage devices, full-body movement for emotional release, animal-assisted therapy, and visual supports informing patients about upcoming events and daily routines. Additionally, the hospital's policy of allowing greater freedom and permitting parents to stay overnight with their children was highly valued. KI#2 recounted:

In this hospital, she (KI#1) had a bedroom where her parents could go to sleep there with her. It's really different. A lot more freedom, going out, seeing animals. It was really good.

These comments illustrate the potential benefits of an inpatient hospital environment that is sensitive to the needs of autistic people and provides interventions aimed at reducing distress and increasing wellbeing.

Compassionate Approach to Self-Harm and Support During Distress

The availability of emotional support during acute episodes was highly valued by participants. KI#1 described:

My head has already started to think. Mike stayed with me for a while, but I already started to hurt myself. Maya stayed too, but it didn't change anything. Then Mike and Maya came and said that if they saw me self-harm, they would cut my nails! They left me alone, but luckily they gave me the tablet, and I watched the swan lake... I had a terrible day, as if everything that I had inside finally came out. Now in the evening, I exploded. Fortunately, Mom was here, and we could talk. It did me good, I think. Now I am a bit more calm and relaxed. But I still want to hurt myself, to die, and to eat nothing… Last night I fell asleep while listening to music and holding Jim's (a hospital staff member) hand. Today it was hard to wake up, but I am ok.

These entries illustrate the effectiveness of a hospital environment that provides emotional support and de-escalation strategies when autistic inpatients experience meltdowns.

Art Therapy and Animal Assisted Therapy

Art therapy was highly valued by both KI#1 and KI#3. KI#3 reported:

We had an art therapist, which I still would like to write to that woman and thank her because she was the one human in the room. And I'm so thankful that that hospital had that program.

KI#1 also wrote about art therapy in her diaries:

The art therapist came, and I painted my hand purple to put on the mural… It looks super cool, everyone told me. As I was super motivated, I painted my foot all blue and did the same on the other side of the paper, and it looks super cool as well.

These entries suggest that art therapy provided motivation and moments of wellbeing. Animal-assisted therapy was another supportive intervention for KI#1: "We did the activity

with the dog. He's really sweet and kind." KI#2 also noted the benefit of animal companionship: "This is something that I wish we had done before…She liked to talk to the cat. Yeah, maybe it's kind of therapeutic to have a cat." These accounts indicate that animal-assisted therapy and animal companionship were beneficial interventions for KI#1.

Harmful or Unhelpful Interventions

(Content warning: The following section discusses distressing and potentially traumatic inpatient experiences.)

Key informants identified several institutional practices that contributed to emotional harm. These included impersonal psychiatric consultations, distressing admission processes, boredom and sensory discomfort, a profound sense of helplessness and lack of agency, use of mechanical restraints, punitive measures for rule violations, side effects from electroconvulsive therapy (ECT), ineffective pharmacological interventions, routine inspections without clothing, and feelings of being treated as a criminal.

These experiences were consistently described by KIs as harmful or unhelpful during inpatient care. As illustrated in Figure 3, quotations describing stressful experiences during hospitalization most frequently co-occurred with codes such as loss of agency, distress, loss of dignity or humiliation, and not feeling understood.

Figure 3. *Ten codes with the most quotations co-occurring with the code "hospital environment stressful."*

Top Code Co-Occurrence with "Hospital Environment Stressful"

10 codes with most quote co-occurence ("Hospital Environment Stressful" had a total of 132 quotes)
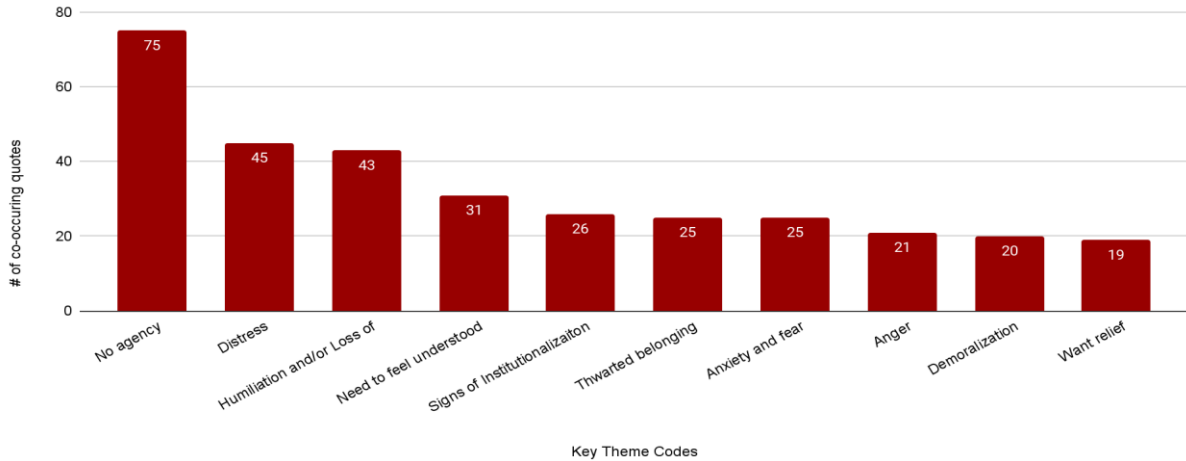
Note. Data derived from participant interviews and journal entries collected by the author (2023–2024). Data available upon request.

Harsh Transition and Impersonal Treatment

The admission process and adaptation to inpatient psychiatric care were described by KI#1, KI#2, and KI#3 as distressing, marked by disorientation and confusion. KI#3 reflected on her experience:

> By the third day, I understood what the schedule was, and how it worked, meals, and whatever, but at first, it was just like... you're thrown into this world where you have no control.

KI#2 described the initial hospitalization of her daughter, Laura, stating:

> The doctors had told us, like, it's a normal thing, they (the inpatients) usually try to make you feel pity and you take them out, but it's better if they stay…And the first two or three days of hospitalization, we could not see her, not phone calls either.

KI#2 further described the impersonal nature of the hospital environment, "You arrive, and they don't even look at you. They just ask questions and look at their computer." She also noted the restrictive visitation policy:

> She (Laura) saw her siblings for the first time after six months. They hadn't seen each other before because the hospital rules (in the hospital) only allowed visits from parents.

KI#3 echoed the impact of impersonal treatment: "There was never a moment they were like, 'Hey, what did you go through?'". These narratives highlight common themes of disorientation, restricted communication, and a perceived lack of emotional attunement during the early stages of hospitalization.

Boredom and Sensory Discomfort

Both KI#1 and KI#3 described experiences of boredom, not feeling understood by staff, and sensory discomfort as distressing and unhelpful. Laura wrote in her journal, "I feel like nobody understands me and I really want to leave this freaking place. I need to distract myself because I can't stand it anymore." KI#3 reported, "The smell of the blankets and the sheets on the bed was very distressing to me…The bright fluorescent ceiling lights were horrible." These experiences were directly linked to increased dysregulation and emotional distress.

Pharmacology and Electroconvulsive Therapy (ECT)

KI#2 expressed uncertainty about the efficacy of pharmacological and ECT interventions her daughter received, "She often complained about the medication. 'It doesn't do anything,' she would say."

Regarding ECT, KI#2 stated:

> Now I think it (ECT) did her more damage than good…She lost even more of her attention span and ability to focus on things. She also had a lot of side effects on a muscular level, like she would pee a lot, without wanting. And yeah, she lost a lot of memory.

ECT is typically reserved as a last-resort treatment when other interventions have failed.

Physical Restraint

Laura described multiple instances where her meltdowns were met with physical restraint:

> Last night was a disaster! The highway of thoughts came back, and I wasn't able to control it. I ended up being restrained because I was hitting my fists and head against the wall… Just want to hit my fists everywhere!!... Having the restraints on my bed

doesn't help because it gives me a wanting to hurt myself. I don't know what to do to stop anything from happening because this isn't helping….

KI#2 found the use of restraint and isolation inhumane: "And I found that very inhuman, to restrain someone and leave them alone, because they scream, they are young." She added:

> When they are 'restrained,' they are tied on the bed with straps, and she hated that, and she's been restrained a few times, and she always had a bad memory, mainly because when she's restrained, there is a room for this, and they are alone.

Laura's journal entry after her first hospitalization supports the possibility of trauma or PTSD symptoms: "This morning around 7 a.m., I woke up and again I had the bad dreams that I was in the hospital and that I was restrained, etc. It was horrible!!".

Loss of Agency and Punishment for Non-Compliance

Loss of agency was a recurring theme for both KI#1 and KI#3. KI#3 shared: "More than anything, what I remember from that hospital experience is a feeling of no agency, of no control over myself. And that was very distressing." Laura described similar distress:

> I feel horrible… I asked to take a shower and I couldn't, I asked to be allowed to take a walk, I couldn't. I started running, but they said I couldn't. So in the end I vomited in front of the door…I couldn't help it! I want to f#cking die!!...

She also reported that loss of agency was used as punishment, often leading to meltdowns:

> They put me in phase 0 with nothing in my room. I asked a few times for rescue medication because I was crying all the time. The time passed super slow and I felt so bad…I asked if I could call or have a visit, and they said NO! So here I am in my room very low again, hitting myself. F#cking rules everywhere.

KI#3 also described loss of agency as a form of punishment:

> I asked for scissors—kindergarten scissors with blunted edges, you know, for making a collage. I approached the nurse station, and they responded, 'No, you can't have scissors…because you know what you did.' It was as if I were a 'bad girl,' a 'bad person' simply because I attempted suicide. It was a horrible experience being in the hospital.

KI#3 elaborated on the long-term impact of being an inpatient:

> They treated me like I was a criminal…Even as I say that, there's still a part of me that wonders, 'What if they're right?…So, what does that lead to? More suicidality, right?...I didn't talk about it (being hospitalized) for years, never mentioned it to

anyone. God, because if someone knew about that, then everything that they had said about me would be right…that I was this broken person…A lot about the hospital, I feel bad every time I think about it. I believe it's such a traumatic experience it just leaves a mark.

These narratives suggest that the loss of agency, particularly when perceived as punitive, contributed to heightened emotional distress and lasting negative associations with psychiatric hospitalization.

Recommendations for Additional Supports or Approaches for Autistic Individuals Experiencing High Suicidality

Key informants suggested a range of supports and approaches to better meet the needs of autistic people experiencing suicidality. These included improved screening for autism in psychiatric hospitals, greater support during hospital admission, tools for managing sensory sensitivities and strong emotions, and opportunities for personal growth and self-esteem. The importance of emotional expression, feeling understood, and meaningful connections was emphasized, as was the value of programs led by autistic mentors or involving nature and communal experiences and co-regulation.

- ***Improved Screening for Autism in Psychiatric Hospitals***

KIs highlighted the under-diagnosis of autism, especially in women, in psychiatric settings. KI#4 stated: "Autism in adults, I think it is still under-diagnosed…it is a disorder that is not easily detected, especially in women…I don't remember anyone with ASD (Autism Spectrum Disorder)." KI#3 commented: "You can't assume that someone is neurotypical." These accounts underscore the perceived gaps in autism recognition within psychiatric contexts, particularly concerning adult women.

- ***Support for Entering the Hospital Setting***

KIs described the need for clear orientation and support upon hospital admission. KI#3 explained: "If someone would just have described, okay, you're in here, and this is what's gonna happen, this is what happened. And let's go over what's going to happen several times, not just once."

- ***Learning to Manage Heightened Sensations and Strong Emotions***

The importance of sensory regulation and learning to manage intense emotions was emphasized. KI#3 shared:

> How do you really deal with your pain and anger, past and present? Emotionally and not just intellectually?… We're not really encouraged to express our emotions or share them…They just tell you the obvious sh#t and we all sit there with this look on our face like 'no sh#t.'... I'm relearning how to not feel dysregulated all the time, because sometimes it's just like sensations are so… the volume is so high… It's taken a lot of work with meditation…to just be like, okay, this is just now, this is not going to last forever…You know, parts work (Internal Family Systems) has really helped to understand the experience… Talking about the hospital is still very emotional for me. I'm still working through it. Internal Family Systems has helped a lot.

This narrative illustrates how sensory overwhelm and difficulty with emotional expression continued to affect daily life and how tools like meditation and parts work were used to manage these challenges. Internal Family Systems (IFS) therapy is a psychotherapeutic approach that conceptualizes the mind as made up of multiple subpersonalities or "parts," each with its own perspective, feelings, and roles (Schwartz & Sweezy, 2019). IFS therapy's non-pathologizing stance, emphasis on therapist curiosity, flexibility, and focus on empowering the client's Self make it a promising model for working with the autistic community (Bartov, n.d.).

- ***The Power of Expression and Meaningful Connections***

Expressing emotions was described as vital for coping. KI#1 wrote:

> I need to express myself somehow and I can't by talking or writing, because it doesn't work. Then a good way could be dancing… If I just dance like this suddenly it could be because I need to say something!!!...I need someone like a friend, I need someone I can trust, I need somebody that likes me and I need an adult I can count on, also a child (a friend I can count on). Somebody I can explain things and not get bored with me like saying, 'you're always negative,' or in the style. I want to have someone that can help me with my problems.

KI#3 described the importance of non-verbal communication and supportive presence:

> When I go into overwhelm, I become nonverbal…I had studied sign language when I was in grad school, and I think part of it was a desire for that… What I would have needed is just for someone to be like, 'Are you okay? What's going on?'... All I wanted at that moment was for someone that I love to say it was all right for me to be overwhelmed and I could rest and just cry…I just want someone to hug me and tell me whatever I feel is ok, and that I can take a break.

These accounts underscore a strong desire for non-verbal avenues of emotional expression and the healing impact of being met with empathy and attunement during moments of distress.

● *Supporting Personal Growth and Self-Esteem*

KIs expressed a longing for environments that nurture personal growth and self-esteem. KI#3 reflected:

> I felt understood in what I read from authors like Roald Dahl…where I felt I found characters that were like me… I want to grow as a person. I don't want to become a 'productive member of society'…I just want to live by my own beliefs.

KI#1 wrote:

> I miss being creative all the time…I want to continue learning what I really want, ballet, and not let it to the side…I want to dance and look forward to seeing what we will do…Now I am so liberated. I was just dancing…Now my body feels weak but full of energy!! I'm ALIVE!!

Pursuing personal passions such as dance and creative expression was described as a source of energy, motivation, and emotional renewal in the face of demoralization.

● *Therapeutic Approaches Beyond Traditional Hospital Settings*

KIs proposed programs involving nature, communal experiences, and peer or mentor support from autistic individuals who have navigated suicidality. KI#2 stated:

> I think she would have benefited from having contact with people that have passed through different, difficult things, like her…that can really understand her. As now, I feel like the people that can really understand me are the people that lost their daughter to suicide…She maybe would have needed someone to say, 'Yes, I know. I know because I wanted to die too. I was in the same hell as you. There was no way out.' And then sharing with her the tools that helped…Instead of just locking them up somewhere, like the hospital… if there was a program that you could take 10 kids …with a nurse, or a social educator, and a person who has passed through similar hardships…Going on a pilgrimage (for example), where you can walk for months, where you can bond with the people you are with, and you, you live outside…I feel that Laura would have liked that.

Such reflections emphasized a desire for healing environments rooted in shared lived experience, connection to nature, and long-term relational support, rather than containment in clinical settings.

Key Informant Feedback

KI#3 provided further reflections after reviewing a draft of the results section:

> We need to shift from the idea that everyone has to handle their own emotions… Regulation is so much harder when you're autistic. I believe so much of the 'problem' of autism, the list of symptoms associated with autism—which is unfortunately almost exclusively how autism is defined—comes down to having a nervous system that is prone to dysregulation…Measures of support in terms of creative and self-expression, in terms of co-regulation, in terms of feeling understood and given a sense of belonging, would go such a long way in suicide prevention.
>
> Reading the results really underlined key points for me to help me understand and give clarity to my hospitalization experiences. Specifically, the importance of creative expression, of opportunities to feel understood and to feel someone truly cared, of environmental aids for nervous system regulation (in terms of textures, lighting, smells), and of opportunities for co-regulation with other humans or animals.

KI#3's reflections highlighted the importance of environmental aids for nervous system regulation (e.g., textures, lighting, smells) and opportunities for co-regulation with humans or animals.

Discussion

This study aimed to provide insights into the manifestation of suicidality, identify both supportive and harmful interventions, and offer a roadmap to enhance suicide prevention protocols for autistic individuals facing acute suicidality in Spain.

Manifestations of Suicidality in Key Informants

The cases of Laura (KI#1) and KI#3 illustrate distinct yet overlapping pathways to suicidality in autistic individuals, characterized by chronic distress, emotional dysregulation, and institutional trauma. Laura's diaries reveal a progression of suicidality beginning at age 12, marked by escalating demoralization, thwarted belonging, and perceived burdensomeness. Her writings reflect intense despair—"I just want to exit this world…Everything is too

intense"—alongside classic features of demoralization, including hopelessness and diminished self-esteem (Ramm et al., 2023; Ibáñez del Prado, 2017) as well a sense of "giving up," lacking resources for change, and feelings of loneliness, uniqueness, and being poorly understood (Ibáñez del Prado, 2017; An et al., 2018). Despite this, her preserved capacity for joy and future-oriented thinking ("I want to get out of here…I will make a list") challenges assumptions linking suicidality exclusively to anhedonia, highlighting the need to disentangle autistic suicidality from traditional depression frameworks.

In contrast, KI#3's suicidality emerged from lifelong sensory and emotional dysregulation, with self-harm serving as a regulatory mechanism rather than a suicidal act. Her suicide attempt, described as impulsive and rooted in overwhelming distress—"Wanting to kill myself as punishment…Life is so unfair"—underscores the role of neuroception (Porges, 2011) in autism, where neutral cues are misinterpreted as threatening, triggering fight-flight-freeze responses (Chua, 2023). Both cases reveal how institutional practices, such as involuntary hospitalization and punitive restraint, exacerbated trauma and reinforced feelings of powerlessness. KI#3's reflection on being "treated like a criminal" during hospitalization aligns with research showing that coercive interventions deepen demoralization and suicidality risk (Costanza et al., 2020). These narratives emphasize the heterogeneity of autistic suicidality, where social exclusion, sensory overwhelm, and loss of agency intersect.

Unhelpful or Harmful Interventions

Key informants described a range of harmful and unsupportive interventions encountered during psychiatric hospitalization, many of which exacerbated distress and undermined wellbeing. Impersonal and disorienting admission processes, lack of meaningful communication, and restrictive visitation policies contributed to a profound sense of helplessness and emotional isolation. Sensory discomfort and boredom, compounded by staff's limited understanding of autism, often resulted in increased dysregulation and emotional distress. The use of mechanical restraints, seclusion, and punitive measures for rule violations was especially damaging, with both Laura and KI#3 describing these interventions as traumatic and dehumanizing—experiences echoed in the broader literature (Lanthen, Rask & Sunnqvist, 2015; Hamid & Daulima, 2018) which documents the disproportionate use of restraint and seclusion among autistic inpatients and the associated risk of psychological harm and post-traumatic stress (House of Commons Library, 2022).

Inappropriate or ineffective pharmacological interventions, including overmedication and adverse effects from electroconvulsive therapy (ECT), further contributed to negative outcomes.

A recurring theme was the loss of agency, with restrictions on personal autonomy and punitive responses to non-compliance leading to meltdowns, internalized shame, and persistent feelings of being treated as a criminal. These findings align with national and international reports highlighting that mental health services frequently fail to accommodate the distinctive needs of autistic individuals, often relying on restrictive practices that can result in long-term trauma, diminished self-worth, and increased suicidality (House of Commons Library, 2022; Calabrese, Sideridis & Weitzman, 2024). If psychiatric hospitalization inadvertently reduces agency, lowers self-esteem, and hinders connections, it may heighten demoralization and, consequently, increase suicidal ideation and risk after discharge. This underscores the need for mental health interventions that actively support agency, emotional regulation, and meaningful connection—rather than relying exclusively on frameworks tailored to major depression (Costanza et al., 2020).

While depression often calls for pharmacological intervention and rest as a first-line approach, interventions for demoralized individuals require a different orientation—one that prioritizes restoring a sense of purpose and self-efficacy (Ibáñez del Prado, 2017; Kugler et al., 2023). Effective strategies for demoralized individuals include facilitating problem resolution, exploring meaning within personal life history, identifying new life goals, strengthening relationships, examining attitudes about hope, addressing cognitive distortions, and creating therapeutic relationships that foster vulnerability and trust (Ibáñez del Prado, 2017). A sustained lack of agency—when individuals feel powerless to influence their circumstances—can deepen demoralization and significantly increase the risk of suicidality, particularly when emotional needs are unmet and coping resources remain out of reach (Costanza et al., 2022; Berardelli et al., 2020).

Helpful interventions

Key informants identified a range of inpatient interventions that were perceived as supportive and beneficial for autistic individuals experiencing acute suicidality. Central to these positive experiences was a compassionate approach to self-harm and the consistent availability of emotional support during moments of distress, which helped de-escalate crises and fostered a sense of safety. Interventions such as art therapy and animal-assisted therapy were highly valued for providing creative outlets and opportunities for emotional expression, as well as for promoting motivation and wellbeing. Sensory modulation techniques—including the use of weighted blankets, massage devices, and access to movement-based activities—were instrumental in helping autistic inpatients regulate their nervous systems and reduce sensory overload. The environment at Mutua Terrassa Hospital, which specialized in serving autistic youth, exemplified many of these best practices: patients benefited from engaging activities, visual supports for daily routines, and policies that allowed greater freedom and parental presence, all of which contributed to a reduction in distress and an increase in wellbeing. The presence of empathetic nursing staff and a minimum restraint protocol further distinguished supportive settings from more restrictive or punitive environments.

Innovative, Autism-Adapted Interventions to Address Suicidality

Key informants suggested a range of innovative, autism-adapted interventions to address suicidality, moving beyond traditional psychiatric models. Recommendations included improved autism screening in psychiatric hospitals—particularly for adults and women, who are often underdiagnosed—as well as structured, supportive onboarding processes that use clear communication and visual aids to reduce distress during admission. Tools and therapies for managing sensory sensitivities and strong emotions were identified as essential, with sensory regulation strategies, mindfulness, and creative outlets such as art, dance, and music described as vital for emotional expression and wellbeing. Internal Family Systems (IFS) therapy, which helps individuals understand and harmonize their internal experiences, was highlighted for its non-pathologizing, empowering approach (Schwartz & Sweezy, 2019; Bartov, n.d.). The importance of co-regulation—soothing and stabilizing emotional states through connection with attuned others—was repeatedly underscored, reflecting both lived experience and neurobiological theory (Bennie, 2024; Porges, 2011; Chua, 2023).

Informants also advocated for programs led by autistic mentors and community-based interventions, including nature-based activities, which foster belonging, mutual understanding, and resilience. Peer mentoring has been shown to enhance social skills, communication, and confidence among autistic individuals (Tuaf & Orkibi, 2023; O'Hagan et al., 2023; Trevisan et al., 2021). Recent research supports these priorities: autism-adapted safety planning interventions have shown promise in reducing self-harm and suicidality when co-developed with autistic people and tailored to their communication and sensory needs (Rodgers et al., 2024). Peer mentoring programs, such as TEAM and AMI, have demonstrated effectiveness in enhancing social support, confidence, and emotional adjustment among autistic youth and adults (O'Hagan et al., 2023; Morris, 2022). In addition, community-based and nature-oriented interventions—such as pilgrimage—may offer therapeutic benefits. While not appropriate as first-line treatment for clinical depression (Hilario & Sy Su, 2023), such experiences have been associated with reduced anxiety and increased emotional well-being through community connection and a change in environment (Morris, 1982; Hilario & Sy Su, 2023).

Roadmap for Tailored Inpatient Interventions

Based on the insights provided by key informants, this exploratory study offers a roadmap for tailoring psychiatric hospitalization protocols to better meet the needs of autistic people. Table 2 presents specific recommendations across domains such as admission and onboarding, therapeutic bond and staff approach, physical environment, emotional strategies, and programs and peer support.

Table 2. Recommendations for Interventions Offered to Autistic Individuals Facing Suicidality

Domain	Recommendation
Admission & Onboarding	- Avoid mechanical restraint during the first journey to the psychiatric hospital. - Explain hospital routines and objectives with visual aids upon and prior to arrival. - Implement autism screening protocols in psychiatric hospitals.
Therapeutic Bond & Staff Approach	- Avoid writing notes on computers while attending to suicidal autistic patients and their parents. - Inquire openly about patients' experiences and apply psychotherapeutic approaches that support agency, explore life history, identify goals, counter hopelessness, and establish therapeutic bonds. - Address self-harm and meltdowns with de-escalation strategies. - Avoid punitive measures for non-compliance and minimize mechanical restraint, as these may have iatrogenic effects.
Physical Environment	- Create a stimulating environment that encourages agency, meaningful connections, motivation, and mastery. - Prioritize sensory regulation and implement practical solutions for sensory sensitivities.
Emotional Strategies	- Address loneliness with a warm and comforting presence, letting patients know that whatever they feel is ok. - Promote emotional regulation strategies, such as mindfulness techniques and interoception exercises. - Encourage emotional expression through various channels, including non-verbal creative outlets.
Programs & Peer Support	Support personal growth through active goal setting with a strengths-based approach. Create programs that incorporate older autistic mentors who have effectively navigated similar challenges and involve outdoor activities.

Note. Recommendations based on the author's analysis of qualitative data (interviews conducted in 2023 and journal entries written between 2015 and 2023), analyzed between 2023 and 2024.

Future Research Directions

This study underscores the necessity of participatory research approaches in autism and suicidality, with autistic individuals and their families meaningfully involved at every stage of research and intervention design. Future research should prioritize recruiting larger and more diverse samples, particularly of autistic women, to deepen understanding of suicidality's manifestations and to inform the development and evaluation of tailored interventions.

Further investigation is warranted into the roles of demoralization, emotional dysregulation, and co-regulation in autistic suicidality, as these dimensions remain insufficiently addressed in current inpatient protocols. Development and validation of assessment tools sensitive to these factors—beyond traditional depression measures—will be critical for both research and clinical practice.

Hospital-based interventions that foster co-regulation and emotional safety should be rigorously evaluated, including comparative studies of co-regulation and compassionate care versus restrictive practices such as physical restraint or seclusion. Research should also address how sensory-friendly environments and multisensory adjustments (e.g., lighting, textures, sound, and scent) can support emotional regulation and wellbeing in autistic patients.

The effectiveness of creative therapies—including art, music, and dance—warrants further study, particularly regarding their impact on emotional expression and resilience. Peer-led interventions, such as autistic peer mentoring for adolescents and young adults, should be systematically evaluated for their potential to reduce suicidality and enhance social connectedness and self-esteem. Community-based and nature-oriented programs, while not a substitute for clinical care, may offer additional benefits and should be explored as complementary supports.

Finally, alternative therapeutic models such as Internal Family Systems (IFS) should be tested for acceptability and efficacy within autistic populations, given their non-pathologizing and empowerment-focused approach. Advancing these research directions will be essential for building a compassionate, evidence-based, and neurodiversity-affirming mental health care system for autistic individuals at risk of suicidality.

Personal Reflections From the Researcher *(Author's Positionality)*

Including a reflexive statement acknowledges the influence of the researcher's perspective and lived experience on the research process and interpretation of findings. Reading Laura's journals fostered in me a deep sense of connection with her. Conducting this research has prompted me to question the current healthcare system's prioritization of 'safety' over individual agency and dignity. My experience of conducting this research has taught me that in moments of distress, what is most needed is compassion, dignity, agency, understanding, co-regulation, and support. Many hospitalization experiences were perceived as dehumanizing and traumatizing, inadvertently reinforcing demoralization and emotional dysregulation. Conducting this study has led me to shift my focus from combatting the suicidal thoughts of patients towards placing the emphasis on understanding their distress and, if possible, supporting them in developing their strengths and hopes and agency.

Conclusion

This study lays an important foundation for developing tailored interventions to support autistic youth grappling with acute suicidality. While its exploratory and qualitative nature limits the generalizability of findings, this study establishes a basis for developing tailored interventions to support autistic youth facing acute suicidality. By centering the voices and experiences of autistic people and their families, this work highlights the importance of agency, emotional regulation, and meaningful connection in both prevention and intervention efforts. Ongoing collaboration with autistic individuals and participatory research will be essential to refining and implementing effective, responsive mental health care.

commitment to advocating for mental health care that is compassionate, inclusive, and responsive to the realities of autistic individuals.

Funding

Conflict of Interest

The author declares no conflict of interest.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

An, E., Lo, C., Hales, S., Zimmermann, C., & Rodin, G. (2018). Demoralization and death anxiety in advanced cancer. *Psycho-Oncology, 27*(11), 2566–2572. https://doi.org/10.1002/pon.4843

ATLAS.ti Scientific Software Development GmbH. (2023). ATLAS.ti (Version 23) [Computer software]. ATLAS.ti. https://atlasti.com

Bartov, Y. (n.d.). IFS and neurodiversity [Webinar]. Internal Family Systems Portugal. https://internalfamilysystems.pt/multimedia/webinars/ifs-and-neurodiversity-yoav-bartov

Benevides, T. W., Shore, S. M., Palmer, K., Duncan, P., Plank, A., Andresen, M. L., Caplan, R., Cook, B., Gassner, D., Hector, B. L., Morgan, L., Nebeker, L., Purkis, Y., Rankowski, B., Wittig, K., & Coughlin, S. S. (2020). Listening to the autistic voice: Mental health   priorities to guide research and practice in autism from a stakeholder-driven project. *Autism: The International Journal of Research and Practice, 24*(4), 822–833. https://doi.org/10.1177/1362361320908410

Bennie, M. (2024, May 1). *Co-regulation–The bridge to self-regulation*. Autism Awareness Centre. https://autismawarenesscentre.com/co-regulation-the-bridge-to-self-regulation/

Berardelli, I., Corabi, F., Navari, S., Sarubbi, S., Cifrodelli, M., Erbuto, D., Innamorati, M., Lester, D., Pompili, M., & Amore, M. (2020). Demoralization and its relationship with depression and suicidal behavior. *Frontiers in Psychiatry, 11*, 186. https://doi.org/10.3389/fpsyt.2020.00186

Botha, M., & Cage, E. (2022). "Autism research is in crisis": A mixed method study of researchers' constructions of autistic people and autism research. *Frontiers in Psychology, 13*, 1050897. https://doi.org/10.3389/fpsyg.2022.1050897

Bottema-Beutel, K., Kapp, S. K., Lester, J. N., Sasson, N. J., & Hand, B. N. (2021). Avoiding ableist language: Suggestions for autism researchers. *Autism in Adulthood: Challenges and Management, 3*(1), 18–29. https://doi.org/10.1089/aut.2020.0014

Butjosa, A., Cruz, D., Richart, T., Ruiz Terradas, M., CCAMH Group, & Lacasa, F. (2024). Rapid response unit for children and adolescents at risk of suicide: Promoting therapeutic linkage and reducing the risk of relapse. *Actas Españolas de Psiquiatría, 52*(2), 72–82. https://doi.org/10.62641/aep.v52i2.1620

Calabrese, M. E., Sideridis, G., & Weitzman, C. (2024). Physical and pharmacologic restraint in hospitalized children with autism spectrum disorder. *Pediatrics, 153*(1), e2023062172. https://doi.org/10.1542/peds.2023-062172

Cassidy, S., Bradley, L., Shaw, R., & Baron-Cohen, S. (2018). Risk markers for suicidality in autistic adults. *Molecular Autism, 9*, 42. https://doi.org/10.1186/s13229-018-0226-4

Cassidy, S. A., Gould, K., Townsend, E., Pelton, M., Robertson, A. E., & Rodgers, J. (2020). Is camouflaging autistic traits associated with suicidal thoughts and behaviours? Expanding the interpersonal psychological theory of suicide in an undergraduate student sample. *Journal of Autism and Developmental Disorders, 50*(10), 3638–3648. https://doi.org/10.1007/s10803-019-04323-3

Cassidy, S. A., Robertson, A., Townsend, E., et al. (2020). Advancing our understanding of self-harm, suicidal thoughts and behaviours in autism. *Journal of Autism and Developmental Disorders, 50*, 3445–3449. https://doi.org/10.1007/s10803-020-04643-9

Cervantes, P. E., Li, A., Sullivan, K. A., Seag, D. E. M., Baroni, A., & Horwitz, S. M. (2023). Assessing and managing suicide risk in autistic youth: Findings from a clinician survey in a pediatric psychiatric emergency setting. *Journal of Autism and*

Developmental Disorders, 53(5), 1755–1763. https://doi.org/10.1007/s10803-022-05448-8

Chua, C. K. (2023). Using Polyvagal Theory to understand autistic meltdown. Asian Journal of Interdisciplinary Research, 6(4). https://doi.org/10.54392/ajir2342

Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. *JAMA Psychiatry, 74*(7), 694–702. https://doi.org/10.1001/jamapsychiatry.2017.1044

Cleary, M., West, S., McLean, L., Hunt, G. E., Hungerford, C., & Kornhaber, R. (2023). A scoping review of autism and the way it changes the presentation of suicidal thoughts and behavior compared to the general population. *Issues in Mental Health Nursing, 44*(4), 282–301. https://doi.org/10.1080/01612840.2022.2132329

Costanza, A., Baertschi, M., Richard-Lepouriel, H., Weber, K., Berardelli, I., Pompili, M., & Canuto, A. (2020). Demoralization and its relationship with depression and hopelessness in suicidal patients attending an emergency department. *International Journal of Environmental Research and Public Health, 17*(7), 2232. https://doi.org/10.3390/ijerph17072232

Costa, A. P., Loor, C., & Steffgen, G. (2020). Suicidality in adults with autism spectrum disorder: The role of depressive symptomatology, alexithymia, and antidepressants. *Journal of Autism and Developmental Disorders, 50*(10), 3585–3597. https://doi.org/10.1007/s10803-020-04433-3

Dillenburger, K., McKerr, L., Jordan, J. A., & Keenan, M. (2016). Staff training in autism: The one-eyed wo/man…. *International Journal of Environmental Research and Public Health, 13*(7), 716. https://doi.org/10.3390/ijerph13070716

Fletcher-Watson, S., Adams, J., Brook, K., Charman, T., Crane, L., Cusack, J., Leekam, S., Milton, D., Parr, J. R., & Pellicano, E. (2018). Making the future together: Shaping autism research through meaningful participation. *Autism, 23*(4), 943–953. https://doi.org/10.1177/1362361318786721 (Original work published 2019)

Friedman, S., Noble, R., Archer, S., Gibson, J., & Hughes, C. (2023). Respite and connection: Autistic adults' reflections upon nature and well-being during the COVID-19 pandemic. *Autism, 27*(8), 13623613231166462. https://doi.org/10.1177/13623613231166462

Hamid, M. A. Y. S., & Daulima, N. H. C. (2018). The experience of restraint-use among patients with violent behaviors in mental health hospital. *Enfermería Clínica, 28*, 295–299. https://doi.org/10.1016/S1130-8621(18)30173-6

Haydon, C., Doherty, M., & Davidson, I. A. (2021). Autism: Making reasonable adjustments in healthcare. *British Journal of Hospital Medicine, 82*(12), 1–11. https://doi.org/10.12968/hmed.2021.0314

Hayes, C., Palmer, V., Hamilton, B., Simons, C., & Hopwood, M. (2019). What non pharmacological therapeutic interventions are provided to adolescents admitted to general mental health inpatient units? A descriptive review. *International Journal of Mental Health Nursing, 28*(3), 671–686. https://doi.org/10.1111/inm.12575

Hedley, D., Cassidy, S., Templin, C., Hayward, S. M., Haschek, A., Bulluss, E., Den Houting, J., Kõlves, K., Maddox, B. B., Morgan, L., Moseley, R., Rabba, A. S., Rose, A., Stokes, M.A., & Young, R. L. (2022). Recommendations from the 2021 Australasian Society for Autism Research "Health, Wellbeing and Suicide Prevention in Autism" conference and roundtable. http://otarc.blogs.latrobe.edu.au/wp-content/uploads/2022/05/ASfAR-conference-final-report-v2.pdf

Hedley, D., Uljarević, M., Cai, R. Y., Bury, S. M., Stokes, M. A., & Evans, D. W. (2021). Domains of the autism phenotype, cognitive control, and rumination as transdiagnostic predictors of DSM-5 suicide risk. *PLOS ONE, 16*(1), e0245562. https://doi.org/10.1371/journal.pone.0245562

Hilario, R. C., & Sy Su, C. C. (2023). The efficacy and limits of pilgrimage as therapy for depression. *Religions, 14*(2), 181. https://doi.org/10.3390/rel14020181

Hirvikoski, T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P., & Bölte, S. (2016). Premature mortality in autism spectrum disorder. *The British Journal of Psychiatry, 208*(3), 232–238. https://doi.org/10.1192/bjp.bp.114.160192

Horowitz, L. M., Thurm, A., Farmer, C., Mazefsky, C., Lanzillo, E., Bridge, J. A., Greenbaum, R., Pao, M., Siegel, M., & Autism and Developmental Disorders Inpatient Research Collaborative (ADDIRC). (2018). Talking about death or suicide: Prevalence and clinical correlates in youth with autism spectrum disorder in the psychiatric inpatient setting. *Journal of Autism and Developmental Disorders, 48*(11), 3702–3710. https://doi.org/10.1007/s10803-017-3180-7

House of Commons Library. (2022, October 31). *Suicide prevention: Policy and strategy* (POST-PN-0722). https://researchbriefings.files.parliament.uk/documents/POST-PN-0722/POST-PN-0722.pdf

Hughes, C., Davies, B., Cassidy, S., & Autistica. (2020). *Supporting autistic children and young people through crisis – An Autistica evidence resource on suicide for crisis workers* [version 1; not peer reviewed]. *AMRC Open Research, 2*, 30. https://doi.org/10.21955/amrcopenres.1114928.1

Hull, L., Petrides, K. V., Allison, C., Smith, P., Baron-Cohen, S., Lai, M. C., & Mandy, W. (2017). "Putting on my best normal": Social camouflaging in adults with autism spectrum conditions. *Journal of Autism and Developmental Disorders, 47*(8), 2519–2534. https://doi.org/10.1007/s10803-017-3166-5

Hutchinson, P., & Foster, B. (2019). *In crisis with autism spectrum disorder: Review of the evidence*. Autism Nova Scotia. https://www.autismnovascotia.ca/wp-content/uploads/2022/11/In-Crisis-with-Autism-Spectrum-Disorder-Review-of-Evidence.pdf

Ibáñez del Prado, C. (2017). Manual para la atención psicosocial y espiritual a personas con enfermedades avanzadas. Intervención psicológica y espiritual [Review of the book *Manual para la atención psicosocial y espiritual a personas con enfermedades avanzadas*]. *Psicooncología, 13*(2-3), 433–434. https://doi.org/10.5209/PSIC.54448

Instituto Nacional de Estadística. (2024). Estadística de defunciones según la causa de muerte. https://www.ine.es/dyngs/Prensa/pEDCM2023.htm

Infocop. (2023). El suicidio se mantiene como la primera causa externa de muerte en España, según el INE. *Consejo General de Psicología en España*. https://www.infocop.es/el-suicidio-se-mantiene-como-la-primera-causa-externa-de-muerte-en-espana-segun-el-ine-2/

Jachyra, P., Lai, M. C., Zaheer, J., et al. (2022). Suicidal thoughts and behaviours among autistic adults presenting to the psychiatric emergency department: An exploratory chart review. *Journal of Autism and Developmental Disorders, 52*, 2367–2375. https://doi.org/10.1007/s10803-021-05102-9

Jager-Hyman, S., Maddox, B. B., Crabbe, S. R., & Mandell, D. S. (2020). Mental health clinicians' screening and intervention practices to reduce suicide risk in autistic

adolescents and adults. *Journal of Autism and Developmental Disorders, 50*(10), 3450–3461. https://doi.org/10.1007/s10803-020-04441-3

Kapp, S. K., Steward, R., Crane, L., Elliott, D., Elphick, C., Pellicano, E., & Russell, G. (2019). 'People should be allowed to do what they like': Autistic adults' views and experiences of stimming. *Autism, 23*(7), 1782–1792. https://doi.org/10.1177/1362361319829628

Kugler, C., Bruehl, A. B., Tschan, T., & Berthoud, L. (2023). Demoralization as a transdiagnostic construct in psychosomatic medicine: A narrative review. *Psychotherapy and Psychosomatics, 92*(3), 139–147. https://doi.org/10.1159/000530760

Lai, M. C., Lombardo, M. V., Ruigrok, A. N., Chakrabarti, B., Auyeung, B., Szatmari, P., Happé, F., Baron-Cohen, S., & MRC AIMS Consortium. (2017). Quantifying and exploring camouflaging in men and women with autism. *Autism, 21*(6), 690–702. https://doi.org/10.1177/1362361316671012

Lanthén, K., Rask, M., & Sunnqvist, C. (2015). Psychiatric patients' experiences with mechanical restraints: An interview study. *Psychiatry Journal, 2015*, Article 748392. https://doi.org/10.1155/2015/748392

Leicestershire Partnership NHS Trust. (n.d.). *Understanding autistic meltdowns and shutdowns*. Autism Space. https://www.leicspart.nhs.uk/autism-space/health-and-lifestyle/meltdowns-and-shutdowns/

MacLennan, K., O'Brien, S., & Tavassoli, T. (2022). In our own words: The complex sensory experiences of autistic adults. *Journal of Autism and Developmental Disorders, 52*(7), 3061–3075. https://doi.org/10.1007/s10803-021-05186-3

Mazefsky, C. A. (2015). Emotion regulation and emotional distress in autism spectrum disorder: Foundations and considerations for future research. *Journal of Autism and Developmental Disorders, 45*(11), 3405–3408. https://doi.org/10.1007/s10803-015-2602-7

Morris, I. F., Matta, C., & Fung, L. K. (2022). A scoping review of peer mentoring programs for autistic college students. *Review Journal of Autism and Developmental Disorders.* https://doi.org/10.1007/s40489-022-00325-7

Morris, P. A. (1982). The effect of pilgrimage on anxiety, depression and religious attitude. *Psychological Medicine, 12*(2), 291–294.

https://doi.org/10.1017/S0033291700046626

National Autistic Society. (2018). Stories from the Spectrum: Alexis Quinn. National Autistic Society. https://www.autism.org.uk/advice-and-guidance/stories/stories-from-the-spectrum-alexis-quinn

National Institute for Health and Care Excellence. (2022). Self-harm: Assessment, management and preventing recurrence (NICE guideline NG225). https://www.nice.org.uk/guidance/ng225

Newell, V., Phillips, L., Jones, C., Townsend, E., Richards, C., & Cassidy, S. (2023). A systematic review and meta-analysis of suicidality in autistic and possibly autistic people without co-occurring intellectual disability. *Molecular Autism, 14*(1), 12. https://doi.org/10.1186/s13229-023-00544-7

O'Hagan, B., Sonikar, P., Grace, R., Castillo, D., Chen, E., Agrawal, M., Dufresne, S., Rossetti, Z., Bartolotti, L., & Krauss, S. (2023). Youth and caregivers' perspective on Teens Engaged as Mentors (TEAM): An inclusive peer mentoring program for autistic adolescents. *Journal of Autism and Developmental Disorders, 53*(6), 2219–2231. https://doi.org/10.1007/s10803-022-05543-w

O'Halloran, L., Coey, P., & Wilson, C. (2022). Suicidality in autistic youth: A systematic review and meta-analysis. *Clinical Psychology Review, 93*, 102144. https://doi.org/10.1016/j.cpr.2022.102144

Porges, S. W., & Furman, G. G. (2011). The early development of the autonomic nervous system provides a neural platform for social behavior: A polyvagal perspective. Infant and Child Development, 20(1), 106–118.

Ramm, M., Jedamzik, J., Lenz, P., Poopana, A., Heuft, G., & Conrad, R. (2023). Psychometric properties and normative values of the revised demoralization scale (DS-II) in a representative sample of the German general population. *BMC Psychiatry, 23*(1), 13. https://doi.org/10.1186/s12888-023-05187-9

Rodgers, J., Goodwin, J., Gordon, I., O'Keeffe, S., Carling, S., Berresford, A., Bhattarai, N., Wilkinson, J., Baird, J., & Cassidy, S. (2024). Feasibility and acceptability of autism adapted safety plans: An external pilot randomised controlled trial. *eClinicalMedicine, 73*, 102662. https://doi.org/10.1016/j.eclinm.2024.102662

Rodgers, J., Goodwin, J., Nielsen, E., et al. (2023). Adapted suicide safety plans to address self-harm, suicidal ideation, and suicide behaviours in autistic adults: Protocol for a

pilot randomised controlled trial. *Pilot and Feasibility Studies, 9*, 31. https://doi.org/10.1186/s40814-023-01264-8

Salvatore, G. L., Simmons, C. A., & Tremoulet, P. D. (2022). Physician perspectives on severe behavior and restraint use in a hospital setting for patients with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 52*(10), 4412–4425. https://doi.org/10.1007/s10803-021-05327-8

Schwartz, R. C., & Sweezy, M. (2019). Internal family systems therapy (2nd ed.). Guilford Press. Trevisan, D. A., Leach, S., Iarocci, G., & Birmingham, E. (2021). Evaluation of a peer mentorship program for autistic college students. Autism in Adulthood, 3(2), 187–194. https://doi.org/10.1089/aut.2019.0087

Tuaf, H., & Orkibi, H. (2023). Community-based programs for youth with mental health conditions: A scoping review and practical implications. *Frontiers in Public Health, 11*, 1241469. https://doi.org/10.3389/fpubh.2023.1241469

Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behaviour. *The Lancet, 387*(10024), 1227–1239. https://doi.org/10.1016/S0140-6736(15)00234-2

Wachob, D., & Pesci, L. J. (2017). Brief report: Knowledge and confidence of emergency medical service personnel involving treatment of an individual with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 47*(3), 887–891. https://doi.org/10.1007/s10803-016-2957-4

Weaver, N. D., Stergachis, A., Franklin, R. C., Abbasi-Kangevari, M., Abdoli, A., Alipour, V., Alvis-Guzman, N., Ancuceanu, R., Aravkin, A. Y., Bärnighausen, T., Bottecchia, M., Castaldelli-Maia, J. M., Choi, J. Y. J., Cornaby, L., Daoud, F., Doku, D. T., Fernandes, E., Florescu, M., ... Murray, C. J. L. (2024). Global, regional, and national burden of suicide,1990–2021: A systematic analysis for the Global Burden of Disease Study 2021. *The Lancet Public Health, 10*(3), e189–e202. https://doi.org/10.1016/S2468-2667(24)00009-1

Zeidan, J., Fombonne, E., Scorah, J., Ibrahim, A., Durkin, M. S., Saxena, S., Yusuf, A., Shih, A., & Elsabbagh, M. (2022). Global prevalence of autism: A systematic review update. *Autism Research, 15*(5), 778–790. https://doi.org/10.1002/aur.2696